

Summary Plan Description

IMPORTANT BENEFITS INFORMATION

FRONTIER CWA 1298 EMPLOYEE MEDICAL PROGRAM

(formerly referred to as “East Bargained”)

(Health Care Network Option)

This is a summary plan description (SPD) for the CWA 1298 Employee Medical Program, a component program under the Frontier Communications Health Care Plan, Plan 505. This SPD replaces the prior Medical SPD for the Health Care Network Option and all of its summaries of material modifications. Please keep this SPD for future reference.

Medical Summary Plan Description/January 1, 2026

PK 094/AF-HCN
PK 095/AG- HCN/ONA

IMPORTANT INFORMATION

In all cases, the official Plan document, which consists of this SPD and all of its SMMs, along with the Plan document for the Frontier Health Care Plan, No. 505, governs and is the final authority on the terms of the Program. Frontier reserves the right to terminate or amend the Program at any time for any reason. Participation in the plans and programs is neither a contract, nor a guarantee of future employment. The Plan provides other benefits, and not all employees are eligible for all benefits under the Plan. Different SPDs describe other benefits and different SPDs apply to different classifications of employees.

What Is This Document?

This document is a summary plan description (SPD) and is a guide to your Program Benefits. This SPD, together with the SMMs issued for this Program, constitute your SPD for this Program with respect to Benefits provided under this Program. See the “Eligibility and Participation” section for more information about Program eligibility and other Programs under the Plan.

What Information Do I Need to Know to Use This SPD?

Eligibility, participation, benefit provisions, forms of payment and other Program provisions depend on certain factors such as your:

- Employment status (for example full-time or part-time)
- Job title classification
- Employer
- Service history (for example, hire date, Termination Date or Term of Employment)

To understand how the various provisions affect you, you will need to know the above information. The Benefits Administrator can provide these details. See the “Contact Information” section for more information on how to contact the Benefits Administrator.

What Action Do I Need to Take?

You should review this SPD in its entirety so that you can understand the details of your Program.

How Do I Use This Document?

As you read this SPD, pay special attention to the key points at the beginning of most major sections and shaded boxes that contain helpful examples and important notes. While Frontier has provided these tools to help you better understand the Program, it is important that you read the SPD in its entirety, so that you can understand the Program details. Also, throughout this SPD, there are cross-references to other sections in the SPD. Please consult the Table of Contents to help you locate these cross-referenced sections.

Keep your SPDs and SMMs for your future reference. They are your primary resource for your questions about the Program.

Questions?

If you have any questions regarding information in this SPD or other questions about the Program, contact the Frontier Benefits Service Center at 1-855-387-2887.

Si usted tiene dificultad que entiende este SPD, entre en contacto con el Frontier Benefits Service Center.

Frontier Benefits Service Center

The Frontier Benefits Service Center offers a Web site called Frontier Benefits Service Center™ where you'll find tools to help you manage your benefits. You can access Frontier Benefits Service Center on the About You page on the Internet at <http://www.frontierbenefitscenter.com>.

The Web site makes finding information fast and easy as it guides you through your benefits transactions, including enrollment. In addition to enrolling on the site, you can:

- Hotlink to other provider sites.
- Create and print personalized provider listings and maps to providers' offices for most plans.
- Review details about your healthcare and insurance plans.
- Select and update your beneficiary designations.
- Verify your Frontier elections that are on file at the Frontier Benefits Service Center.
- Change Frontier Benefits Service Center password.
- Give yourself a helpful "hint" in case you forget your password.

Frontier Benefits Service Center representatives are available should you have questions about your benefits. To reach the Frontier Benefits Service Center via telephone, call 1-855-387-2887. Via this toll-free telephone number, you also can connect with other Frontier benefit providers.

Changes to the Plan

While Frontier Communications (Frontier) expects to continue the Plan indefinitely, Frontier also reserves the right to amend, modify, suspend or terminate the Plan at any time, at its discretion, with or without advance notice to participants, subject to any duty to bargain collectively, by action of its Board of Directors or its delegate or by publication of any SPD, summary of material modification, enrollment materials or other communication relating to the Plan, as approved by Frontier.

Decisions regarding changes to, or termination of, benefits are made at the highest levels of management. Frontier employees below those levels do not know whether Frontier will adopt any particular change and are not in a position to speculate about such changes. Unless and until changes formally are adopted and officially are announced, no one is authorized to assure that any particular change will or will not occur.

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

- *The Frontier Communications Health Care Plan, Plan Number 505 (Plan) is a welfare benefit plan providing coverage for health and welfare benefits through component Programs. Not all component Programs are available to all employees.*
- *This is a Summary Plan Description (SPD) for the Plan with respect to Benefits under the Frontier CWA 1298 Employee Medical Program.*
- *This document is an SPD for the portion of the Program that applies to eligible Bargained Employees of Participating Companies.*

This is a Summary Plan Description (SPD) for the Frontier Communications Health Care Plan (Plan). The Plan incorporates certain welfare plans sponsored by Frontier. Benefits under the Plan are provided through separate component programs. A program is a portion of the Plan that provides benefits to a particular group of participants or beneficiaries. Each program under the Plan applies to a specified set of benefits and group of Employees.

This SPD is a legal document that provides comprehensive information about the Frontier CWA 1298 Employee Medical Program (Program).

It provides information about eligibility, enrollment, contributions and legal protections for the Program Benefits for active Bargained Employees of Participating Companies under the Health Care Network (HCN) Option.

The Program also offers a Preferred Provider Organization (PPO) Option. You can find information about the PPO in the PPO Option SPD for the Program. Keep this SPD with your important papers and share it with your covered dependents.

Use this SPD to find answers to your questions about your Program Benefits in effect as of January 1, 2026. This SPD replaces all previously issued SPDs and Summary of Material Modifications (SMMs) for the portion of the Program covered in this SPD. To learn whether this SPD describes the Program provisions that apply to you, see the “Eligibility and Participation” section.

Company Labels and Acronyms Used in This SPD

Most of the information in this SPD applies to all participants. However, some Program provisions regarding eligibility, contributions, enrollment changes and Benefit levels may differ depending on your employment status, job title, employing Company and service history. When the SPD identifies differences that apply to participants of an employing Company or an employee group, acronyms are used to refer to the employing Company or the employee group rather than the official name of the employing Company or group.

Section References

Many of the sections of this SPD relate to other sections of the document. You may not obtain all of the information you need by reading only one section. It is important that you review all sections that apply to a specific topic. Also, see the footnotes and notes embedded in the text. They further clarify content, offer additional information or identify exceptions that apply to certain Covered Persons. These notes are important to fully understand Program Benefits.

Terms Used in This SPD

Certain words and terms are capitalized in this SPD. Some of these words and terms have specific meaning (see the “Definitions” section for their meaning).

Program Responsibilities

Your Physician or other health care Providers are not responsible for knowing or communicating your Benefits. They have no authority to make decisions about your Benefits under the Program. This Program determines Covered Health Services and Benefits available. The Plan Administrator has delegated the exclusive right to interpret and administer applicable provisions of the Program to Program fiduciaries. Their decisions, including in the Claims and Appeals process, are conclusive and binding and are not subject to further review under the Program. Neither the Program, its administrators nor its fiduciaries make medical decisions, and they do not determine the type or level of care or Course of Treatment for your personal situation. Only you and your Physician determine the treatment, care and Services appropriate for your situation.

Summary of Benefits and Coverage

This medical option also has a Summary of Benefits and Coverage (referred to as an “SBC” or “Summary”). The Summary is based on a short model document required by the Affordable Care Act. The Affordable Care Act requirement is intended to standardize the description of medical options in the United States so that individuals can easily compare medical option choices. While the Summary is a concise “snapshot” of the medical benefits under this Medical Option, the Summary is not intended to take the place of this Summary Plan Description (SPD) or the official plan document. Nothing in a Summary makes you eligible for this Program or any medical benefits under this Program unless the official plan document and this SPD provide for such eligibility or benefits. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents and the applicable SPD.

Health Insurance Marketplace

Most U.S. citizens are able to purchase health coverage for themselves and their family members through the Health Insurance Marketplace (otherwise known as an Exchange). If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if the Company does not offer you coverage under a health plan that is “affordable” and provides “minimum value.” The Company believes that the coverage provided by this Plan provides minimum value and is affordable for substantially all participants. You will be given a notice at certain times which explains the coverage offered through Marketplace and any tax credit that may be available to you. You should review that notice carefully. You may request a copy of this notice from the Plan Administrator at any time, and one will be provided free of charge.

If you purchase a health plan through the Exchange instead of accepting health coverage offered by the Company, then you will lose any employer contribution (if any) toward the employer-coverage. Also, remember that this employer contribution – as well as your employee premium for employer coverage – is often excluded from income for Federal and State income tax purposes. Alternatively, premium payments for coverage through the Marketplace are made on an after-tax basis.

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ELIGIBILITY AND PARTICIPATION

KEY POINTS

- *You and your dependents are eligible for coverage under this Program if you meet the eligibility requirements described in this section.*
- *Eligibility rules differ based upon your employing Company and employment classification.*
- *The Program provides various levels of coverage for you or you and your dependents.*
- *You may be eligible for one or more coverage options under the Program.*

Eligibility at a Glance

This section includes information to help you determine if you are eligible for this Program. Review the next section “What Coverage Options are Available” for the level of coverage (e.g. Individual or Family) available under the Program and the “Program Options” subsection to determine what Program options are available under the Program. To determine if your dependents are eligible for this Program, see the “How to Determine if Your Dependents are Eligible for this Program” section.

In order to determine your eligibility for the Program, you need to know your employment classification and if you are in a bargaining unit or population group of Frontier referred to as CWA 1298.

Special eligibility rules apply to employees who transfer or change positions under circumstances specified in your collective bargaining agreement. If you move between bargained groups, contact the Frontier Benefits Service Center.

If you do not meet the eligibility requirements for the Program described in this Summary Plan Description (SPD), contact the Frontier Benefits Service Center for assistance in identifying the SPD that might apply to you.

Enrollment is not automatic. You must be enrolled in the Program to receive coverage. See the “Enrollment and Changes to Your Coverage” section for information on how and when you must enroll and effective dates of coverage.

Eligibility Rules	
Eligible Employees	
You are an Eligible Employee if...	<p>You are</p> <ul style="list-style-type: none"> (1) Actively at Work and employed by a Participating Company (2) A member of one of the covered bargaining units listed below; and (3) Classified by your Participating Company as one of the types of Employees listed below as eligible under the Program for your bargaining unit.
Population Groups: Employee Classifications	<p>CWA 1298</p> <ul style="list-style-type: none"> • Regular, or Temporary Employee

Eligibility Rules	
Dual Enrollment - Special Rule	
Dual Enrollment	While you may be eligible under more than one status (for example, as an Employee, Eligible Former Employee and a dependent in the Program), you are not allowed to be enrolled in this Program or any other medical program or plan sponsored by a member of the Frontier Controlled Group at the same time. In addition, you and your Spouse/Partner cannot cover your dependents at the same time. See the "Dual Enrollment" section for more information.

According to the employer mandate provisions of the Affordable Care Act, an employer may use the monthly measurement method and the look-back measurement method to determine an employee's full-time status for eligibility purposes. Under the look-back measurement method, an employer determines the status of an employee as a full-time employee during a future period (referred to as the "stability period"), based upon the hours an employee works in a prior period (referred to as the "measurement period"). For more information concerning your eligibility under the Plan, please contact the Frontier Benefits Service Center at 1-855-387-2887 or visit the Frontier Benefits Service Center Website at www.frontierbenefitscenter.com.

Rehired Eligible Former Employees

You are considered a "rehired retiree," also known as a "rehired Eligible Former Employee" and special eligibility rules apply if:

- You previously terminated employment as a CWA 1298 employee and at that time were eligible for medical coverage as an Eligible Former Employee (sometimes referred to as an eligible Retiree).
- Your eligibility for Post-Employment Benefits was a result of Age and Service Based Eligibility or Pension Based Eligibility.
- You are subsequently rehired by Frontier as a CWA 1298 employee.

If you are eligible to receive Benefits available to Eligible Former Employees (Retirees) as a CWA 1298 employee and you become employed as a regular CWA 1298 Bargained Employee, you are eligible to elect to receive Program coverage as an Active Employee in lieu of your Eligible Former Employee (Retiree) coverage. At the time of your re-employment, you will have the opportunity to make an irrevocable election between retaining your Eligible Former Employee (Retiree) coverage and choosing coverage as an Active Employee. If you do not contact the Frontier Benefits Service Center Eligibility within 31 days of your statement date and elect to receive coverage as an Active Employee, you will be deemed to have waived your option for Active Employee coverage and to have elected to continue your Eligible Former Employee (Retiree) coverage.

If you have questions, contact the Frontier Benefits Service Center.

How to Determine if Your Dependents Are Eligible for This Program

Review this section to determine if your dependents are eligible to enroll in the Program. Coverage for your Eligible Dependents is not automatic. **You must enroll your dependents if you want them to be covered under the Program.**

Unless your dependent's eligibility for coverage is due to surviving dependent status, military orders under Military Service Leave for those called to involuntary active duty by Presidential Executive, or COBRA continuation coverage, your dependent(s) cannot be enrolled in the

Program, unless you are also enrolled. In general, if more than one coverage option is available under the Program, you and your Eligible Dependents must be enrolled in the same coverage option, unless one or more of you and your Eligible Dependents are Medicare Eligible and others are not. However, in some instances, your Eligible Dependent(s) may be permitted to enroll in a different coverage option due to certain Network geographic restrictions. See the “Enrollment and Changes to your Coverage” section for more information. You may not cover a Spouse and a Partner as Eligible Dependents under the Program at the same time. In addition, there may be restrictions on whether you can cover another Employee or Eligible Former Employee as a dependent under this Program. See the “Dual Enrollment” section for more information.

The Company reserves the right to verify eligibility of any enrolled dependents. See the “Dependent Eligibility Verification” section for more information. Once a dependent is enrolled, it is your responsibility to contact the Frontier Benefits Service Center to cancel coverage whenever you have a dependent that is no longer eligible, including, for example, when you are divorced. See the “Enrollment and Changes to Your Coverage” section for more information.

If one of your dependents does not meet the eligibility requirements of the Program, the Program will not pay Benefits for any expenses incurred for that dependent. Also, if the Program pays Benefits for a dependent while the dependent is ineligible, you may be required to reimburse the Program for all such payments.

Note: If coverage for your dependent is based upon the terms of a Qualified Medical Child Support Order (QMCSO), see the “Alternate Recipients Under Qualified Medical Child Support Order” section for coverage information.

Eligible Dependents

Eligibility Rules	
Eligible Dependents	
Your dependents who meet the eligibility rule are eligible for Program coverage.	<p>(1) Your Spouse/Legally Recognized Partner (LRP).</p> <p>(2) Your Child(ren) until the end of the month in which the Child reaches the age of 26 regardless of marital status.</p> <p>The term Child(ren) means any of the following until the end of the month in which they reach age 26:</p> <ul style="list-style-type: none"> • Your biological Child(ren). • Child(ren) placed with you for purposes of adoption. • Child(ren) you have legally adopted or, your stepchild(ren). • The Child(ren) of your LRP. • Child(ren) for whom either you or your Spouse/LRP is a Legal Guardian. The term does not include wards of the state or foster Child(ren) who are not placed for adoption. <p>(3) Your unmarried Disabled Child(ren) who is mentally or physically disabled before the end of the month in which the Child reaches the age of 26. You must provide satisfactory evidence of disability in order for your Disabled Child(ren) to be eligible for coverage under the Program. In addition, an independent medical examination of your dependent may be required. See the “Disabled Children Eligibility” section for information on how to certify disability.</p>

Dual Enrollment

The Program is designed to provide coverage for you and your Eligible Dependents. However, the Program has rules limiting Dual Enrollment, as described below. Dual Enrollment means that you are enrolled for Program coverage and at the same time enrolled in another Company-sponsored medical program under a different eligibility status.

The Program does not permit you or a dependent to be enrolled in the Program as an Employee, Eligible Former Employee or Eligible Dependent at the same time. In addition, you and your dependents cannot be enrolled in this Program at the same time as you are enrolled in any other medical program or plan sponsored by Frontier.

Audits of Enrollment Status and Proof of Dependents

The Company reserves the right to audit at any time any enrollment election or other information you have provided to the Company in connection with your enrollment. This right to audit includes auditing the status of your enrolled spouse/partner and dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of your marriage/domestic partnership and for your enrolled dependent children. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be dis-enrolled from Company benefits, possibly retroactively.

This right to audit also includes whether the correct premium or contribution is being charged for your coverage, including any premium surcharge or additional premium. The application of the correct premium or contribution is always and completely subject to audit. The Company may apply the correct premium or contribution retroactively (due to an audit or otherwise).

Providing the Company with false or misleading information regarding your enrollment, a spouse/partner or dependent child, enrolling an individual who does not satisfy the eligibility criteria, or failing to drop an enrolled individual in a timely manner when he/she no longer satisfies the eligibility criteria may constitute fraud or misrepresentation. If the Company determines that fraud or misrepresentation has occurred, the Company may also terminate or suspend the employee's plan coverage, require repayment of an ineligible individual's prior claims, require payment of the total value of an ineligible individual's coverage or take other corrective action (retroactively or otherwise).

Classification of Employees

An individual shall not be treated as being in an employee classification, as of a particular time, unless the individual is formally assigned to an employee classification by the Company as of such time. This assignment can only be given to an individual in the unrestricted discretion of the Company, and the nature of the individual's role with the Company is irrelevant in determining whether an individual is classified as an employee for purposes of any benefit plan. An individual who is classified by the Company as an independent contractor or in another non-employee position shall not be treated as an employee eligible for any benefit plan. Any ambiguity or conflict in the employment records that relate to classification as an employee shall be resolved in all cases to deny the individual eligibility for the benefit plan. The Company shall determine whether an individual may be classified as an employee in its sole discretion.

Paying for Coverage

You and the Company share the cost of the plan. Log on to the Frontier Employee Benefits Center at www.frontierbenefitscenter.com to review your per paycheck contribution for coverage or refer to your collective bargaining agreement.

Note that employee contributions taken from Frontier payroll deductions generally are deducted on a before-tax basis.

The amount you pay for medical coverage is determined by:

- The option you choose
- Coverage level you choose

Note: If you are on Short-term disability or any other paid leave status and don't have sufficient wages to pay for your coverage, the unpaid portion of the premium for the group coverage will go into arrears and will be collected from your first paycheck upon returning to work. If you are on an unpaid leave you will be direct billed, on a monthly basis, from the Frontier Benefits Service Center. If you fail to pay the direct bill on a timely basis, your benefits will be terminated.

Sydney Health

Discover a powerful and more personalized health app. View all Your benefits and access wellness tools to improve Your overall health with the Sydney Health app.

The Sydney Health mobile app works with You by guiding You to better overall health — and for You by bringing Your benefits and health information together in one convenient place. Sydney Health has everything You need to know about Your benefits, so You can make the most of them while taking care of Your health.

Working with You

- Reminding You about important Preventive Care needs
- Guiding You with insights based on Your history and changing health needs
- Empowering You with personalized tools to find and compare healthcare Providers and check costs
- Storing Your Member Identification Card so You can show, email, or fax it right from Your phone

24/7 NurseLine

You may have emergencies or questions for nurses around the clock. 24/7 NurseLine provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, You can make more

informed decisions about the most appropriate and cost-effective use of healthcare services. A staff of experienced nurses is trained to address common healthcare concerns, such as medical triage, education, access to healthcare, diet, social/family dynamics, and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting, and refer You to programs and tools appropriate to Your condition.
- Bilingual RNs, language line, and hearing-impaired services.
- Access to the Audio Health Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 Emergency Services, poison-control, and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

Building Healthy Families

This digital program can help support Your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through our Sydney Health mobile app or at www.anthem.com, and features an extensive content library covering topics to support diverse families, including single parents and same-sex or multicultural couples. In addition, the app features many tools including fertility, diaper change, and feeding trackers, due date calculators, and blood pressure monitoring. Visit the Sydney Health app or www.anthem.com to enroll today.

WHAT COVERAGE OPTIONS ARE AVAILABLE

KEY POINTS

- *The Program provides coverage under one or more options.*
- *The Program options available to you are generally determined based on the ZIP code for your home address in Company records.*

Program Options

The Program provides coverage under one or more options. The Company Self-Funded Option(s) available to you and your enrolled dependents are determined based on the requirements specified below.

You will be able to elect one of the Company Self-Funded if you meet the requirements described below:

- **Company Self-Funded Health Care Network (HCN) Option:** The HCN includes the Network and ONA Options. Network and ONA Option availability will be determined based on your ZIP code in Company records. If your ZIP code is in the Network Area, you will be able to elect the HCN Network option. If your ZIP code is outside the Network Area, you will be able to elect either the HCN Network or ONA options.

- Company Self-Funded Preferred Provider Organization (PPO) Option availability is not determined by your ZIP code.

A separate Summary Plan Description (SPD) is available for your Company Self-Funded PPO.

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

- *You must enroll to receive Program coverage.*
- *For your dependents to receive Program coverage, you and your dependents must be enrolled.*
- *You must act within the required time frames for enrolling and making changes to your Program coverage. If you miss the window of opportunity to enroll or make changes to your elections, you may have a gap in coverage or may not be able to make changes you desire to your coverage.*
- *You have certain responsibilities. You must notify the Frontier Benefits Service Center if:*
 - Your address changes.
 - You have a change in enrollment.
 - You receive a Qualified Medical Child Support Order (QMCSO).
 - You or a covered dependent enrolls in Medicare.
 - An enrolled dependent loses eligibility for any reason, such as divorce and attaining a certain age.

Enrollment Levels of Coverage

The Program offers the following levels of coverage:

- Individual – You only
- Individual + 1 – You and one Eligible Dependent*
- Individual + 2 or more – You and two or more Eligible Dependents*

*This level of coverage is also known as Family Coverage.

Your Cost of Coverage varies depending on the level of coverage you choose.

Generally, all family members must be covered under the same coverage option. However, if an Eligible Dependent does not live within the Network Area of the coverage option elected, you may elect a different coverage option for that dependent. If different coverage options apply to you, each option has its own Annual Deductible and Annual Out-of-Pocket Maximum. Expenses under one option do not count towards the Annual Deductible and Annual Out-of-Pocket Maximum of another option.

Enrollment at a Glance

The “*Enrollment Rules for You*” table below indicates the enrollment opportunities for which you and your dependents are eligible, as well as the time frames for electing coverage and making changes. For more detailed information regarding types of enrollment, see the sections following the “*Enrollment Rules for You*” table.

Enrollment	
Newly Eligible Enrollment	Within 31 days of the later of your Hire Date or the date appearing on your enrollment materials - for coverage to be effective on your date of hire for Regular Employees or if you are a Temporary Employee, for coverage to be effective the first day of the month you complete six months of service provided you enroll within the 31-day initial enrollment period. If you miss the 31-day deadline, you will not be able to enroll until Annual Enrollment or if you are permitted to enroll due to a "Change-in-Status".
Annual Enrollment	During Annual Enrollment - for coverage to be effective on the first day of the following Plan Year.
Prospective Enrollment	At any time, changes to current coverage or newly elected coverage resulting from Prospective Enrollment are effective on the first day of the month following the request for enrollment. Prospective Enrollment does not permit you to change Program options. See the "Prospective Enrollment" section for further information about eligibility and how to prospectively enroll.
Change-in-Status Enrollment	See the "Change-in-Status Enrollment" section.

Initial Enrollment

To enroll for coverage, you must log on to www.frontierbenefitscenter.com or call the Frontier Benefits Service Center at 1-855-387-2887. You must enroll by the date established by the Plan Administrator for initial enrollment.

If you do not enroll by the date established by the Plan Administrator, you can only enroll for coverage effective as of the next annual enrollment period or special enrollment period, if earlier.

If you do not enroll your eligible Dependent when you first enroll, then you cannot enroll your Dependent for coverage until the next annual enrollment period or special enrollment period, if earlier.

Special Enrollment

If you declined medical coverage for yourself or your Dependents because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your Dependents in the Program if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependent's other medical coverage ends (or after the employer stops contributing towards the other coverage).

If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Program. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You may be able to enroll yourself and your Dependents in the Program (1) if your or your Dependent's coverage under a Medicaid plan or a State Children's Health Insurance Program ("CHIP") plan terminates due to loss of eligibility for such coverage, or (2) if you or your Dependents become eligible for premium assistance with respect to the Plan's medical coverage under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date of termination of such coverage or the date you or your Dependent are determined to be eligible for such assistance, whichever is applicable.

If you are already enrolled in medical coverage for yourself, you may be able to change your own medical coverage election in connection with enrolling a Dependent under the above special rules.

To request special enrollment or obtain more information, call the Frontier Benefits Service Center at 1-855-387-2887. Representatives are available Monday through Friday from 9:00 am to 6:00 pm Eastern Time.

Annual Enrollment

Annual Enrollment occurs each fall. During Annual Enrollment, you will be notified of the coverage options available to you for the next Plan Year. Your enrollment materials will also include information on coverage assigned to you if you do not take action.

IMPORTANT: The assigned coverage will be effective for the next Plan Year if you do not make an election.

It is important to review the materials and take action if needed. Your options, including your assigned coverage, may be different than your current coverage. Some options require you to actively enroll. Coverage begins January 1 of the following Plan Year.

IMPORTANT: If you have a Change-in-Status Event on or after the annual enrollment period and want to change your coverage, you need to make two separate elections:

- 1) Change your current coverage in effect through the end of the Plan Year, and
- 2) Update your Annual Enrollment elections for coverage beginning January 1.

You can enroll online through the Frontier Benefits Service Center website or by calling the Frontier Benefits Service Center.

Prospective Enrollment

Prospective Enrollment means the ability to drop or add coverage for yourself or a dependent outside of Annual Enrollment, newly eligible enrollment or Change-in-Status Events. In general, Prospective Enrollment is available to all Covered Persons who are Active Employees and Eligible Former Employees.

Change to current coverage or newly elective coverage resulting from Prospective Enrollment are effective on the first day of the month following the request for enrollment.

Change-in-Status Enrollment

Circumstances often change. You may get married, welcome a Child to the family, lose benefits under another employer's medical plan or you or a family member takes a leave of absence. These important events are called "Change-in-Status Events" and the Program allows you to change your enrollment when you experience specific Change-in-Status Events. See the "Change-in-Status Event" section for more information on events that are considered a Change-in-Status.

- Your ability to change your Program enrollment when you experience a Change-in-Status Event during a Plan Year is in addition to Annual or Prospective Enrollment opportunities.

If a Change-in-Status event also triggers a right to enroll mid-year in a Marketplace plan, you may be allowed to drop your medical coverage under this Program and enroll in a Marketplace plan. However, your new coverage must be effective beginning on the date following the last day of coverage under this Program. For additional information, you should call the Frontier Benefits Service Center.

Notice of a Change-In-Status Event

It's important to consider how a change will impact your benefits. If any Change-in-Status Event occurs and you want to change your enrollment choices, you must inform the Frontier Benefits Service Center within 31 days after the event.

There are some exceptions to this rule:

- If you gain or lose eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, you must provide notice within 60 days of the gain or loss of coverage.
- If you or a covered dependent dies, the Frontier Benefits Service Center should be notified as soon as possible to initiate the appropriate changes to Program enrollment.

The Effective Date of Your Change-In-Status Enrollment

It is very important that you provide the required notice within the time frames stated above when requesting a change to your enrollment. Your eligibility to make a change and the effective date of your request for your change in enrollment depends on when you request that change.

To change your enrollment, contact the Frontier Benefits Service Center.

As noted above, your change in enrollment request is subject to review by Frontier. This review could have an impact on the effective date of your enrollment. For example, if you request enrollment for your newly eligible Child, your enrollment is subject to the same rules that apply to newly Eligible Employees and dependents, including submitting any required documentation. Failure to submit the documents on time may delay his or her effective date of coverage under the Program beyond the effective dates listed below. See the "Dependent Eligibility Verification" section for more information.

If you request your enrollment change within the specified time frame and you provide all documentation requested by the Frontier Benefits Service Center within the time required, your new enrollment will become effective either on:

- The date of the Change-in-Status Event in the case of birth, adoption or placement for adoption.
- On the first of the month after the event for all other Change-in-Status Events.
- If you do not provide notification within the time frames noted above, your enrollment will become effective on the first day of the month following the date you notify the Frontier Benefits Service Center.

Your Change in Status May Affect Your Tax Treatment of Your Contributions

A change in enrollment may lead to an adjustment to your required contributions and may also affect the tax treatment of your new contribution amount.

IMPORTANT: This section does not contain information about your right to change the amount of your before-tax contribution. The section outlines your right to change your Program coverage enrollment only. For more information on how contributions are affected by Change-in-Status Events, please see the “Before-Tax and After-Tax Contributions” section.

Enrollment Rules for Your Dependents

Program coverage is not automatic for you or your Eligible Dependents. You must enroll through the Frontier Benefits Service Center to have coverage. To enroll a dependent, you must be enrolled in coverage.

IMPORTANT: Special enrollment provisions apply if you do not enroll when you are first eligible. See the “Enrollment Rules for You” section.

Your dependent enrollment elections can be made:

- During Annual Enrollment — for coverage beginning the first day of the following Plan Year.
- Within 31 days of the later of your Hire Date or the date on your enrollment materials — for coverage beginning on your date of hire.

As a Regular Employee, you may defer when coverage begins for you and your Eligible Dependents until you are eligible for the Company contribution toward your medical coverage. See the “Eligibility and Participation” and “Contribution” sections for information.

- After a Change-in-Status Event. See the “Change-in-Status Events” section for additional information, including a list of Change-in-Status Events and the changes in coverage you are allowed to make. A Change-in-Status-Event includes the date you are first eligible for the Company contribution toward your medical coverage.
 - For Prospective Enrollment, at any time during the year with coverage beginning at a later date. See the section on “Prospective Enrollment” for more information.

For information about contributions required to maintain your Program coverage, see the “Contributions” section.

IMPORTANT: If you are denied enrollment in the Program, you have the right to file a Claim for Eligibility. See the “How to File a Claim for Eligibility to Enroll or Participate in the Program” section for information.

Dependent Eligibility Verification

Your dependent may participate in the Program if he or she is eligible under the terms of the Program and enrolled.

In order to enroll your dependent, you must call the Frontier Benefits Service Center and provide the information and documentation requested. For example, to enroll a new dependent, you may

be required to provide a copy of a birth certificate and/or other specified document that establishes the Child's relationship to you.

IMPORTANT: You must provide documentation proving the eligibility of your dependent within the deadlines provided and before your dependent's coverage can become effective under the Program.

If the Frontier Benefits Service Center denies your application to add your dependent for coverage under the Program, you may file a Claim on this decision. If your initial Claim is denied, you may appeal that decision. See the section on "How to File a Claim for Eligibility to Enroll or Participate in the Program."

If you do not provide the required documentation prior to the deadline stated, your dependents will not be enrolled for coverage under the Program retroactively.

Note: Enrollment of an ineligible dependent in the Program constitutes benefits fraud, which may result in legal action and financial consequences.

Disabled Children Eligibility

A physically or mentally disabled child, who meets the above requirements under "Required Child Coverage" or "Other Child Coverage", is eligible for coverage even though he or she has reached the maximum age limit, if:

- your child is enrolled for coverage and disabled on the date coverage would usually end (for example, prior to age 26 when coverage would end for a biological or adopted child),
- your child satisfies the rules to be your dependent for federal tax purposes,
- your child is unmarried,
- your child was covered under the Plan prior to the date the disability began, and you provide proof of your child's disability (for example, a copy of the Social Security Disability Award).

If you are a new or an existing employee and you have a physically or mentally disabled child who is over the age limit, your child may be eligible for coverage provided:

- the disability occurred prior to reaching the applicable age limit,
- your child satisfies the rules to be your dependent for federal tax purposes,
- your child is unmarried,
- you provide proof that the child had continuous major medical health coverage through a prior employer or your spouse's or domestic partner's employer from the date of disability up to the date in which you try to add the child to your Plan coverage, and
- you provide proof of your child's disability (for example, a copy of the Social Security Disability Award).

If you don't want your child's claim processing to be delayed, provide proof that your child satisfies the above rules to be disabled at least 120 days before the child's coverage usually would end. If your disabled child is already older than the age limit when you are first eligible to enroll, you should submit evidence that you satisfy the above rules of your child's disability to the Plan

Administrator. During initial and subsequent enrollment periods you may be required to provide additional information regarding your child's continuous disability.

As set forth above, you must provide proof that your child satisfies the rules to be your dependent for federal tax purposes. This does not mean that you must claim your child as your tax dependent- only that your child must meet the rules to be your dependent. This means that your child must satisfy the rules to be your "qualifying child" or your "qualifying relative" as those terms are used for federal tax purposes. If you need additional information on how to satisfy these rules, you should contact your legal or tax advisor.

You must recertify a Disabled Child(ren) by providing satisfactory evidence of his or her disability at the discretion of the Plan Administrator, in order to continue eligibility for Program coverage. In addition, an independent medical examination of your unmarried Disabled Child(ren) may be required at the time of certification or recertification.

Change-in-Status Events

Permissible Change-in-Status Enrollment Events

Change-in-Status Events permit you to change your Program enrollment. For a detailed description of each of these events, see *Appendix A*. The permitted enrollment changes reflected in *Appendix A* are based on the terms and conditions of the Program and are consistent with federal law. The Plan Administrator has the discretion to determine whether or not a requested enrollment change is consistent with the event. See the "Status Change Codes legend" at the end of the tables in *Appendix A* for an explanation of the codes used in the tables.

There are certain requirements that your change in enrollment request must meet in order to be permitted under the Program.

- The enrollment change must be consistent with the event: The Change-in-Status Event must:
 - Affect eligibility and coverage under the Program; and
 - Must be on account of and consistent with the event.
- Request your enrollment before the deadline: Your request for a change in your enrollment must occur within 31 days after the Change-in-Status Event.
- Document your event: While not always required, the Program has the right to request documentation that supports your Change-in-Status Event, such as a marriage or birth certificate.

Change in Coverage Tier

If You Add or Drop a Dependent Resulting in a Change to Your Coverage Tier

If you add a dependent midyear and the addition changes your medical option coverage tier, the amount of your Annual Deductible and Annual Out-of-Pocket Maximum will change to the full annual amount applicable to your new coverage tier, effective with the change in coverage. Expenses incurred by your dependent before he or she is added to your Program option coverage will not count toward meeting your new Annual Deductible and Annual Out-of-Pocket Maximum.

If you drop a dependent midyear for any reason, Eligible Expenses associated with that dependent while covered under the Program will continue to count toward meeting your Annual Deductible or Annual Out-of-Pocket Maximum for the remainder of the Plan Year. If your dropped dependent elects COBRA continuation coverage, a separate Annual Deductible and Annual Out-of-Pocket Maximum will apply to your dependent's COBRA coverage for the remainder of the Plan Year and will not be adjusted, even though they will be in effect for only a portion of the Plan Year. Eligible Expenses associated with that dependent while covered under the Program will count toward meeting the dropped dependent's Annual Deductible or Annual Out-of-Pocket Maximum associated with the dependent's COBRA coverage for the remainder of the Plan Year.

Action	Medical Tier Changes	Annual Deductible and Annual Out-of-Pocket Maximum
Add a dependent midyear	Change from Individual to: <ul style="list-style-type: none"> • Individual + 1", or • Individual + 2" or more 	Increase consistent with new coverage tier
Drop a dependent midyear	Change from: <ul style="list-style-type: none"> • Individual + 1" to Individual, or • Individual + 2 or more to Individual + 1, or" • Individual + 2" or more to Individual 	Previous expenses for dropped dependent are not transferable
*May also be referred to as Family Level of Coverage.		

Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum

Your Annual Deductible and Annual Out-of-Pocket Maximum are transferred following midyear changes to your coverage option or coverage tier, provided you call the Benefits Administrator and request the prior expenses be counted.

LEAVE OF ABSENCE

KEY POINTS

- *Special rules apply if you are on a leave of absence. You may be required to pay for coverage that continues during your leave of absence.*
- *If you do not continue coverage while on a leave of absence, you may be required to re-enroll upon your return to work.*

Your eligibility for continued coverage under this Program and whether you are required to pay for this coverage during your leave of absence, depends on the type of absence and, in some cases, on the duration of your leave. If you are on an approved leave of absence, you will receive a notice explaining what coverage you are eligible to continue to receive and whether

you will be required to pay for this coverage. If you continue coverage, you must make all contributions during the required time frame to avoid interruption of your benefits. If you do not continue coverage under the Program while you are on your leave of absence, you must re-enroll upon your return to work by contacting the Frontier Benefits Service Center. All coverage that continued while you were on leave will be continued when you return to work unless your eligibility has changed, for example, a change in your position results in eligibility for a different benefit program.

Special rules apply if you are absent from work by reason of Military Service or on a leave of absence subject to the Family and Medical Leave Act (“FMLA leave”). These rules are covered in the next two sections.

Because your coverage generally will be continued until the end of the month in which your active employment ends, a leave of absence that begins and ends in the same month will not affect your eligibility for coverage, but you may be required to re-enroll for coverage upon your return to work in order to continue your coverage uninterrupted.

Extended Coverage for Employees on Active Military Duty

The Uniformed Services Employment and Re-employment Rights Act of 1994, as amended (USERRA) provides the right to elect continued coverage under this Program for an Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services.

The terms “Uniformed Services” or “Military Service” mean the United States Armed Forces, the Army National Guard and Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the United States Public Health Service and any other category of persons designated by the President of the United States in time of war or national emergency.

If you are qualified to continue coverage pursuant to USERRA, you may elect to continue your coverage under this Program by notifying the Frontier Benefits Service Center in advance and providing payment of any required contribution for this coverage. This may include the amount the Company normally pays on your behalf. If your Military Service is for a period of time shorter than 31 days, you will not be required to pay more than your regular contribution amount for your coverage under this Program.

You may continue your coverage under USERRA for up to the shorter of:

- The 24-month period beginning on the day of your absence from work due to Military Service.
- The day after the date on which you fail to apply for, or return to, a position of employment with the Company.

Regardless of whether you continue coverage under this Program while in Military Service, if you return to employment with the Company, your coverage and coverage for your Eligible Dependents will be reinstated under the Program. No exclusions or waiting period will be imposed in connection with this reinstatement unless a sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of Military Service.

Extended Coverage While on an FMLA-Protected Absence or on FMLA

During a leave covered by the Family and Medical Leave Act (FMLA leave), the Company will maintain your coverage under the Program during the approved leave under FMLA on the same terms and conditions as applicable to similarly situated Active Employees who are not on FMLA leave. If you receive pay while on an FMLA leave, your required contributions will continue to be taken from your pay. If you do not receive pay while on an FMLA leave, you will be required to pay your required contributions each month. If your coverage ceases during the FMLA leave period, you may resume your coverage upon return from FMLA leave on the same terms as before the leave began (e.g., no new conditions or waiting periods will apply to the coverage upon your return to work).

You may be entitled to FMLA leave for the following reasons:

- birth of a child, and to care for such child;
- placement of a child with you for adoption or foster care;
- to care for your seriously ill spouse, child, or parent;
- a serious health condition that makes you unable to perform your job functions;
- a “qualifying exigency” arising because your spouse, child or parent is on covered active duty or has been notified of a call or order to covered active duty in the armed forces; or
- to care for a service member of the armed forces who is your spouse, child, parent or next of kin.

The Company is responsible for the determination of your eligibility, rights, or the length of leave under FMLA, and shall notify the Plan for purposes of continuing your coverage under this Plan.

State FMLA laws may also grant additional or different rights than set forth above. Contact your local Human Resources office for information.

Repayment of Cost of Health Care Coverage Paid or Advanced by the Company

If you do not return to work for the Company following FMLA leave for a reason other than the continuation, recurrence or onset of a serious health condition that entitles you to approved FMLA leave or as a result of other circumstances beyond your control (for example, a layoff), you may be required to reimburse the Company for the cost of your Program coverage during your FMLA leave. If you return to work for the Company following FMLA leave, you will be required to reimburse the Company for the Employee contributions that were not paid during your FMLA leave.

Continuation of Coverage under COBRA

If you do not return to active employment after your FMLA leave ends or you notify the Company that you do not intend to return after the end of your FMLA leave, you will be eligible to continue coverage through COBRA. The period of COBRA coverage will begin on the earlier of:

- The date your FMLA leave ends if you do not return to active employment.
- The date you notify the Company that you do not intend to return after the end of your FMLA leave.

For More Information

FMLA leave information is available from the Frontier Benefits Service Center.

CONTRIBUTIONS

KEY POINTS

- *Your contribution is the amount you are required to pay monthly for Program coverage.*
- *The coverage option you choose and the number of Eligible Dependents you cover impact your contribution cost.*

IMPORTANT: Your hire date is not necessarily the date used to determine your Term of Employment (also known as net credited service).

The amount you contribute toward the Cost of Coverage is affected by a number of factors, including:

- The date you were hired, rehired or transferred.
- Your employment status (for example, Actively at Work).
- The number of hours that you are scheduled to work.
- The medical option you are enrolled in.
- Whether your coverage is continued through Company Extended Coverage (CEC) or COBRA.

You can view information concerning the contribution amount that applies to you by logging on to the Frontier Benefits Service Center website at www.frontierbenefitscenter.com

How Contributions Are Made

Contributions are deducted from your paycheck. If your contributions are not deducted from your paycheck (for example, you are on a leave of absence (LOA)), you will be required to make your monthly payments, generally through check or money order. Contact the Frontier Benefits Service Center to determine what payment options are available to you.

IMPORTANT: You have a 60-day grace period from the day your payment is due to make your payment before coverage is terminated. Failure to pay all required contributions for both you and any covered dependents will result in loss of coverage retroactive to the last day of the month for which full payment was received. Coverage will be canceled and you may not be eligible to re-enroll until the next Annual Enrollment unless you experience a Change-in-Status Event that permits you to enroll sooner. In addition, if you are making contributions toward coverage under any other Company health and life insurance plans, coverage under those health and life plans will be canceled as well, and you may not be able to re-enroll in those plans, if at all, until the next Annual Enrollment unless you experience a Change-in-Status Event that permits you to enroll sooner.

EXAMPLE: If your monthly contributions are medical \$400, vision \$50 and supplemental life insurance \$150 for a total of \$600 and you pay through March in full but have \$150 left to pay toward your contributions for April coverage, coverage for medical, vision and supplemental life insurance will be terminated effective April 1, if payment of the remaining \$150 balance is not made in full by May 31.

Before-Tax and After-Tax Contributions

If you are an Active Employee, your Program contributions will automatically be deducted from your pay on a before-tax basis upon enrolling in the Program. If you do not want these contributions deducted on a before-tax basis, you must elect after-tax contributions when you enroll.

If your contributions are paid on a before-tax basis, your ability to make changes to these contributions mid-year is governed by the Frontier Flexible Spending Account (FSA) Plan. As a result, even if you are eligible to change your medical coverage to an option with lower or higher contributions due to a Change-in-Status Event or Prospective Enrollment, you cannot change the amount of your before-tax contributions unless you experience a qualified Change-in-Status Event as defined in the FSA Plan. Although generally similar, not all Change-in-Status Events under the Program are considered qualified under the FSA Plan. Refer to the FSA Plan SPD for more information on before-tax contributions and for a list of events that are considered qualified Change-in-Status Events.

If you are not an Active Employee, you must pay your Program contributions on an after-tax basis.

IMPORTANT: Active Employee contributions are automatically deducted from your paycheck on a before-tax basis, so if you want these contributions deducted on an after-tax basis, you must make this election during your enrollment period.

Contribution Policy

You are required to pay a monthly contribution to participate in the Program for you and your dependents as specified in the “*Contribution Rules*” table below. To use the table, you must first find the row in the “*Employee Classification*” column that contains the information that applies to you. Your contribution rule will be on that row in the “*Contribution Rules*” column unless a special rule described in the table applies to you.

Special contribution rules apply to Bargained Employees who transition or change positions. If you move between bargaining groups or change positions, contact the Frontier Benefits Service Center.

Employee Classification		Contribution Rules
Regular Employee (less than 6 months Term of Employment)	Full-time or Part-time	You pay 100% of the monthly Cost of Coverage, until the 1st of the month in which you will achieve a Term of Employment of at least six months.
Regular Employee (at least 6 months Term of Employment)	Full-time	All Employees (current and eligible New Hires) pay the following monthly contributions effective January 1, 2026 through December 31, 2026: Individual: \$145 Family: \$290
	Part-time (regardless of scheduled hours per week)	Hired on or before December 31, 1980; Same as Full-time
	Part-time (25 or more scheduled hours per week)	Hired on or after Jan. 1, 1981; Same as Full-time
	Part-time (at least 17 scheduled hours, but less than 25 scheduled hours per week)	Hired on or after Jan. 1, 1981; You pay 50% of the monthly Cost of Coverage.
	Part-time (less than 17 scheduled hours per week)	Hired on or after Jan. 1, 1981; You pay 100% of the monthly Cost of Coverage.
Temporary Employee	Full-time or Part-time	You pay 100% of the monthly Cost of Coverage regardless of Term of Employment.
Former Employees	Former Employee	If you are eligible for continued coverage, the amount you pay depends on the event that triggers Post-Employment Benefits. See the "Extension of Coverage - COBRA" section in this SPD if you are eligible for continued coverage under COBRA and the "When Coverage Ends" section if you are eligible for continued coverage under severance or other similar benefits. If you are an Eligible Former Employee, see the SPD for Eligible Former Employees for more information.
Some Employee classifications may not apply (for example, Term). See the "Eligible Employees" section for your specific eligibility requirements.		

Surviving Dependents

Company contributions toward the Cost of Coverage are available to your surviving dependents receiving Company Extended Coverage (CEC) for up to six full months following your death, as long as a surviving dependent remains eligible for and enrolled in CEC. Your surviving dependent(s) who continue coverage under CEC after the six-month period will pay 100% of the Cost of Coverage with no Company contribution.

As described in the "Surviving Dependent Coverage" section, CEC is integrated with COBRA continuation coverage. As a result, COBRA contributions will be reduced by the amount of Company contributions available under CEC. Once Company contributions under CEC end, your surviving dependent(s) will pay 100% of the Cost of Coverage for continued COBRA coverage for up to 30 months (total of 36 months).

Tax Consequences of Coverage for Partners and Their Dependents

The Company's level of contribution toward Program coverage for a Partner and a Partner's Child(ren) is the same as the Company's contribution for coverage of a Spouse and a Spouse's Children.

However, when a Partner or Partner's Child(ren) are covered under the Program, and your relationship is not recognized as a marriage under the applicable state law or federal law, the Company may be required to include the Cost of Coverage as taxable income on your annual tax reporting statement, unless you provide information each year that your covered dependents qualify as tax dependents under the Internal Revenue Code as well as your state and local income tax laws, if applicable.

The amount reported as taxable income on your annual tax reporting statement is based on the total Cost of Coverage under the Program, including any before-tax contributions that you have paid for a Partner and his or her Child(ren). This amount is subject to federal, FICA income and any applicable state and local tax withholding.

Rehired Eligible Former Employee Contributions

You are considered a "rehired retiree" also known as a "rehired Eligible Former Employee" and special contribution rules apply if:

- You previously terminated employment as a CWA 1298 employee and at that time were eligible for medical coverage as an Eligible Former Employee;
- Your eligibility for post-employment coverage was a result of Age and Service Based Eligibility or Pension Based Eligibility; and
- You are subsequently hired by Frontier as a CWA 1298 employee.

If you are eligible to receive Eligible Former Employee benefits as a CWA 1298 employee and you become employed as a regular CWA 1298 Bargained Employee, you are eligible to elect to receive Program coverage as an Active Employee, in lieu of your Eligible Former Employee (Retiree) coverage. At the time of your re-employment, you will have the opportunity to make an irrevocable election between retaining your Eligible Former Employee benefits and choosing coverage as an Active Employee. If you do not contact the Frontier Benefits Service Center within 31 days of your statement date and make an election for coverage under the active provisions, you will be deemed to have waived your option for coverage as an Active Employee and to have elected to continue your Eligible Former Employee benefits.

If you have questions, contact the Frontier Benefits Service Center.

Employees on Leave of Absence

If you are on an approved leave of absence (LOA), you will receive a notice explaining what Program coverage you are eligible to continue and any contributions that you are required to pay for this coverage. Payment is due monthly.

If you have questions concerning billing or payment of your contribution, contact the Frontier Benefits Service Center.

IMPORTANT: You have a 60-day grace period from the day your payment is due to make payment before coverage is terminated. Failure to pay all required contributions will result in loss of coverage retroactive to the last day of the month for which full payment was received. You may not be eligible to re-enroll until you return from your LOA. If you do not continue coverage under the Program while you are on LOA and you would like to re-enroll upon your return to work, you must contact the Frontier Benefits Service Center to determine if you are eligible. If you are eligible to re-enroll, you will also receive enrollment materials upon your return to work.

Individuals Covered Through COBRA

If you or your Eligible Dependents are continuing coverage through COBRA, you or your Eligible Dependents will be required to pay for the coverage. See the “Extension of Coverage — COBRA” section for more information about COBRA rights. Additional information on paying for COBRA coverage is provided in the “Paying for COBRA Continuation Coverage” subsection. See the “How Contributions are Made” section for details on the direct billing process. If you have questions concerning billing or payment of COBRA continuation coverage, you can contact the Frontier Benefits Service Center.

Conditions for Program Benefits

Program Benefits are available if you meet all of the following:

- You are a Covered Person, which means you meet all eligibility requirements for Program coverage and are properly enrolled for coverage.
- You continue to meet all of the eligibility requirements and all required contributions for your coverage are paid timely.
- You receive Covered Health Services while your Program coverage is in effect – after you meet eligibility requirements and before coverage ends, as described in the “When Coverage Ends” section.
- You or your Provider file a timely Claim for Benefits, as described in the “Claims for Benefits” section and provide any required information in support of your Claim.

BENEFITS AT A GLANCE

KEY POINTS

- *Program Benefits are summarized in the Benefits at a Glance table. More detailed information, including exclusions and limitations, are listed in the “What Is Covered” section.*
- *The Benefits at a Glance table(s) provides information on how you and the Program share in the cost of the most commonly used Covered Health Services.*

The following *Benefits at a Glance* table(s) provides you:

- **A summary, not an exhaustive list, of the most commonly used medical and MH/SA Covered Health Services.** See the “What Is Covered” section for more detailed information on what is covered. Even if a Service is listed as a Covered Health Service, certain exclusions or limitations may apply that affect Benefits payable under the Program. Other Services are specifically excluded from coverage regardless of the circumstances. For information on what is not covered, as well as circumstances affecting whether a Service is covered, see the “Exclusions and Limitations” section.
- **A summary of limitations specific to the Covered Health Services in the table.** This information is not exhaustive. See the “What Is Covered” section for more detailed information on limitations to the Covered Health Services.
- **Cost-sharing information.** You and the Program share in the cost of care as summarized in the table(s) below. The following *Benefits at a Glance* table(s) provides information on how you and the Program share in the cost of the most commonly used Services. However, circumstances specific to your situation may impact your level of cost sharing. To better understand these cost-sharing features and how they impact your Benefits, see the “Cost Sharing” section of this SPD.
- **Information on when Notification or Preauthorization is required.** The Program requires notification or Preauthorization for certain Services or circumstances. If you do not provide Notification or Preauthorization when it is required, your Benefits may be reduced or denied. The “Notification and Preauthorization Requirements” section of this SPD provides more detailed information.

This section does not include information on Prescription Drug coverage; see the “Prescription Drug Coverage” section.

IMPORTANT: No coverage will be provided for Services that the Benefits Administrator does not determine are Medically Necessary. Medically Necessary means that a specific Covered Health Service is required, in the reasonable medical judgment of the Benefits Administrator, for the treatment or management of a medical symptom or condition, and that the Service provided is the most efficient and economical Service that can safely be provided. Just because a Provider prescribes, orders, recommends, approves or views a Service as Medically Necessary does not make the Service Medically Necessary and does not mean the Program will pay the cost of that Service. See the “Medically Necessary” section for a complete description.

For a complete understanding of Benefits coverage, read this SPD in its entirety. If you have any questions about your Medical and MH/SA Benefits, contact your Benefits Administrator.

	Network	Non-Network	ONA	Limitations and Exceptions
Notification and Preauthorization Requirements				
Notification and Preauthorization Requirements	See the “Notification and Preauthorization Requirements” section for more information.	See the “Notification and Preauthorization Requirements” section for more information.	See the “Notification and Preauthorization Requirements” section for more information.	
Cost Sharing				
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the “Cost Sharing” section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the “Cost Sharing” section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the “Cost Sharing” section of this SPD for more information.	
Annual Deductible	Medical, including MH/SA For Individual and Family: \$650/\$1,300	Medical, including MH/SA For Individual and Family: \$1,300/\$2,600	Medical, including MH/SA For Individual and Family: \$650/\$1,300	Unless otherwise noted, the Annual Deductible Applies
Annual Out-of-Pocket Maximum	Medical, including MH/SA For Individual and Family: \$2,000/\$4,000; Does not include deductible	Medical, including MH/SA For Individual and Family: \$6,000/\$12,000; Does not include deductible	Medical, including MH/SA For Individual and Family: \$2,000/\$4,000; Does not include deductible	
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the “Cost Sharing” section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the “Cost Sharing” section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the “Cost Sharing” section of this SPD.	

	Network	Non-Network	ONA	Limitations and Exceptions
Preventive Care Services				
Preventive Care	0% Coinsurance	Not covered	0% Coinsurance	Annual Deductible does not apply See the "What Is Covered" section for information about Preventive Care Services.
Emergency Services				
Emergency Room (Emergency Medical Condition)	20% Coinsurance	20% Coinsurance	20% Coinsurance	
Ambulance Services (Emergency)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Non-Emergency Services				
Emergency Room (Non- Emergency)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Urgent Care Facility (Non-Emergency)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Ambulance Services (Non-Emergency)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
LIVEHEALTH ONLINE Online visits from LiveHealth Online Provider	20% Coinsurance	N/A	20% Coinsurance	
Inpatient Services				
Facility Charge	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Room and Board	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Lab and X-Ray	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Physician and Surgeon Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Outpatient Services				
Office Visit				
Office Visit (Non-Specialist)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Office Visit (Specialist)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Outpatient Care				
Outpatient Surgery	20% Coinsurance	40% Coinsurance	20% Coinsurance	

	Network	Non-Network	ONA	Limitations and Exceptions
Outpatient Lab and X-Ray Services (excluding Preventive Care)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Outpatient Chemotherapy	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Mental Health and Substance Abuse Services				
Mental Health				
Mental Health Outpatient Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Mental Health Inpatient Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Substance Abuse				
Substance Abuse Outpatient Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Substance Abuse Inpatient Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Family Planning/Maternity Services				
Office Visit (Pre/Postnatal)	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Hospital Delivery Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Infertility Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	Benefits limited to \$20,000 per lifetime for Network, Non-Network and ONA combined, including Prescription Drugs

	Network	Non-Network	ONA	Limitations and Exceptions
Rehabilitation Services				
Physical Therapy	20% Coinsurance	40% Coinsurance	20% Coinsurance	Limited to 40 visits per calendar year; limited to 52 visits in a calendar year if combined with Chiropractic visits; visit limit is total for Network, Non-Network and ONA Services combined. These Physical Therapy limits do not apply to Children under age 18.
Occupational Therapy	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Speech Therapy	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Cardiac Rehabilitation Therapy	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Additional Services				
Acupuncture	Not covered	Not covered	Not covered	
Chiropractic	20% Coinsurance	40% Coinsurance	20% Coinsurance	Limited to 40 visits per calendar year; limited to 52 visits in a calendar year if combined with Physical Therapy visits; visit limit is total for Network, Non- Network and ONA Services combined
Durable Medical Equipment	20% Coinsurance	40% Coinsurance	20% Coinsurance	

	Network	Non-Network	ONA	Limitations and Exceptions
Home Health Care	20% Coinsurance	40% Coinsurance	20% Coinsurance	Non-Network/ONA Limited to 200 visits in a calendar year, up to 80 of which may be home health aide Services and 120 of which may be skilled nursing visits. Four hours of home health aide Services will count as one visit (120 days in facility. 80 visits to home or combined 200 visits.)
Hospice Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	
Organ and Tissue Transplant Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	Network/ONA: See Appendix B for additional benefits that may be available if you use a Designated Network Provider.
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	

* The medical Annual Out-of-Pocket Maximum takes into account most cost-sharing amounts that you pay under the medical portion of the Program (e.g., copayments, coinsurance or similar charges) but it does not include amounts that you pay towards the Annual Deductible. In addition, the medical Annual Out-of-Pocket Maximum does not include the following –

- Cost-sharing under the prescription drug portion of the Program,

- Premiums,
- Charges for non-covered services,
- Co-insurance for non-network claims,
- Provider balance-billed amounts,
- Any charges or expenses not considered covered expenses under the Program or otherwise excluded or limited by the Program,
- Expenses above the maximum allowed amount,
- Any amounts you pay because the precertification requirements were not met, and
- Charges above plan limits.

Please Note: A separate out-of-pocket maximum applies separately to prescription drug costs. This separate out-of-pocket limit is discussed in the prescription drug section. In addition, the medical out-of-pocket maximum and the prescription drug out-of-pocket maximum when combined will not be more than the maximum out-of-pocket limit allowed by the Affordable Care Act for in-network coverage. For 2026, the maximum amount is \$10,150 for single coverage and \$20,300 for all other dependent tiers. Additional information regarding the maximum out-of-pocket limit for medical and prescription drugs is provided later in this SPD.

Your Program Coverage Overview

The Program offers Benefits to help you pay the cost of medical, including Mental Health/Substance Abuse Services for you and your Eligible Dependents. The Program also offers Prescription Drug Benefits, which are explained in the “Prescription Drug Coverage” section of this SPD.

This section of the SPD includes further details about your Medical and Mental Health/Substance Abuse Program Benefits. It is important you read these sections of this SPD to receive the maximum Benefits from the Program. As you read the details of the Program, it is important to keep the following in mind:

- The *Benefits at a Glance* table only provides a high-level summary of your Benefits. To best understand the full extent of Covered Health Services and any limitations or exclusions applicable to your Benefits, see the “What Is Covered” and “Limitations and Exclusions” sections of this SPD.
- You and the Program share the cost of most Covered Health Services. See the “Cost Sharing” section for information on how you and the Program share in this responsibility. The following are exceptions to the general cost-sharing provisions contained in this section of the SPD:
 - Preventive Care Services are covered at 100 percent of the Allowable Charge if these Services are provided by a Network Provider. However, the Program will pay no Benefits, and you will be responsible for the full cost of Services, if Preventive Care Services are provided by a Non-Network Provider (except in limited circumstances, as explained below, or unless you have ONA coverage. If you have ONA coverage, Preventive Care Services are provided without cost sharing, regardless of whether you use a Network or Non-Network Provider. However, your Benefits will be limited to the amount of the Allowable Charge. For information specific to your Preventive Care Services Benefits, see the *Benefits at a Glance* table and “Preventive Care Services” section.

- Emergency Services are covered the same whether you receive care at a Network or Non-Network facility, as long as the Service is provided for an Emergency Medical Condition. See the “Definitions” section for the definition of Emergency Medical Condition and Emergency Services. For more information on your Benefits for Emergency Services, see the “Emergency Services” section.
- The Program gives you access to a Network of Physicians and other health care Providers to maximize your Benefits under the Program. You are not required to designate a Primary Care Physician to receive Program Benefits. Also, you do not need prior authorization to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology
- However, if you use Network Providers, you will receive the Network level of Benefits and generally pay less out of pocket for Covered Health Services. Also, the Benefits Administrator and the Network Provider negotiate an agreed amount for the Provider’s Services, and your Network Provider will not charge you for any amounts that are more than the Negotiated Rate. For more information, see the “What You Need to Know About Providers” section.
- If you receive Services from a Non-Network Provider, you generally will pay more for Covered Health Services because your portion of the cost sharing may be greater and Providers have not agreed to a Negotiated Rate for Covered Health Services. You also may be required to pay any amount above the Allowable Charge determined by the Benefits Administrator. For more information, see the “Non-Network Coverage” section.
- If you reside in an area that is not within a Network Area and are enrolled in ONA coverage, you have the flexibility to choose either a Network or Non-Network Provider whenever you receive care and receive the same level of Benefits. If your care is provided by a Network Provider, you will generally pay less out of pocket because you will receive the advantage of a Negotiated Rate. You also are not required to designate a Primary Care Physician to receive Program Benefits. For more information, see the “Outside Network Area (ONA) Coverage” section.
- Services are not considered a Covered Health Service unless they are determined to be Medically Necessary. See the “Medically Necessary” section for more information.
- Some Services require Notification and/or Preauthorization for maximum coverage under the Program. See the “Notification and Preauthorization Requirements” section for information.

IMPORTANT: The Benefits Administrator determines whether a Service is covered and what Benefits the Program will pay, based on the terms of the Program. No other person has the authority to make any statement, decision or representation regarding coverage under this Program. See the “Plan Administration” section for information.

COST SHARING

KEY POINTS

- *You and the Company share in the cost of Benefits provided under the Program.*
- *Cost sharing may be in the form of an Annual Deductible, Coinsurance, an Annual Out-of-Pocket Maximum, Allowable Charge or other provisions.*

Cost Sharing

You and the Program share in the cost of your care. You should be aware of how the cost-sharing provisions affect your Benefits.

This section describes cost-sharing features that are built into the Program. See the *Benefits at a Glance* table(s) for specific amounts.

Annual Deductible

The Annual Deductible is the amount that you (and your covered family members) pay each year in Allowable Charges before the Program begins to pay Benefits for most Covered Health Services (other than Preventive Care Services obtained from Network Providers).

There are separate Network and Non-Network Annual Deductibles:

- Network Allowable Charges you are responsible for are counted toward meeting your Network Annual Deductible but do not count toward the Non-Network Annual Deductible.
- Non-Network Allowable Charges you are responsible for are counted toward meeting the Non-Network Annual Deductible but do not count toward the Network Annual Deductible.

For ONA coverage (see “Outside Network Area (ONA) Coverage”), only the ONA Annual Deductible applies and Allowable Charges will count toward the ONA Annual Deductible, regardless of whether you use Network or Non-Network Providers. If you switch to Network coverage during the year, the amounts applied to your ONA Annual Deductible will apply to your Network Annual Deductible for the rest of the year in which you switch.

There are different individual and family levels of both the Network and Non-Network Annual Deductibles.

- If one family member meets the individual Network Annual Deductible, the Program will begin to cover additional Allowable Charges for Network Covered Health Services for that family member.
- The family Network Annual Deductible may be met by combining Allowable Charges for Network Covered Health Services of all covered family members in the same Program option up to the applicable individual Network Annual Deductible amount for each person.
- Once you meet the family Network Annual Deductible, individual Network Annual Deductibles for all family members will be considered met for the rest of the year unless you change Program options. See the section called “Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum.”
- The individual and family Non-Network Annual Deductibles operate in the same manner when you use Non-Network Providers.

This is an example only. The actual terms of your Program, such as the applicable Annual Deductible amounts, will govern; you can substitute the Annual Deductible for your Program to see how this could affect you.

For example, suppose Joe covers his wife, Elaine, and their son, Tom, in the Program with an individual Annual Deductible of \$350 and a family Annual Deductible of \$700. Joe has the first medical procedure in his family for the year and pays out of pocket \$350 in Allowable Charges for Network care, thus meeting the individual Annual Deductible. Joe will begin receiving Network Benefits for the year — even though the \$700 family Annual Deductible has not been met. The \$350 Joe paid also counts toward the family Annual Deductible, but any additional Allowable Charges he incurs this year will not count toward the family Annual Deductible.

If Elaine then has a procedure for Network care where she also pays \$350 in Allowable Charges out of pocket, she will have met her individual Annual Deductible and also contributed another \$350 toward the family Annual Deductible. Any additional Allowable Charges she incurs this year will not count toward the family Annual Deductible.

Now, when Tom needs Network care, he will begin receiving Benefits because the \$700 Network family Annual Deductible has been met.

- Only medical and MH/SA Allowable Charges apply to the Annual Deductible; outpatient Prescription Drug costs do not apply to this Annual Deductible. The following table summarizes what does and does not apply to the Annual Deductible.

	Counts toward the Network Annual Deductible?	
	Yes	No
Amounts that exceed Allowable Charges for Eligible Expenses		X
Contributions		X
Ineligible expenses		X
Network Allowable Charges	X	
Non-Network Allowable Charges		X
Notice or Preauthorization penalties		X
Outpatient Prescription Drug expenses		X

	Counts toward the Non-Network Annual Deductible?	
	Yes	No
Amounts that exceed Allowable Charges for Eligible Expenses		X
Contributions		X
Ineligible expenses		X
Network Allowable Charges		X
Non-Network Allowable Charges	X	
Notice or Preauthorization penalties		X
Outpatient Prescription Drug expenses		X

See the *Benefits at a Glance* table(s) following the “Conditions for Program Benefits” section for Annual Deductible amounts and information on what Services are subject to the Annual Deductible.

If you change from Individual coverage to Individual + 1 or Individual + 2 or more during the year, see the section called “Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum.”

Coinsurance

Coinsurance is the percentage of Allowable Charges you pay for Covered Health Services except Network Preventive Health Services.

The Coinsurance percentage varies depending on the Covered Health Service. For Covered Health Services that are subject to a Network requirement, the Coinsurance percentage also varies, depending on whether or not you use a Network Provider.

If you use a Provider who charges more than the Allowable Charge for a Covered Health Service, you also will be responsible for any charges in excess of the Allowable Charge.

This is an example only. The actual terms of your Program, such as the applicable Coinsurance amounts, will govern; you can substitute the Coinsurance amounts for your Program to see how this could affect you.

For example, if the Program pays 80 percent of Allowable Charges if you use a Network Provider and 60 percent if you use a Non-Network Provider and you visit a Network Provider for a Covered Health Service, the Network Provider will accept a Negotiated Rate. If the Negotiated Rate is \$10,000 and you have met your Annual Deductible, the Program will pay \$8,000 (80% x \$10,000). You will be responsible for the \$2,000 Coinsurance amount (20% x \$10,000).

If you visit a Non-Network Provider, the Provider’s billed charge may be higher than the Allowable Charge. If the Allowable Charge is \$10,000, the Provider bills \$14,000 and you have met your Annual Deductible, the Program will pay \$6,000 (60% x \$10,000). You will be responsible for the \$4,000 Coinsurance amount (40% x \$10,000) plus the remaining \$4,000 difference between the amount billed (\$14,000) and the Allowable Charge (\$10,000).

Note: If you are enrolled in a coverage option that does not pay Benefits differently based on whether you use a Network Provider, the Program will pay the same percent of Allowable Charges whether you use a Network Provider or not. However, if you use a Network Provider, your Coinsurance amount will be based on the Negotiated Rate and, because the Network Provider accepts the Negotiated Rate as payment for the Covered Health Services, you will not be responsible for the difference between the amount billed and the Allowable Charge.

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum limits the amount you pay for Covered Health Services each year. Once your payments for Covered Health Services reach the applicable Annual Out-of-Pocket Maximum, the Program pays 100 percent of any Allowable Charges for *most* Covered Health Services for the rest of the year, unless you change your Program option. See the section called “Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum.”

Please Note: Notwithstanding that the Annual Out-of-Pocket Maximum limits for the Program do not include the Annual Deductible, the Network Allowable Charges for Eligible Expenses you pay out of pocket for a calendar year (including the deductible) for Covered Health Services (including Prescription Drugs) may not exceed the limit specified for each year by the Affordable Care Act (\$10,150 for single coverage and \$20,300 for all other dependent tiers in 2026).

In calculating whether this limit is met, if you enroll in coverage for yourself only, you must meet the individual out-of-pocket limit (e.g., \$10,150) before the Program will cover claims with coinsurance, for the balance of the year, at 100%. If you enroll in anything other than single coverage, the Affordable Care Act out-of-pocket limit is treated as a combined amount for all persons enrolled. However, no individual will have to pay more than the individual out-of-pocket limit before the plan pays claims with coinsurance at 100%, for the balance of the year, for that person. Additionally, no one member of the family will contribute more than the individual out-of-pocket limit amount in meeting the combined family out-of-pocket limit.

If You Are Enrolled in Network Coverage

Separate Annual Out-of-Pocket Maximums apply for Network and Non-Network Covered Health Services:

- Network Allowable Charges do not count toward the Non-Network Annual Out-of-Pocket Maximum.
- Non-Network Allowable Charges do not count toward the Network Annual Out-of-Pocket Maximum.

This means that even if you meet the Network Annual Out-of-Pocket Maximum, you must still meet the Non-Network Annual Out-of-Pocket Maximum before the Program begins to pay 100 percent of Allowable Charges for Non-Network Covered Health Services.

IMPORTANT: When you use Non-Network Providers, any amounts you pay for Covered Health Services that exceed the Allowable Charge do not apply toward your Non-Network Annual Out-of-Pocket Maximum. In addition, the Program will not pay these excess amounts even if you reach your Non-Network Annual Out-of-Pocket Maximum.

There are different individual and family Network and Non-Network Annual Out-of-Pocket Maximum amounts for Covered Health Services. Once an individual reaches the individual Network Annual Out-of-Pocket Maximums, the Program will begin paying 100 percent of any Allowable Charges for Network Eligible Expenses that person incurs. Once payments for all family members reach the family Network Annual Out-of-Pocket Maximums, individual Network Annual Out-of-Pocket Maximums for all family members will be considered met for the rest of the year, and the Program will begin paying 100% of Allowable Charges for Network Eligible Expenses that any family member incurs, unless you change your Program option. The Non-Network Annual Out-of-Pocket Maximum operates in the same manner when you use Non-Network Providers.

Amounts that apply to the Network and Non-Network Annual Out-of-Pocket Maximums only include Allowable Charges you pay toward the cost of medical and MH/SA Covered Health Services. Amounts you pay toward the cost of outpatient Prescription Drug Eligible Expenses do not apply to the Annual Out-of-Pocket Maximum. There is a separate maximum that applies to Prescription Drug Eligible Expenses.

The following tables summarize what does and does not apply to the Network and Non-Network Annual Out-of-Pocket Maximum.

	Counts toward the Network Annual Out-of-Pocket Maximum?	
	Yes	No
Amounts that exceed Allowable Charges for Eligible Expenses		X
Annual Deductible		X
Coinsurance for Network Covered Health Services	X	
Contributions		X
Ineligible expenses		X
Non-Network Allowable Charges		X
Notice or Preauthorization penalties		X
Outpatient Prescription Drug expenses		X

	Counts toward the Non-Network Annual Out-of-Pocket Maximum?	
	Yes	No
Amounts that exceed Allowable Charges for Eligible Expenses		X
Annual Deductible		X
Coinsurance for Non-Network Covered Health Services	X	
Contributions		X
Ineligible Expenses		X
Network Allowable Charges		X
Notice or Preauthorization penalties		X
Outpatient Prescription Drug expenses		X

If You Are Enrolled in Outside Network Area (ONA) Coverage

If you are enrolled in ONA coverage, only the ONA Annual Out-of-Pocket Maximum applies. Your Allowable Charges count toward meeting the ONA Annual Out-of-Pocket Maximum regardless of whether you use Network or Non-Network Providers.

The Annual Out-of-Pocket Maximum is designed to limit the amount you pay for Covered Health Services each year. Once your payments for Covered Health Services reach the Annual Out-of-Pocket Maximum, the Program pays 100 percent of Allowable Charges for most Covered Health Services for the rest of the year unless you change Program options. See the section called “Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum.”

There are different individual and family Annual Out-of-Pocket Maximum amounts. Once an individual reaches the individual ONA Annual Out-of-Pocket Maximum, the Program will begin paying 100 percent of Allowable Charges for Eligible Expenses that person incurs. Once payments for all family members reach the family ONA Annual Out-of-Pocket Maximum, the individual ONA Annual Out-of-Pocket Maximum for all family members will be considered met for the rest of the year, and the Program will begin paying 100 percent of Allowable Charges for Eligible Expenses that any family member incurs, unless you change your Program option.

Amounts that apply to the ONA Annual Out-of-Pocket Maximum only include Allowable Charges you pay toward the cost of medical and MH/SA Covered Health Services. Amounts you pay toward the cost of outpatient Prescription Drug Eligible Expenses do not apply to the ONA Annual Out-of-Pocket Maximum.

IMPORTANT: Any amounts you pay for Covered Health Services that exceed the Allowable Charge for an Eligible Expense do not apply toward your Annual Out-of-Pocket Maximum. In addition, these amounts are not paid by the Program even if you reach your Annual Out-of-Pocket Maximum.

The following table summarizes what does and does not apply to the ONA Annual Out-of-Pocket Maximum.

	Counts toward the ONA Annual Out-of-Pocket Maximum?	
	Yes	No
Amounts that exceed Allowable Charges for Eligible Expenses		X
Annual Deductible		X
Coinsurance for Covered Health Services	X	
Contributions		X
Ineligible expenses		X
Notice or Preauthorization penalties		X
Outpatient Prescription Drug expenses		X

Allowable Charge for Eligible Expenses

The Program Benefits payable for an Eligible Expense are limited to the Allowable Charge determined by the Benefits Administrator. Benefits are not paid for amounts billed for a Covered Health Service that are above the Allowable Charge.

The Benefits Administrator determines Allowable Charges for Eligible Expenses based on whether you are covered under the Network/Non-Network or ONA provisions, the type of Provider (Network or Non-Network) and whether or not this Program’s coverage is primary or Medicare is primary. A special provision applies for Emergency Services.

The following table indicates the basis used by the Benefits Administrator to determine the Allowable Charge for Eligible Expenses. For example, if the Eligible Expense is for a Covered Health Service provided by a Network Provider and the Program coverage is primary, the Allowable Charge will be the Negotiated Rate determined by the Benefits Administrator.

If this Program Is Primary	
Network Providers	Non-Network Providers
Negotiated Rate	<ul style="list-style-type: none"> Maximum Allowed Amount (MAA)
For Emergency Services	
Network Providers	Non-Network Providers
Negotiated Rate	<ul style="list-style-type: none"> See Maximum Allowed Amount in “definitions” section
If Medicare Is Primary	
<ul style="list-style-type: none"> If Provider accepts Medicare assignment, then the Medicare Allowable amount. If Provider does not accept Medicare assignment, then the Medicare charge limit. 	
If Another Coverage is Primary	
See the “Coordination of Benefits” section for more information.	

Benefit Maximums

A Benefit Maximum is a limit on how much the Program will pay for a Covered Health Service over a specified period. For example, the Program may include an annual or lifetime Benefit Maximum on a specific Covered Health Service.

Any lifetime or annual Benefit Maximum applies only to those Covered Health Services that are not Essential Health Benefits, as defined by the Patient Protection and Affordable Care Act (PPACA). In addition, Preventive Care Services are not subject to Benefit Maximums.

Benefit Maximums are shown in your *Benefits at a Glance* table.

MEDICAL BENEFITS

KEY POINTS

- *The overview provides you with key concepts to understand your Medical Benefits.*
- *The Benefits at a Glance table gives you a broad overview of your medical coverage.*

OVERVIEW

This section describes Medical Benefits, including Mental Health/Substance Abuse Benefits, under this Program. Topics in this section include what is covered and excluded, cost-sharing provisions, Provider Networks and Notification Preauthorization requirements. See the “Prescription Drug Coverage” section for information about the Prescription Drug Program. To take advantage of the Benefits noted in this section, you must be enrolled in the Program at the time you receive Covered Health Services. Also, you (or your Provider) must file a timely Claim for Benefits. See the “Claims Filing Deadline” section for deadline information. Here is an overview of this section:

- **Network vs. Non-Network Providers.** *Even when you are enrolled in Network coverage, you are not required to use Network Providers. However, you generally pay more if you use Non-Network Providers, except for Emergency Services. Note: Emergency Services are paid at the same level regardless of the Provider’s Network status.*
- **Network vs. Out-of-Network Area.** *You are assigned Network coverage if your home ZIP code falls in the Network Area. If your home ZIP code does not fall in the Network Area, you are assigned Outside Network Area (ONA) coverage, but you may elect Network coverage.*
- **Allowable Charge.** *Program Benefits are based on the Allowable Charge, which is determined by the Benefits Administrator. Amounts above the Allowable Charge do not count toward the Annual Deductible or Annual Out-of-Pocket Maximum. See the “Cost Sharing” section for more information.*
- **Shared Cost of Benefits.** *Generally, you and the Program share the cost of Medical Benefits, including Mental Health/Substance Abuse Covered Health Services.*
- **Annual Deductible.** *Except for eligible Preventive Care Services, you must meet an Annual Deductible before the Program begins to pay benefits. There are separate Network and Non-Network Annual Deductibles. Note: Deductibles and Out-of-Pocket Maximums start over each year.*
- **Coinsurance.** *After you meet the Annual Deductible, you and the Company share the cost of Covered Health Services in the form of Coinsurance. The amount you pay in Coinsurance has a limit each year (Annual Out-of-Pocket Maximum). There are separate Network and Non-Network Out-of-Pocket Maximums. Once you meet the applicable Annual Out-of-Pocket Maximum, the*

Program reimburses at 100 percent of the applicable Allowable Charges for the remainder of the year.

- **Preventive Care Services.** Eligible Preventive Care Services are covered at 100 percent of Allowable Charges and are not subject to an Annual Deductible or Coinsurance when you use Network Providers or if you are enrolled in ONA. If you are enrolled in Network coverage, Preventive Care Services generally are not covered when you use Non-Network Providers.
- **Notification and Preauthorization.** Some Services require you to notify the Benefits Administrator within a certain period of time before or after receiving care. Other Services require you to preauthorize care. For special Services associated with certain medical conditions (for example, transplants), you must obtain Preauthorization before receiving care. See the “Notification and Preauthorization Requirements” section for more information.
- **Covered Health Services.** This section of your Summary Plan Description (SPD) includes a list of medical and Mental Health/Substance Abuse Covered Health Services and restrictions on those services, as well as a list of Services that are not covered by the Program. The lists are not exhaustive. Generally, a Covered Health Service is a Service that is Medically Necessary and appropriate for your condition, and that is not Experimental or Investigational or otherwise excluded.
- **Mental Health Services and Substance Abuse (MH/SA).** Eligible MH/SA Services generally are covered at the same level as other covered medical expenses, to the extent required by law. Your MH/SA Benefits are managed by the same Benefits Administrator as your Medical Benefits and the term “Medical Benefits” applies to both medical and MH/SA. For information on how to contact the medical and Prescription Drug Benefits Administrator, see the “Contact Information” section.

What You Need to Know About Providers

The Benefits Administrator or its affiliates arrange for health care Providers to participate in a Network.

The Benefits Administrator negotiates rates with Physicians, Hospitals and other Providers who have agreed to join the Network administered by the Benefits Administrator. Each Provider who joins the Network goes through a process to confirm information about his or her licenses and other credentials. This process confirms that Network Providers meet certain standards established by the Program or the Benefits Administrator. However, this credentialing process does not assure the quality of the Services provided.

A list of Network Providers is available online at the applicable Benefits Administrator’s website. You must verify your Provider’s Network status before you receive care, even when you are referred by another Network Provider. At any time, a Provider’s status may change as Providers may drop out of or join the Network throughout the year. Network Providers also may not be accepting new patients or Medicare. If a Provider leaves the Network or is not available to you, you must choose another Network Provider to receive Network level of Benefits. You can verify the Provider’s status by contacting your Benefits Administrator.

Do not assume that a Network Provider's agreement includes all Covered Health Services at Negotiated Rates. Some Network Providers contract to provide only certain Covered Health Services. For example, a Physician may participate in the Benefits Administrator's Network for cardiology Services only and not for primary care. Contact your Benefits Administrator for information about the type of Covered Health Services offered by a Network Provider.

Providers do not determine your Program Benefits and are not qualified or authorized to advise you about Eligible Expenses. Network Providers are independent Practitioners. They are not Employees of the Company or Benefits Administrator.

Medicare Eligible Covered Persons

Medicare's rules apply if your primary coverage is Medicare. If you are Medicare primary and you use a Network Provider that accepts Medicare assignment, then the Medicare Allowable Amount is used as a basis for payment. If the Network Provider does not accept Medicare assignment, then the Medicare charge limit is used as a basis for payment.

How Network Areas Are Determined

Whether you live in a Network Area can be a significant factor in determining your Benefits payable under the Program. Network areas are determined based on ZIP code. Your home ZIP code listed on Company records is used to determine your level of coverage.

You are considered to be in a Network Area and assigned Network coverage if:

- At least two internists, two family practice Physicians, two pediatricians and two obstetricians/gynecologists (OB/GYNs) are within five miles of your home ZIP code.
- At least one Network Hospital is within 15 miles of your home ZIP code.

If your home ZIP code is not in a Network Area, you are assigned Outside Network Area (ONA) coverage. If you are assigned ONA coverage, you may elect Network coverage. See the "Outside Network Area (ONA) Coverage" section for more information.

Network Benefits

Each time you need care, you choose which Provider to use. Generally, the choice you make affects the level of Benefits you receive and any Benefits limitations that may apply.

You are eligible for the Network level of Benefits under the Program when you receive Covered Health Services from Providers who have contracted with the Benefits Administrator to provide Services in the Network, as applicable.

For facility Services (such as an outpatient surgery center or Hospital), the Program reimburses charges from the anesthesiologist, Hospital, Physician, consulting Physician, pathologist and radiologist based on whether or not the facility is part of the Network. For example, care received at a Network facility will be reimbursed at the Network Benefits level, whether or not the individual Provider participates in the Network.

Emergency Services are always paid at the Network level. To learn more, see the "Emergency Services" section.

Generally, when you receive Covered Health Services from a Network Provider, you pay less than you would if you receive the same care from a Non-Network Provider.

In addition, when you use a Network Provider, the Network Provider will generally file your Claims.

IMPORTANT: If you or your covered dependent are Medicare Eligible and Medicare is your primary coverage (see the “Coordination of Benefits” section), Benefits will be paid based on the Medicare assigned rate, whether or not you use a Network Provider. However, Medicare is generally not primary for those in current employment status, and their dependents.

Designated Network Providers

If you have a medical condition that needs special Services, your Benefits Administrator may direct you to a Designated Network Provider.

For example, if you need a transplant, additional Benefits may be available when you use a Designated Network Provider that your Benefits Administrator chooses. For a description of these additional Benefits, see the “What Is Covered” section.

Non-Network Provider Benefits Paid as Network Benefits

If specific Covered Health Services are not available from a Network Provider, you may be eligible for the Network level of Benefits when those Services are received from a Non-Network Provider. In this situation, you or your Network Provider must notify your Benefits Administrator, who will work with you and your Network Provider to coordinate care through a Non-Network Provider.

Non-Network Coverage

When you are enrolled in Network coverage and you receive care from a Non-Network Provider, you will generally pay more out of pocket than if you received care from a Network Provider due to the following:

- The Program shares less of the cost for Covered Health Services received from a Non-Network Provider.
- The Program only shares the cost for Covered Health Services up to the Allowable Charge determined by the Benefits Administrator. See the discussion above concerning Allowable Charge and the “Definitions” section for a definition of Allowable Charge. When you use a Network Provider, you are not responsible for charges in excess of the Allowable Charge. However, when you receive Non-Network Services, your Provider may require payment for billed amounts above the Allowable Charge. This amount will not count toward your Annual Deductible and Annual Out-of-Pocket Maximum. You may want to ask your Non-Network Provider how much you will be billed for a Service before you receive care.

For certain types of care, different provisions may apply. See the *Benefits at a Glance* table for more information.

If you must receive care outside of the Network, exceptions to Non-Network cost sharing apply. For more information, contact your Claims Administrator.

See the “Cost Sharing” and “Comparison of Claims/Financial Responsibility” and “Definitions” sections for more information, and the *Benefits at a Glance* table for specific information about what the Program pays.

Outside Network Area (ONA) Coverage

You will be assigned ONA coverage if your home ZIP code is not in a Network Area. The Program pays ONA coverage at the same level of Benefits regardless of whether your care is provided by a Network or Non-Network Provider.

It may still be to your benefit to use a Network Provider, however, as Network Provider discounts are generally available to you, which means you can lower your out-of-pocket expenses by using a Provider that is in the Benefits Administrator's Network. Any amounts that you pay out of pocket will be based on the Negotiated Rate, which is generally less than what the Network Provider usually charges for the Service. In addition, when you use a Network Provider, you are not responsible for any amounts that exceed the Negotiated Rate.

When you use a Non-Network Provider, you will still receive the same level of Benefits, but the Benefits the Program pays will be based on the Allowable Charge, and you will be billed for the amount the Provider's fees exceed the Allowable Charge, which can be considerable. This is referred to as Balance Billing. See the "Cost Sharing," "Allowable Charge for Eligible Expenses" and "Comparison of Claims/Financial Responsibility" sections for more information.

You may verify a Provider's status by contacting the Benefits Administrator or visiting the applicable Benefits Administrator's website.

IMPORTANT: ONA provisions, including Notification and Preauthorization requirements and cost-sharing requirements, apply if you are enrolled in ONA coverage, whether or not you use a Network Provider. See the "Cost Sharing" section for information.

Electing to Enroll in Network Coverage

If you are assigned ONA coverage, you may choose to enroll in Network coverage at any time by calling the Frontier Benefits Service Center. However, before you elect Network coverage, you should consider if there are enough Network Providers in your area to meet your needs and/or if you are willing to travel the distance required to access Network Providers. If you choose to enroll in Network coverage, your change takes effect the first of the month after you inform the Frontier Benefits Service Center of your choice to elect Network coverage.

Once you elect Network coverage, you may not return to ONA coverage until the next Annual Enrollment period unless you experience a status change event that would allow you to change your level of coverage. Note that a Provider leaving the Network is not a status change event that would allow you to return to ONA coverage if you have previously elected to change from ONA to Network coverage.

Even if you do not enroll in Network coverage, your out-of-pocket expenses will generally be lower when you receive care from a Network Provider because Network Providers have agreed to Negotiated Rates. See the "Comparison of Network, Non-Network and ONA Benefits" section for information.

Comparison of Network, Non-Network and ONA Benefits

The following table provides an overview of the differences in out-of-pocket expenses, Notification and Claim filing requirements and how Emergency Services are covered among Network, Non-Network and ONA levels of Benefits. This does not apply to Preventive Care; see the separate "Preventive Care" subsection under the "What Is Covered" section for information on Preventive Care Benefits.

	Network Benefits (Network Provider Used)	Network Benefits (Non-Network Provider Used)	Outside Network Area (ONA) Benefits
Out-of-pocket expenses	<p>Your out-of-pocket expenses are lower when you use Network Providers:</p> <ul style="list-style-type: none"> • The Benefits Administrator and the Network Provider negotiate an agreed amount for the Provider's Services. The agreed amount is considered the Negotiated Rate for Program Benefits. • The Network level of Benefits pays a greater portion of the Allowable Charge determined by the Benefits Administrator, which is based on the Negotiated Rate. • Your Network Provider will not charge you for any amounts that are more than the Negotiated Rate. 	<p>Your out-of-pocket expenses are greater when you use Non-Network Providers:</p> <ul style="list-style-type: none"> • Non-Network Providers generally do not agree to a Negotiated Rate for the Provider's Services; however, the Program only pays Benefits up to the Allowable Charge. • The Non-Network Provider has not agreed to accept a Negotiated Rate for the Provider's Services. This means that you must pay any amount above the Allowable Charge determined by the Benefits Administrator. • The amount to which your Coinsurance applies may be greater. 	<p>Your out-of-pocket expenses are lower when you use Network Providers:</p> <ul style="list-style-type: none"> • The Benefits Administrator and the Network Provider negotiate an agreed amount for the Provider's Services. The agreed amount is considered the Negotiated Rate for Program Benefits. • Your Network Provider will not charge you for any amounts that are more than the Negotiated Rate. <p>Your out-of-pocket expenses are greater when you use Non-Network Providers:</p> <ul style="list-style-type: none"> • If a Negotiated Rate is not agreed upon, the Provider may charge you for any billed amounts that are more than the Allowable Charge determined by the Benefits Administrator.
<p>See the Benefits at a Glance table following the "Conditions for Program Benefits" section for cost-sharing amounts.</p>			

	Network Benefits (Network Provider Used)	Network Benefits (Non-Network Provider Used)	Outside Network Area (ONA) Benefits
Notification and Preauthorization requirements	It is your responsibility to determine whether you or your Provider will complete this process. If you receive Services from a Network Provider, in most cases, the Provider will complete the process for you. If your Provider does not provide this Service, or if you are using a Non-Network Provider, you will need to complete the process yourself.	You must notify your Benefits Administrator within a certain time frame when you use a Non-Network Provider for certain Covered Health Services. Failure to do so may result in reduced or no Benefits.	It is your responsibility to determine whether you or your Provider will complete this process. If you receive Services from a Network Provider, in most cases, the Provider will complete the process for you. If your Provider does not provide this Service, or if you are using a Non-Network Provider, you will need to complete the process yourself.
<i>See the "Notification and Preauthorization Requirements" section for information about Services that require Notification or Preauthorization and associated penalties when Notification or Preauthorization is not provided or is not provided timely.</i>			
Claims	Your Provider files Claims for you.	You must file Claims, unless your Provider agrees to file for you.	You must file Claims, unless your Provider agrees to file for you.
Emergency Services	Emergency Services are paid at the Network level for true emergencies. See the "Emergency Services" subsection under the "What Is Covered" section for more information.	Emergency Services are paid at the Network level for true emergencies, even when you use Non-Network Providers. See the "Emergency Services" subsection under the "What Is Covered" section for more information.	Emergency Services are paid at the same Level of Benefits regardless of whether you use a Network or Non-Network Provider. See the "Emergency Services" subsection under the "What Is Covered" section for more information.

Comparison of Claims/Financial Responsibility

What are the financial consequences of using Non-Network Providers when you have Network coverage (or access to Network Providers)? Here's an example.

Mary receives a bill for a \$12,000 Hospital stay. Assuming she has already met her Annual Deductible, the following table shows what she could pay depending on the Provider she uses.

	Network	Non- Network	ONA (Network Provider Used)	ONA (Non- Network Provider Used)
Provider charge for Covered Health Service	\$12,000	\$12,000	\$12,000	\$12,000
Allowable Charge (determined by the Benefits Administrator)	\$9,000	\$10,500	\$9,000	\$10,500
Percentage of Allowable Charge paid by the Program	90%	60%	90%	90%
Total amount paid by the Program	\$8,100	\$6,300	\$8,100	\$9,450
Mary's percentage/Coinsurance of Allowable Charge	10%	40%	10%	10%
Amount exceeding Allowable Charge	\$0	\$1,500	\$0	\$1,500

	Network	Non-Network	ONA (Network Provider Used)	ONA (Non-Network Provider Used)
Total amount Mary owes Provider	\$900	\$5,700	\$900	\$2,550

If Mary receives care from a Network Provider, she pays only \$900 out of pocket (her portion of the Allowable Charge for that Covered Health Service). However, if Mary receives care from a Non-Network Provider, she is responsible for her portion of the Allowable Charge plus the difference between the amount the Provider charges for the Covered Health Service and the Allowable Charge for that Covered Health Service determined by the Benefits Administrator.

Choosing Your Providers

If you are enrolled in a Network level of coverage, you choose whether or not to use a Network Provider each time you need Medical Benefits. When you use a Network Provider, you receive the Network level of Benefits and generally pay less out of pocket. When you use Non-Network Providers, you receive the Non-Network level of Benefits, which may result in more out-of-pocket expenses for you.

If you are enrolled in an ONA level of coverage, you receive the same level of Benefits no matter which Provider you use. However, when you use Network Providers, you generally pay less out of pocket because charges are based on the Allowable Charge.

See the “How Your Choice of Providers Affects Your Benefits” section for more information.

How Your Choice of Providers Affects Your Benefits

The amount you pay may be affected by whether you use a Network or Non-Network Provider. Network Providers include medical and MH/SA Network Providers.

- **Network Providers.** Your Benefits Administrator has identified a group of Providers who are “in Network” and have agreed to provide Covered Health Services at a Negotiated Rate (or discounted rate). Generally, these Negotiated Rates are lower than what Non-Network Providers would charge. This means you pay less. The Network Provider will generally bill and be reimbursed by the Benefits Administrator.
- **Non-Network Providers.** When you receive Covered Health Services from a Non-Network Provider, the Provider’s fees are not subject to Negotiated Rates. The Program only pays up to the amount that the Benefits Administrator determines is the Allowable Charge for a given Service in your area. This means that if your doctor charges above this determined Allowable Charge, you may have to pay the remainder. In most cases, you also will have to file a Claim for Benefits with the Benefits Administrator.

Note: In some circumstances, a Negotiated Rate arrangement will apply even when you use a Non-Network Provider. If a Negotiated Rate arrangement between a Provider and the Benefits Administrator or one of its vendors, affiliates or subcontractors applies, the Negotiated Rate will be the Allowable Charge, and you will not be responsible for any difference between the amount the Provider bills and the Allowable Charge for Eligible Expenses. This can occur with Non-Network Providers, for example, if the Provider participates in a Network administered by the Benefits Administrator other than the Network utilized by the Program or the Benefits Administrator is able to negotiate an agreed fee for your Service.

IMPORTANT: The Benefits Administrator will provide you an Explanation of Benefits (EOB) that identifies the amounts the Benefits Administrator paid on your behalf and amounts that you must pay. Some administrators may refer to this statement by another name, such as Personal Health Statement (PHS).

Showing Your ID Card

You will receive an identification (ID) card from your Benefits Administrator after you enroll. Be sure to carry your ID card with you at all times and show it to your Provider when you receive Services. Your ID card includes important information about your Program Benefits and lets your Provider know that you are enrolled in the Program and that Negotiated Rates may apply.

Transition of Care

If Network areas change due to a change in Benefits Administrator, transition of care allows you to continue care for certain Covered Health Services with your current Provider — and receive Network Benefits – for a period of time before you must transfer to a Network Provider to continue to receive the Network level of Benefits. Note that transition of care is not available for all Covered Health Services. If you have a question or need to apply for transition of care, contact the Benefits Administrator. See the *Benefits Administrator* table in the “Contact Information” section for contact information.

You must meet your Benefits Administrator’s conditions for transition of care and your Benefits Administrator must approve the request in advance to be eligible for transition of care.

In addition, you may be eligible for transition of care assistance if the Benefits Administrator determines (at its sole discretion) that there have been substantial changes to your local Network that affect your treatment plan.

Different transition of care procedures apply depending on the type of care, as detailed below.

Non-MH/SA Transition of Care Procedures

Contact your Benefits Administrator to request a transition of care application. You must submit your application no later than 30 days after the Benefits Administrator changes.

Transition of care is only available for the following clinical conditions:

- End-stage renal disease and dialysis (applies to the Physician or other Provider, or dialysis center), limited to 30 days.
- Nonsurgical cancer therapies, including chemotherapy and radiation, limited to 30 days or completion of the current cycle, whichever is longer.
- Pregnancy, through the postpartum follow-up visit.
- Symptomatic AIDS, limited to 30 days.
- Transplants (solid organ and bone marrow).

If you apply for a transition of care, you must contact your Benefits Administrator or a Network Provider, who must request approval of care obtained from a Non-Network Provider. See the “Non-Network Providers Paid as Network Benefits” section for more information.

If more documentation is needed, the Benefits Administrator will contact you or your Provider. Generally, the Benefits Administrator decides whether to approve the transition of care application within two business days from when all requested information is received, but this could be longer.

If your request is denied, you or your Provider will be notified in writing of the decision and of your Appeal rights. To start the Appeals process, you must submit an Appeal in writing within the period described in the denial letter and send the Appeal to the address shown in the letter. See the “Questions and Appeals” section for information on the Appeals process.

To find out the status on your transition of care request, contact the Benefits Administrator.

MH/SA Transition of Care Procedures

Contact your Benefits Administrator within 30 days after the effective date of your enrollment to request transition of care. See the “Contact Information” section for Benefits Administrator contact information.

- **Inpatient Care.** If you are hospitalized or being treated on an intermediate care basis (i.e., residential, partial/day, intensive outpatient) when you become covered, coverage will continue under your current program until you are discharged or transitioned to a less intensive level of care. The Benefits Administrator will work with your current care representative.
- **Outpatient Care.** If you are receiving Covered Health Services from a Provider who is not in the Network when you become covered, you may request a transition MH/SA Benefit for up to three months (90 days from the transition of care effective date). If you are still in treatment with the Non-Network Provider after the three-month transition period, outpatient MH/SA care will be covered at the Non-Network Benefits level.

Notification and Preauthorization Requirements

The Program requires you to provide Notification to or obtain Preauthorization from the Benefits Administrator before you receive certain Covered Health Services. The Notification and Preauthorization process is in place to verify that Services are Medically Necessary and that treatment provided is the proper level of care. For more information on how a Service is determined to be Medically Necessary, see the “Medically Necessary” section of this SPD.

Depending on the Service your Provider has recommended you receive, you may need to do one of the following:

- *Notify* the Benefits Administrator.
- *Preauthorize* your care.

IMPORTANT: Notification, Preauthorization and predetermination of benefits do not mean Benefits are payable. The Service for which you are seeking Benefits must be a Covered Health Service, and you must meet the Program’s eligibility requirements and any other Program requirements related to the Covered Health Service at the time the Covered Health Service is provided.

Notification and Preauthorization Process

It is your responsibility to determine whether you or your Provider will complete this process. If you receive Services from a Network Provider, in most cases the Provider will complete the process for you. If your Provider does not provide this Service, or if you are using a Non-Network Provider, you will need to complete the process yourself. Refer to your ID card for the appropriate number to call. Contact information is also located in the "Contact Information" section of this SPD.

When you, your Provider or authorized representative contact the Benefits Administrator, you are likely to be asked to provide the following information:

- The name of the attending and/or admitting Physician.
- The name of the Hospital where the Admission has been scheduled and/or the location where the Service has been scheduled.
- The scheduled Admission and/or Service date.
- A preliminary diagnosis or reason for the Admission and/or Service.

Once the Benefits Administrator receives all required information, a representative will assist you in determining the course of treatment through an established case management and review program. This program is designed to:

- Determine whether the planned Service and associated Admission is a Covered Health Service under the Program by:
 - Reviewing the information that is provided and seeking additional information if necessary.
 - Issuing a determination that the Services are either Medically Necessary or not Medically Necessary.
- Educate you about the types of treatment available to you under the Program.
- Offer treatment alternatives if your situation warrants Alternate Care.
- Monitor your progress during ongoing treatment.

Notification and Preauthorization Requirements Table

The following table identifies the procedures that require Notification or Preauthorization, the time frame for providing Notification or obtaining Preauthorization and any penalties for noncompliance. There may be other circumstances where the Benefits Administrator requires notification or additional information in order to determine Benefits available under the Program.

Note: It is important to follow the procedures and timing noted below. Failure to provide Notification or receive Preauthorization may affect your Benefits. If you do not provide Notification or receive Preauthorization, your Benefits may be denied or may be significantly reduced. If you have any questions about the Notification or Preauthorization requirements, contact your Benefits Administrator at the telephone number on your ID card. Contact information is also located in the "Contact Information" section of this SPD.

IMPORTANT: In an emergency, seek care immediately, then call your Physician as soon as reasonably possible for further assistance and directions on follow-up care.

	Notification and Preauthorization Requirements	Timing	Penalties
Alternate Care in Lieu of Hospitalization	Preauthorization: Required	As soon as possible and before Services are received	Benefits will be denied
Inpatient Hospital Admission	Preauthorization: Required	As soon as possible and before Services are received	Benefits will be denied
Cardiac Rehabilitation	Preauthorization: Required	Prior to receiving Services	Benefits payable will be reduced by 50%
Durable Medical Equipment (DME)	Preauthorization: Required	Prior to receiving DME or if a piece of equipment needs repair or replacement	Benefits will be denied
Emergency Room	Notification: Not required unless admitted. See the <i>Hospital Admission after an Emergency</i> row for more information.	See the <i>Hospital Admission after an Emergency</i> row for more information	See the <i>Hospital Admission after an Emergency</i> row for more information
Home Health Care	Preauthorization: Required	Prior to receiving Services	Benefits payable will be reduced by 50%
Hospital Admission after an Emergency	Notification: Required. See the "Notification and Preauthorization Requirements" section for more information.	Within 24 hours of Admission	Benefits payable will be reduced by 50%
Infertility	Preauthorization: Required	Prior to receiving any treatment, Services or supplies	Benefits will be denied
Maternity Hospital Admission	Notification: Required. See the "Notification and Preauthorization Requirements" section for more information.	Two business days if the inpatient stay for the mother or newborn exceeds 48 hours for normal vaginal delivery or 96 hours for cesarean section	Benefits payable will be reduced by 50%
Organ and Tissue Transplant	Preauthorization: Required. There are specific guidelines regarding Benefits for transplant Services. In order to receive special Services you must contact the Benefits Administrator. Additional Benefits are available for certain Programs, see <i>Appendix B</i> for more information.	As soon as the possibility of a transplant arises (and before the transplant center performs a pre-transplantation evaluation)	Benefits payable will be reduced by 50%
Outpatient Procedures/Surgery	Notification: Required before outpatient surgery is performed	As soon as you know that outpatient surgery is required. A minimum of five to seven business days advance notice is preferred.	Benefits payable will be reduced by 50%
Private Duty Nursing	Preauthorization: Required	Prior to receiving Service	Benefits payable will be reduced by 50%

	Notification and Preauthorization Requirements	Timing	Penalties
Scheduled Hospital Admission	Notification: Required	Before elective Admission (five to seven business days advance Notification is preferred)	Benefits payable will be reduced by 50%
Skilled Nursing Facility or Extended Care Facility	Preauthorization: Required	Prior to receiving Service	Benefits payable will be reduced by 50%
Surgery	Notification: Required for outpatient surgeries	As soon as you know that outpatient surgery is required. A minimum of five to seven business days advance notice is preferred.	Benefits payable will be reduced by 50%
Applied Behavior Analysis (ABA) for treatment of autism	Preauthorization: Required	Prior to receiving Service	Benefits will be denied
Transcranial Magnetic Stimulation (TMS)	Preauthorization: Required	Prior to receiving Service	Benefits will be denied
Behavioral Health: Intensive Outpatient Therapy (IOP). Partial hospitalization (PHP) In-home Programs Residential Care	Preauthorization: Required	Prior to receiving Service	Benefits will be denied
Advanced Diagnostic Radiology, including MRI, MRA, Ct-Scan, PET, Echocardiography, Nuclear Cardiology	Notification & Preauthorization: Required	Prior to receiving service	Benefits will be denied
Spine and Joint Surgery and Interventional Pain Treatment	Preauthorization: Required	Prior to receiving service	Benefits will be denied

Predetermination of Benefits

If you want to know if a Service is covered under the Program before receiving the Service, you may ask your Benefits Administrator for a “predetermination.” This gives you and your Provider an idea of what may be covered so you can plan your treatment. To request a predetermination of benefits under the Program, please have your Physician contact the Benefits Administrator at the toll-free telephone number on your ID card. It is important that you or your Provider submit the predetermination well before treatment is planned. Once you receive the predetermination, you can compare it with your Physician’s quoted fee to determine what portion of the bill will be your responsibility.

A predetermination of benefits is not required, nor is it considered a Pre-Service Claim as described in the “Pre-Service Claims” subsection of the “Claims for Benefits” section. A predetermination is valid for 90 days from the date of the predetermination letter. Procedures not performed within this period require a new review.

Completion of a predetermination of benefits does not guarantee that Services will be covered when performed. The final Allowable Charge determination will be made at the time the bill is submitted and will be based on the actual Service provided. The predetermination is based on the information provided and status at the time provided. If circumstances change or a different Service is performed, Benefits payable may vary considerably from the predetermination.

Your Program covers Medically Necessary Covered Health Services as determined by the Benefits Administrator based on the terms of the Program. Although decisions regarding the course of treatment you receive are entirely between you and your Provider, whether or not a Service is “Medically Necessary” determines payment as a Covered Health Service under the Program.

A specific Service is Medically Necessary if, in the reasonable medical judgment of the Benefits Administrator, the Service meets the requirements described in the definition of Medically Necessary below.

Definition of Medically Necessary

Medically Necessary means those Covered Health Services provided by a Hospital, Physician or other Provider for the purpose of preventing, evaluating, diagnosing or treating an Illness (including a Mental Illness), Injury, substance abuse disorder, condition, disease or its symptoms, that are all of the following as evaluated and determined by the Benefits Administrator or its designee, within the Benefit’s Administrator’s sole discretion. The Services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your Illness, Injury, Mental Illness, substance abuse disorder, disease or its symptoms and not an Experimental, Investigational or Unproven Service.
- Provided for the diagnosis or the direct care and treatment of the Illness, Injury, Mental Illness, substance abuse disorder, condition disease or its symptoms.
- Not primarily for convenience purposes (for example, convenience of the Covered Person, Physician, other Provider or family member).
- Not more costly than an alternative drug or Service(s) that is at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of your Illness, Injury, disease or symptoms.

For example, when applied to hospitalization, Medically Necessary means that the Covered Person requires acute care as a bed patient because the nature of the Services cannot be safely and adequately delivered as an outpatient.

For purposes of determining Medical Necessity, “Generally Accepted Standards of Medical Practice” means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Services Considered Not Medically Necessary

Charges will not be considered Medically Necessary when diagnosis, care or treatment is:

- Of unproven or questionable value.
- Unnecessary when performed in combination with other care.
- Custodial in nature.
- Unlikely to provide a Physician with additional information when used repeatedly.
- Not ordered by a Physician. *Note: The fact that a Physician may prescribe, order, recommend or approve a Service does not itself make that Service or supply Medically Necessary.*
- Considered a cosmetic procedure. Services are considered cosmetic procedures when they improve appearance without making an organ or body part work better.

Examples of Services Considered Not Medically Necessary

Examples of hospitalization and other Covered Health Services that are not Medically Necessary include, but are not limited to:

- Hospital Admissions to observe or evaluate a medical condition that could have been provided safely and adequately in another setting such as a Hospital's outpatient department.
- Hospital Admissions primarily for diagnostic studies (X-rays, laboratory and pathological Services, and machine diagnostic tests) that could be safely done in another setting on an outpatient basis.
- Continued inpatient Hospital care when the patient's medical symptoms and condition no longer require continued stay.
- Hospitalization or Admission to a Skilled Nursing Facility, nursing home or other facility for the primary purpose of Custodial Care, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or Admission to a Skilled Nursing Facility for the convenience of the patient or Physician, or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities or routine supportive care, or to provide Services for the convenience of the patient and/or his or her family.
- Reshaping a nose with a prominent bump that did not occur as a result of accidental Injury or surgery, or that is not having an effect on a function like breathing, would be considered a cosmetic procedure.
- Upper eyelid surgery at times will improve vision and be covered as a reconstructive procedure, while on other occasions improvement in appearance is the primary purpose of the procedure and, therefore, the surgery would be considered cosmetic and not covered.

The Benefits Administrator will determine whether hospitalization or other health care Services are Medically Necessary and therefore, eligible for payment. If you have any questions about whether a Service is considered Medically Necessary, contact your Benefits Administrator before care is obtained. Care that is not Medically Necessary will not be covered.

See the “Exclusions and Limitations” section of this SPD for further details regarding Medically Necessary care and other exclusions from coverage.

Determination of Medically Necessary Covered Health Services

After the Benefits Administrator makes a determination as described in the “Notification and Preauthorization Requirements” and “Claims Procedures” sections, you, your Provider and/or the facility will receive Notification of whether or not a Service is considered Medically Necessary. The Notification will specify the dates and Services that were considered during the process.

The Benefits Administrator determines the Medical Necessity of Services as it specifically relates to each individual Claim after the Service is received, based on the actual Service provided. In the event that the Benefits Administrator determines that all or any portion of an inpatient hospitalization or other health care Service is not Medically Necessary, the Program will not be responsible for any related Hospital or other health care Service charge incurred. Remember that the Program does not cover the cost of hospitalization or any health care Services that are not determined to be Medically Necessary.

IMPORTANT: Keep in mind that a Medically Necessary determination does not guarantee that Benefits are available. Benefits are only payable for Services that are a Covered Health Service and not subject to any exclusion or limitation. The Medically Necessary determination does not override the Program’s Benefits provision or the final determination on that Claim for Benefits.

See the “Notification and Preauthorization Requirements” and “Claims Procedures” sections of this SPD for more information.

WHAT IS COVERED

KEY POINTS

- *See this section to determine what medical Services are covered by the Program. You may be required to take additional action to receive certain Benefits.*

This section provides detailed information about the kinds of Medical Benefits, including Benefits for Mental Health/Substance Abuse Services, the Program provides. For specific information about what you pay for these Covered Health Services, see the *Benefits at a Glance* table. To better understand how to use this section and better understand what is covered, here is some important information:

- Covered Health Services are grouped by category and follow the order of the *Benefits at a Glance* table. Covered Health Services that do not fit into a specific category are included in the “Additional Services” section.
- The Program only covers Covered Health Services that are Medically Necessary.
- Even though a Service is included as a Covered Health Service, certain circumstances can cause the Benefits to be reduced or denied.
 - You must provide Notification or obtain Preauthorization for some Covered Health Services. See the “Notification and Preauthorization Requirements” section for more information. While references to this section are made in the description of certain Covered Health Services, it is your responsibility to consult this section and be familiar with when Notification or Preauthorization is required, even if no reference is made in the description of the Service.
 - Certain circumstances may result in the Program not providing Benefits for what would generally be a Covered Health Service. For example, if the Claim for Benefits is filed after the time period for filing Claims has passed. See the “Exclusions and Limitations” section for information.
- The Benefits Administrator may provide an opportunity for Covered Persons to lower their out-of-pocket costs through a specialized Network of health care Providers. See *Appendix B* for additional information on the programs available to you through the Benefits Administrator. Specialized Benefits provided by this Network of health care Providers are not available when care is covered by Medicare as your primary coverage.
- This section does not include information on Prescription Drug coverage; see the “Prescription Drug Coverage” section.

Preventive Care Services

The Program covers Preventive Care Services. Preventive care focuses on evaluating your current health status when you are symptom-free and taking the necessary steps to maintain your health. Appropriate preventive care will vary from person to person based on age, gender and other risk factors, including family history. Consult with your Provider to discuss medical appropriateness and frequency for your individual situation. Special Program provisions apply when you receive preventive care that qualifies as Preventive Care Services under the Program.

Preventive Care Services are those Services that are determined by the Benefits Administrator to provide preventive care and are included in the Benefits Administrator's preventive care policy. The fact that a Service is coded by a Provider as preventive care does not determine whether the Service is covered as a Preventive Care Service. At a minimum, Preventive Care Services include the preventive care required pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA). The Services covered as Preventive Care Services will change from time to time as new medical evidence emerges and evidence-based recommendations change.

Services that are Preventive Care Services in some circumstances may also be provided for purposes other than the routine preventive care covered as Preventive Care Services. When this occurs, these Services are **not** covered as Preventive Care Services. However, they may be covered under other provisions of the Program, subject to applicable cost sharing, including Co-payment, Coinsurance and an Annual Deductible. Examples of Services that can be Preventive Care Services in some circumstances but not others include mammograms (including 3D), colonoscopies and blood tests such as cholesterol tests.

Information concerning whether specific Services are Preventive Care Services should be obtained from the Benefits Administrator. The current guidelines for Preventive Care Services under the Program can be obtained by accessing the Benefits Administrator's website, or you can receive a copy, free of charge, by calling the Benefits Administrator's customer service at the toll-free number on your identification card. As these guidelines may change from time to time, it is important to receive up-to-date information on what the Benefits Administrator has determined to be Preventive Care Services. Your Benefits Administrator's contact information is also located in the *Benefits Administrator* table in the "Contact Information" section of this SPD. Generally, Preventive Care Services include the following:

- Evidence-based items or services that have in effect a rating of A or B at the time of service in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. For those recommendations that apply specifically to high risk groups, the individual's attending physician will determine whether the individual is in the high risk group.
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committees on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved Separate recommendations exist for:
 - Individuals age 0 through 6 years;
 - Individuals age 7 through 18 years;
 - Individuals age 4 months through 18 years who start late or are more than 1 month behind; and
 - Individuals age 19 or older.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Service Administration. These recommendations are also referred to as the Bright Futures Recommendations for Preventive Pediatric Health.

- With respect to women, to the extent not included in previous requirements, the following are considered preventive care services evidence-informed preventative care screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
 - Well-woman visits;
 - Screening for gestational diabetes;
 - Human papillomavirus testing;
 - Counseling and in some cases screening for sexually transmitted infections;
 - Counseling and screening for human immune-deficiency virus;
 - Contraceptive methods and counseling (includes all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity);
 - Breastfeeding support, supplies, and counseling;
 - Genetic counseling and evaluation for BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes
 - Screening and counseling for interpersonal and domestic violence

A comprehensive listing of all of the required Preventive Care items and services may be found at <http://www.healthcare.gov/center/regulations/prevention.html>. If a specific Preventive Care item or service does not specify a limitation on the frequency, method, treatment or setting, the Plan shall apply reasonable medical management techniques to establish applicable limitations on the frequency, method, treatment or setting. You may contact the Benefits Administrator for further information regarding coverage for Preventive Care items and services and applicable limitations.

Special coverage provisions apply to Preventive Care Services. Preventive Care Services are covered at 100 percent of the Allowed Amount without participant cost sharing, such as a Co-payment, Coinsurance or Annual Deductible, but only when you receive Preventive Care Services on an outpatient basis from a Network Provider. Benefits for Preventive Care Services are subject to other Program requirements, such as setting and appropriateness. If a Preventive Care item or service is billed separately from an office visit, then the Plan will impose the applicable cost sharing requirement with respect to the office visit unless the office visit itself is Preventive Care. If a Preventive Care item or service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of Preventive Care items or services, then the Plan will not impose any cost-sharing requirement with respect to the office visit. If a Preventive Care item or service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of Preventive Care item or service, then the Plan will impose the applicable cost-sharing requirement with respect to the office visit.

No coverage is provided for Preventive Care Services if you receive these Services from a Non-Network Provider, unless you are enrolled in coverage that does not utilize a Network, such as an indemnity or out-of-network area (ONA) option. If you are in coverage that utilizes a Network but does not cover a particular preventive care item or service that you need, the Plan will cover the item or service when performed by a Non-Network Provider at 100% without any cost-

sharing. If you are having difficulties finding a Network Provider to provide the services, contact the Benefits Administrator before obtaining the services from a Non-Network Provider.

Preventive Care Transition of Care

If a Service is added to Preventive Care Services under the Program while you are undergoing a course of care and, as a result, the Service will no longer be covered if you use a Non-Network Provider, preventive care transition of care is available. Preventive care transition of care allows you to continue the preventive care with your current Non-Network Provider — and still receive Non-Network Benefits — for a period up to 12 months. The transition period will be no longer than required for the current course of care as determined by the Benefits Administrator. At the end of your transition period, you must transfer to a Network Provider to receive Benefits for Preventive Care Services.

Preventive care transition of care requires Preauthorization by the Benefits Administrator. If you are receiving a Service from a Non-Network Provider that the Benefits Administrator determines will become a Preventive Care Service, you or your Provider must contact the Benefits Administrator to request a transition of care plan within 60 days of the effective date the care you are receiving is added to Preventive Care Services. If you have a question or need to apply for a transition of care plan, contact the Benefits Administrator. See the *Benefits Administrator* table in the “Contact Information” section for contact information.

Emergency Services

Emergency Room (Emergency Medical Condition)

If you have an Emergency Medical Condition, you should immediately get the necessary medical treatment at the nearest Emergency Facility. The Program provides Benefits for outpatient treatment of an Emergency Medical Condition at a Hospital, Alternative Facility or Physician’s office.

Emergency Services due to an Emergency Medical Condition that are provided by a Non-Network Provider will be covered at the Network level of Benefits, that is, the Network cost-sharing requirements will apply no matter where you receive treatment. See the “Cost Sharing” section for information. The Allowable Charge for covered Non-Network Emergency Services Benefits will be the Maximum Allowed Amount (see “definitions” section).

The Provider may bill you for the amount not covered by the Program as an Allowable Charge. This special coverage provision only applies to Emergency Services provided in a Hospital emergency room to treat an Emergency Medical Condition.

Neither Notification nor Preauthorization is required for coverage of Emergency Services in the event of an Emergency Medical Condition. However, the use of Emergency Services is subject to review to determine whether the medical condition was a true Emergency Medical Condition. See the *Benefits at a Glance* table for information on coverage if you receive care in an emergency room that is not treatment to address an Emergency Medical Condition.

You should notify the Benefits Administrator if you are admitted to the Hospital from the emergency room. See the “Notification and Preauthorization Requirements” section for more information. If you are admitted to a Non-Network Hospital, you may be required to transfer to a Network Hospital to continue receiving Network Benefits after your condition is stabilized.

Note: Anesthesia administered due to an Emergency Medical Condition will be covered as Emergency Services.

Emergency Room (Nonemergency)

If you or your enrolled dependent requires care for a nonemergency or routine medical condition, you should first contact your primary care Physician or other Network Provider. The following table provides examples of covered emergency conditions and “nonemergency or routine” medical conditions.

Conditions Suggesting the Need for Emergency Services	Conditions Suggesting the Need for Nonemergency or Routine Services
<ul style="list-style-type: none"> • An apparent heart attack, including chest pain extending to the arms and jaw • Shortness of breath or difficulty breathing • Excessive bleeding • Loss of consciousness • Convulsions • Symptoms of a stroke, including sudden paralysis and/or slurred speech, lack of responsiveness, severe headache • Severe or multiple Injuries, including fractures • Allergic reactions • Apparent poisoning 	<ul style="list-style-type: none"> • Sprains, strains • Fevers • Bad cuts • Skin rashes • Excessive vomiting • Stomach pain or cramps • Prolonged diarrhea • Bad colds, sore throats, coughs • Minor burns • Swollen glands

See the *Benefits at a Glance* table for information on coverage if you receive care in an emergency room that is not treatment to address an Emergency Medical Condition.

Urgent Care Facility

Illnesses and Injuries that are of a less serious nature than an emergency may be treated more economically by a visit to an Urgent Care Facility. Urgent Care Facilities are usually open evenings, weekends and holidays and are designed to give patients fast, effective service and to prevent a serious decline in health. Urgent Care Facilities commonly treat conditions like the following:

- Minor Injuries and cuts
- Upper respiratory infections
- Ear infections
- Sprains
- Sore throats
- Urinary tract infections

Online Visits

Your coverage will include online visit from a LiveHealth Online Provider. Covered services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation

information. Online visits are not covered from Providers other than those contracted with LiveHealth Online. Non-Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation.

Log on to www.livehealthonline.com to register for and access this service.

Ambulance Services

The Program provides Benefits for professional licensed ambulance transportation Services as follows:

- When the Ambulance Service is necessary to transport a person due to an Emergency Medical Condition.
- To move a Covered Person to the nearest Hospital qualified to provide Medically Necessary treatment.
- An ambulance may also be used for transportation between Hospitals or upon discharge from a local Hospital when the use of the ambulance is Medically Necessary.
- Transportation by air ambulance is a covered expense if ground Ambulance Service is not available or if air Ambulance Service is Medically Necessary.

See the *Benefits at a Glance* table for more information.

Inpatient Services

The Program provides Benefits for Hospital Services in the following categories, subject to the following conditions:

- The Service is ordered by a Physician and normally furnished by a Hospital.
- You notify or receive Preauthorization from the Benefits Administrator; see the “Notification and Preauthorization Requirements” section.
- The Service provided is at the level appropriate for your condition (for example, acute care, intensive care, isolation care or rehabilitation unit).
- Hospitalization is necessary to prevent, diagnose or treat an Illness or Injury.

Room and Board

- Covered Health Services include room and board charges for a Semi-private Room or an intensive care unit. Private room accommodation is covered only if Medically Necessary. Items dispensed or provided for the convenience of the patient or visitor is not covered, such as toiletries, guest meals and television rental.

Lab and X-Ray

- Laboratory Services
- Blood and plasma (transfusion): For the cost of blood and blood plasma
- X-rays

Other Inpatient Services

- Biotech or biotechnology products. Benefits are available for medications administered in the Hospital.
- Dental Services (accident only). Accidental Injury to sound natural teeth and removal of bony impacted or partially bony impacted wisdom teeth and certain other dental surgeries when performed in a Hospital.
- Drugs (while in the Hospital). "Take-home drugs" filled at the Hospital Pharmacy are paid under the Prescription Drug coverage. See the "Prescription Drug Coverage" section for outpatient Prescription Drug Benefits information.
- Eye care. Covered surgical care is paid for the surgeon and the facility charge subject to the Inpatient Admission cost-sharing requirements. Routine vision care, such as refraction, lenses and frames are not covered. However, the initial pair of glasses or contact lenses following cataract surgery will be considered a Covered Health Service.
- Gynecological care (non-routine exam by an obstetrician or gynecologist). Surgical care and Hospital Admissions for obstetric or gynecological care are payable the same as any other Medically Necessary Service.
- Nursing Services (including private duty nursing). For the Services of licensed technical or professional medical personnel given in a Hospital.
- Physicians' Services.
- Prescribed drugs and medicines received in a Hospital, as well as surgical supplies such as bandages and dressings.
- Radiation Therapy.
- Radiology.
- Surgery. Surgical Benefits include inpatient surgery, including Physician Services and facility charges.
- Surgical procedures (multiple). The primary procedure is subject to the applicable cost-sharing requirements. The second and third procedures are covered at 50 percent and additional procedures at 25 percent.

Outpatient Services

The Program provides Benefits for outpatient Services. In many instances, you can avoid an overnight Hospital stay by having a Service or surgery performed as an outpatient at a Hospital, an Alternative Facility or a Provider's office. The Program covers the following outpatient Services:

Office Visits

- Services of a Physician for an office visit for diagnosis and/or treatment of an Injury, Illness or disease, including Pregnancy.
- Physician Services that are Preventive Care Services are covered under the “Preventive Care Services” Benefits provisions. See the “Preventive Care Services” section and *Benefits at a Glance* table for more information.

Outpatient Care

- Allergy testing and treatment.
- Biotech or biotechnology products: Benefits are available for medications administered in the Physician’s office or outpatient facility. Certain specialty drugs administered in the doctor’s office must be coordinated through the Prescription Drug Benefits Administrator. Contact your Prescription Drug Benefits Administrator for information. See the *Prescription Drug Benefits Administrator* table in the “Contact Information” section for contact information.
- Chemotherapy. Eligible Expenses for drugs for chemotherapy obtained through a prescription are payable under the Prescription Drug coverage. See the “Prescription Drug Coverage” section for more information.
- Dental Services (accident only). Accidental Injury to sound natural teeth and removal of bony impacted or partially bony impacted wisdom teeth and certain other dental surgeries when performed in an outpatient surgical facility.
- Eye care. Covered surgical care is paid for the surgeon and the facility charge subject to the outpatient surgery cost-sharing requirements. Routine vision care, such as refraction, lenses and frames are not covered. However, the initial pair of glasses or contact lenses following cataract surgery will be considered a Covered Health Service.
- Hospital Services (outpatient).
- Laboratory Services.
- Mammograms (diagnostic) (including 3D). Diagnostic mammograms (including 3D) are covered when Medically Necessary, regardless of age.
- Nursing Services (including private duty nursing): For the Services of licensed technical or professional medical personnel through a Home Health Care Agency.
- Physicians’ Services.
- Radiation therapy.
- Radiology (X-rays, MRIs, CAT Scans, etc.).
- Surgery. Surgical Benefits include outpatient surgery, including Physician Services and facility charges.
- Surgeon’s or assistant surgeon’s fees. Surgery done in the office setting is subject to the applicable cost-sharing requirement. An assistant surgeon must be under the direction of a surgeon.

- Surgical procedures (multiple). The primary procedure is subject to the applicable cost-sharing requirements. The second and third procedures are covered at 50 percent and additional procedures at 25 percent.
- Urgent Care (walk-in) Facility. See the “Urgent Care Facility” section above for information.

Certain outpatient Services that are Preventive Care Services will be covered under the “Preventive Care Services” Benefits provisions. See the *Benefits at a Glance* table and the “Preventive Care Services” and “Notification and Preauthorization Requirements” sections for more information.

Mental Health and Substance Abuse (MH/SA) Services

Mental health conditions and substance abuse conditions will be determined by the Benefits Administrator, having reference to the mental health and substance abuse conditions defined and categorized in: (1) the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV); (2) the most current version of the *International Classification of Diseases* (ICD-10); or (3) state or federal guidelines, as appropriate.

The sections that follow provide information about the MH/SA care covered under the Program. For more information on the specific Benefit levels that apply, see the *Benefits at a Glance* table.

Only Services determined to be Medically Necessary by the Benefits Administrator are covered under the Program. Certain Services require Notification or Preauthorization. See the “Notification and Preauthorization Requirements” section for more information. For inpatient Network and Non-Network Services, documentation of Medical Necessity of Services will be required in order to be considered an eligible charge (this is called retrospective review). See the definition of Medically Necessary in the “Definitions” section for what is considered Medically Necessary MH/SA care.

MH/SA Professional Services

The following Services are covered under the MH/SA Benefits when Medically Necessary, regardless of whether they are provided on an inpatient or outpatient basis:

- Clinical laboratory Services.*
- Consultation to evaluate a Covered Person’s condition.
- Crisis intervention Services.
- Applied behavior Analysis (ABA) services for the treatment of autism is covered. **(Precertification is required, otherwise the plan does not provide coverage.** Call Anthem Autism Spectrum Disorder department at 1-844-269-0538 to obtain pre-certification.)
- Residential Treatment
- Detoxification, including:
 - Physical or mental examination.
 - Administration of psychotropic drugs.
 - Consultation for further evaluation.

- Electroconvulsive shock therapy (ECT) and electrophysiological testing.
- Individual, family or group psychotherapy Counseling.
- Initial assessments of conditions related to alcohol and substance abuse.
- Physical or mental examinations for assessment and diagnosis.
- Psychotropic drugs and medicines and their administration are covered as an inpatient. Outpatient psychotropic drugs and medicines and their administration are covered under the Prescription Drug Benefit. See the “Prescription Drug Coverage” section for information on Benefits and cost sharing.
- Psychological testing, including charges for related materials.
- X-rays and other Diagnostic Services.*
- If you receive nutritional counseling with the primary diagnosis of mental health and/or substance use disorder, cost shares will process according to the mental health and substance use disorder benefit.

*If ordered by a psychiatrist for treatment of the MH/SA condition.

MH/SA Inpatient Hospital Care

If you or a covered dependent is hospitalized as an inpatient, goes to a residential care facility for treatment or receives care under a partial hospitalization program (including detoxification or rehabilitation associated with alcohol or substance abuse), Hospital charges for the following Services when Medically Necessary are covered under the MH/SA Benefits:

- Anesthesia and its administration and related resuscitative procedures when required in connection with ECT, except when anesthesia is provided by the Practitioner who administers the ECT, no separate Benefit is available.
- Assessment, diagnosis, medication management, individual and group therapy, and vocational rehabilitation Services when included as part of an inpatient treatment program.
- Electroconvulsive shock therapy and electrophysiological testing.
- Laboratory and radiology Services.*
- Inpatient Services such as meals and general nursing care.
- Intravenous injections and solutions.
- Semi-private Room or multi-bed unit (private rooms are covered only if they are Medically Necessary, the Facility offers only private rooms or the Hospital or acute psychiatric Hospital provides private rooms as the principal room accommodations for its patients). If a Covered Person elects to receive a private room as the principal room of accommodation for a reason other than as described, the Covered Person will be financially responsible for the amount by which the private room rate exceeds the cost of a Semi-private Room.

*If ordered by a psychiatrist for treatment of the MH/SA condition.

MH/SA Emergency Services

If you or a covered dependent requires Emergency Services for treatment of a mental condition or alcohol or substance abuse, charges for Emergency Services and facilities will be eligible for Network coverage under the MH/SA Benefits provided the MH/SA Benefits Administrator is notified within the required time following Admission. See the *Benefits at a Glance* table and the “Emergency Services” and “Notification and Preauthorization Requirements” sections for information.

If you or a covered dependent requires Emergency Services for treatment of a mental condition or alcohol or substance abuse, MH/SA Benefits include the following Medically Necessary Services when provided in a facility emergency room to treat an Emergency Medical Condition:

- Direct physical or mental examination of the Covered Person for assessment and diagnosis
- Crisis intervention
- Clinical laboratory Services and supplies
- Medication management

Covered Health Services include Ambulance Services required to move you or a covered dependent to the nearest Hospital qualified to provide Medically Necessary treatment. An ambulance may also be used for transportation between Hospitals or upon discharge from a local Hospital when the use of the ambulance is Medically Necessary. Transportation by air Ambulance Service is covered if ground Ambulance Service is not available or if air Ambulance Service is Medically Necessary.

- **[LiveHealth Online –Online Visits** (including Telehealth and/or Telephonic) when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. Examples of Providers from whom You can receive Covered Services include:
 - Psychiatrist;
 - Psychologist;
 - Licensed Clinical Social Worker (L.C.S.W.);
 - Mental Health Clinical Nurse Specialist;
 - Licensed Marriage and Family Therapist (L.M.F.T.);
 - Licensed Professional Counselor (L.P.C.); or
 - Any agency licensed by the state to give these services, when they have to be covered by law.

Intensive In-Home Behavioral Health Programs

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Out-of-Network facility-based Programs for Intensive Outpatient Therapy (IOP), Partial Hospitalization (PHP) and Residential Treatment must occur at Facilities that are both licensed and accredited.

MH/SA Information Requests

Participants have the right to request additional information with respect to mental health and substance abuse coverage and benefits. For example, participants may request information on how medical necessity is determined for mental health and substance abuse coverage. Any requests should be addressed to your medical carrier. If you have any questions, you may also contact the Frontier Benefits Service Center.

Family Planning/Maternity Services

- Gynecological care (non-routine exam by an obstetrician or gynecologist). Surgical care and Hospital Admissions for obstetric or gynecological care are payable the same as any other Medically Necessary Service.
- Infertility Services. Coverage of infertility treatment, including Services aiding conception (e.g. in-vitro fertilization, artificial insemination, GIFT or ZIFT procedures) is subject to a lifetime individual maximum Benefit of \$20,000. Benefits will be determined using the Program's Benefit levels for the type of Service received, including any cost sharing applicable to the Service. Infertility Benefits are available to a Covered Person who has been determined by an infertility specialist to be infertile as defined by the then-current standards of the American College of Obstetrics and Gynecology (ACOG) and who has not been voluntarily sterilized. Diagnosis of infertility and treatment of underlying medical causes of infertility are covered the same as any other medical illness, not subject to the infertility treatment limit. See the "Prescription Drug" section for additional information on medications covered under the Prescription Drug program.
- Obstetrical and newborn care in the Hospital. See the "Newborns' and Mothers' Health Protection Act" section of this SPD for information on your rights regarding Hospital stays after normal vaginal delivery or cesarean section.
- Prenatal and postnatal care.

Certain family-planning and prenatal Services are covered as Preventive Care Services. See the "Preventive Care Services" section for information.

<p>IMPORTANT: Your newborn is eligible for coverage at birth, but you must take the necessary steps to enroll the newborn in the Program within the time frame required to receive Program Benefits.</p>

Rehabilitation Services

The Program provides the following Benefits for rehabilitation Services recommended by a Physician that are determined by the Benefits Administrator to meet the requirements under the Program.

- Cardiac rehabilitation: Rehabilitation Services must be performed by a licensed therapy Provider under the direction of a Physician.
- Occupational Therapy: Medical care and treatment by an occupational therapist.
- Physical Therapy;

- Speech Therapy.
- Vision therapy: For evaluating and developing a plan of treatment for the training by an optometrist or orthoptic technician. Routine vision care, such as eye refractions, lenses and frames, or contact lenses, is not covered under the Program.

Note: Any combined In & Out of Network limits for physical, occupational and speech therapy will not apply if You receive care with the primary diagnosis of **Autism**.

Note: Any combined In & Out of Network limits for physical, occupational and speech therapy will not apply if You receive care with the primary diagnosis of mental health and/or substance use disorder. Cost-shares for physical therapy, speech therapy and occupational therapy will process according to the mental health and substance use disorder benefit.

Additional Services

Alternate Care

Benefits are available for Alternate Care under the terms of an Alternate Care Plan developed by the Benefits Administrator or its designee. During the course of a patient's care under the Program, the Benefits for a specific needed treatment or modality (therapeutic method) may be depleted. If additional treatment or an extension of a certain Service is needed, the Benefits Administrator or its designee may consider, if appropriate, creating an Alternate Care Plan to either continue the current care in lieu of, or to avoid, a potentially more costly alternative or offer a more cost-effective Alternate Care.

If it is determined that a patient is eligible for an Alternate Care Plan, the Benefits Administrator or its designee will contact the patient and/or the Provider to explain the benefits of an Alternate Care Plan. If the patient and the Provider agree that the Alternate Care Plan is a medically appropriate alternative, the Benefits Administrator or its designee will provide the patient with an Alternate Care Plan agreement. The agreement must be signed by the patient and the Provider and returned to the Benefits Administrator or its designee.

The patient is not required to participate in the Alternate Care Plan. The patient and the Provider can, at any time, end or change the course of care. However, any changes to the course of care will not be governed by the Alternate Care Plan and may not be covered under the Program.

The following are some instances in which the patient is not eligible for Alternate Care:

- The Program is the secondary Coverage Plan. See the "Coordination of Benefits" section for more information.
- The Service is specifically excluded under the Program.
- The coverage for the Service has already reached a Benefit Maximum, unless continuation of such Service is in lieu of or avoids a potentially more costly alternative.
- The compared "in lieu of" care or Service is not medically appropriate for the diagnosis as determined by the Benefits Administrator or its designee.
- The compared "in lieu of" care or Service is not more cost effective in comparison with another Course of Treatment covered by the Program as determined by the Benefits Administrator or its designee.

Alternate Care Benefits will be terminated if the Benefits Administrator or its designee determines that:

- A normal requirement for payment of Benefits under the Program is not met (e.g., the patient is no longer eligible to participate).
- Alternate Care is not being provided by duly licensed Providers within the scope of their license.
- Alternate Care is determined not to be a Covered Health Service or is otherwise excluded under the Program.
- Payment of Alternate Care Benefits is not cost effective, as determined in the sole discretion of the Benefits Administrator or its designee.
- Any established durations or other limitation set forth in the Alternate Care Plan agreement has been met or exceeded.

All Alternate Care must be preauthorized. See the “Notification and Preauthorization Requirements” section for more information.

Provision of Alternate Care Benefits in one instance shall not result in an obligation to provide the same or similar Benefits in any other instance. In addition, the provision of Alternate Care Benefits shall not be construed as a waiver of any of the terms, conditions, limitations and exclusions of the Program.

Chiropractic Treatments

- Outpatient Services by a Physician, including a licensed chiropractor or naturopath.

Durable Medical Equipment

Following are examples of medical supplies and Durable Medical Equipment covered under the Program, as long as they meet the Medically Necessary requirement:

- An appliance to replace a lost body organ or part to help a disabled person return to functioning capacity, for example, an artificial limb or eye. Only the charge for the first appliance in the patient’s lifetime is covered for each body organ or part, except for replacements needed due to a change in the patient’s physical condition (including normal physical growth).
- Custom-made orthotics.
- Oxygen and the charges for giving it, including rental of required equipment.

Gene Replacement Therapy/Gene Therapy – Please contact the Claims Administrator (“Anthem”) to check for benefits.

Gender Dysphoria (Reassignment) Treatment

To be covered under the Program, the gender dysphoria (reassignment) treatment must be Medically Necessary. The determination of whether the treatment is Medically Necessary will be made by the Benefits Administrator based on generally accepted medical standards of care such

as the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders.

Factors for consideration may include whether the individual meets the following criteria:

- Be at least 18 years of age.
- Have a diagnosis of Gender Identity Disorder (GID) of transsexualism.
- Undergo a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a Physician.
- Complete a minimum of 12 months of successful, continuous, full-time, real-life experience in their new gender, with no returning to their original gender.
- Acquire a legal gender-identity-appropriate name change.
- Provide documentation to the treating therapist that other people know that the he or she functions in the desired gender role.
- Regularly participate in psychotherapy during the real-life experience, as recommended by a treating medical or mental health Practitioner.
- Have a letter* completed by a Physician or mental health Provider who has treated the individual for a minimum of 18 months.
- Have a letter* from a second Physician or mental health Provider familiar with the individual's treatment and the psychological aspects of GID, corroborating the information provided in the first letter.
- Have a letter from the surgeon that confirms they have personally communicated with the treating mental health Provider or Physician, as well as the individual, and confirms that the individual meets the above criteria, understands the ramifications and possible complications of surgery, and that the surgeon feels that the individual is likely to benefit from surgery.

*At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W. or Psy.D.) and be capable of adequately evaluating co-morbid psychiatric conditions.

Note: Travel and lodging are not covered under this Benefit.

Gender Reassignment Surgery Reversal – If determined to be medically necessary to avoid complications this will be a covered service. Elective reversal is not covered.

Hearing Benefit

In addition to the initial cost of a hearing aid following ear surgery or an ear Injury, Covered Persons in the Program are eligible for:

- A hearing test/exam, when Medically Necessary. Associated office visits, exams and tests are not subject to the maximum dollar amount.

Reimbursement of up to \$1,000 of expenses incurred to purchase a Medically Necessary hearing aid appliance(s) in any rolling 36-month period* including FDA-approved over-the-counter

hearing aids. If you purchase an over-the-counter hearing aid a prescription, receipt and claim form are required for reimbursement consideration.

- Reimbursement for the cost of repair of your hearing aid appliance. The cost for the repair does not count toward the maximum dollar amount.

**Note: The Program will cover the first hearing aid following ear surgery or Injury, and it is not subject to the maximum dollar amount. Batteries for hearing aid appliances are not eligible for reimbursement. See the “How the Rolling 36-Month Period Is Calculated” table for more information.*

Special reimbursement rules apply under the “Hearing Benefit” provisions of the Program. If you do not follow the special rules, you will not be reimbursed. The information that follows explains how to get reimbursed for the following:

- Medically Necessary hearing tests/exams
- Medically Necessary hearing aid appliances
- Repairs to hearing aid appliances

In most cases, your Physician will refer you to an audiologist for your hearing test or to obtain a hearing aid appliance. In general, you will need to obtain a prescription or letter from your Physician to establish the Medical Necessity of the hearing test and/or hearing aid appliance. When you file a Claim for reimbursement, the prescription or letter must accompany your Claim or you will not be reimbursed. If your doctor writes one prescription or referral that covers both a hearing test and hearing aid appliance, you may use the same prescription or letter to obtain reimbursement for both expenses. See the *Benefits Administrator* table in the “Contact Information” section for information on where to file your Claim.

Your Physician’s office may file your Claim for you. If your Physician’s office does not submit a bill/Claim for your hearing aid appliance purchase, you must submit, along with your bill/Claim, either a prescription or a signed letter from your Physician on his or her letterhead that refers you to an audiologist for testing and/or establishes Medical Necessity for you to purchase a hearing aid appliance.

You are required to submit a bill/Claim for reimbursement for repairs to the hearing aid appliance.

Example:

How the Rolling 36-Month Period Is Calculated		
Hearing appliances (hearing aids) are subject to a maximum dollar amount within a 36-month rolling period for eligible Covered Persons under the Program. The example below shows how the reimbursement formula works.		
Date	What Happened	Result
Jan. 5, 2023	Hearing appliance purchased at \$350. The 36-month rolling period for the \$1,000 hearing appliance Benefits begins.*	Total Benefits used: \$350 Total Benefits remaining through Jan. 4, 2026: \$650
April 1, 2025	Hearing appliance purchased: \$350.	Total Benefits used: \$700 Total Benefits remaining through Jan. 4, 2026: \$300

Jan. 5, 2026	A new 36-month rolling period begins.	The hearing appliance reimbursement amount is reset to \$1,000
March 5, 2029	Hearing appliance purchased at \$500. A new 36-month rolling period begins.	Total Benefits used: \$500 Total Benefits remaining through March 4, 2032: \$500
*The \$1,000 is calculated beginning from the first date of Service indicated on the bill. It does not reset until 36 months later.		

Coverage for Clinical Trials

The Plan covers “routine patient costs” for items and services incurred by a “qualified individual” in connection with participation in an “approved clinical trial.” “Routine patient costs” include all items and services that would be covered typically under the Plan for individuals who are not otherwise participating in a clinical trial.

It does not include the following items and services:

- The investigational items, devices or services themselves;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If the approved clinical trial is only offered outside the patient’s state of residence, the Plan must cover routine patient costs of services and items which are provided by out-of-network providers. Otherwise, the Plan is not required to provide benefits for routine patient costs if the services are provided by an out-of-network provider unless the Plan otherwise covers services by out-of-network providers.

To be a “qualified individual,” you must meet two requirements. First, you must be eligible to participate in an approved clinical trial (defined below) according to the trial protocol. Second, your attending physician must determine that your participation in the trial is appropriate, or you must provide medical and scientific information establishing that you meet the eligibility standards of the trial protocol and that your participation in the trial is appropriate.

An “approved clinical trial” is a phase I, II, III or IV clinical trial that is (1) conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition (i.e., likely to lead to death unless the course of the disease or condition is interrupted), and (2) is any one of the following:

- Federally-funded by one or more government agencies or entities designated in Section 2709(d)(1)(a) of the Public Health Service Act;
- Conducted under an investigational new drug application requirements;
- Is a drug trial that is exempt from the investigational new drug application requirements.

NOTE: If one or more Network Providers are participating in the approved clinical trial, you must use the Network Provider for the approved clinical trial provided he or she will accept you as a patient.

Home Health Care

Home Health Care includes Home Health Care Agency Services, nursing care, Physical Therapy, Occupational Therapy and Speech Therapy at home. The following Home Health Care expenses will be covered to the extent that they would have been covered under the Program if the person had stayed in the Hospital:

- Medical supplies.
- Drugs and medications ordered by a Physician other than those available through the Prescription Drug program. Certain specialty drugs administered at home must be dispensed through the Prescription Drug Benefits Administrator. Contact your Prescription Drug Benefits Administrator for information. See the *Prescription Drug Benefits Administrator* table in the "Contact Information" section for contact information.
- Laboratory Services given or ordered by a Hospital Physician.

Hospice Care

Hospice care is designed for terminally ill patients with a life expectancy of twelve months or less. It includes Physician, nurse, social worker, clergy, psychologist, psychiatrist and other professional Services, as well as Counseling for family members after the patient dies. The Hospice must meet specific Program requirements, including state licensing and/or Medicare Hospice certification and the provision of 24-hour a day care to control the symptoms of the terminal illness. The attending Physician must certify that the patient is terminally ill.

Medical Equipment (Rentals or Purchase)

The rental or initial purchase (or necessary repair) of Durable Medical Equipment and certain medical supplies prescribed by a Physician for treatment of an illness or injury are covered. The Program does not cover any changes made to your home, automobile or personal property, such as air conditioning or remodeling. Rental coverage is generally limited to the purchase price of the Durable Medical Equipment.

Organ or Tissue Transplants

- Organ and tissue transplants performed by a Designated Network Provider ensure you receive the maximum level of Benefits. Contact the Benefits Administrator as soon as the possibility of needing a transplant arises to preauthorize your care, to determine your coverage, to locate a Designated Network Provider and to approve coverage for the patient and a companion for transportation and lodging if the transplant cannot be provided in your area. The Program pays expenses for charges incurred:
 - By the transplant recipient and donor if both are covered by the Program.
 - By the transplant recipient and donor if only the recipient is covered under the Program, provided the donor is not otherwise eligible for these Benefits under any other plan. Benefits provided to the donor will be charged against the recipient's coverage under the Program.
 - By the donor if only the donor is covered under the Program, provided the donor is not eligible for these Benefits under any other plan.

- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not covered unless the search is made in connection with a transplant procedure arranged by a Designated Network Provider.

Additional Benefits may be available through the specialized Network made available through the Benefits Administrator. See *Appendix B* for further information.

Skilled Nursing Facility

Skilled nursing Services must be in lieu of an inpatient Hospital stay. Benefits include room and board charges for a Semi-private Room or an intensive care unit.

Carelon Musculoskeletal Program

Certain orthopedic and pain management services will be subject to mandatory precertification and possible redirection to alternative sites of care. Through Anthem's musculoskeletal program, a team of experts will help ensure you are receiving quality care at the most cost-effective setting. Your doctor that is managing your care will contact Anthem for a collaborative review to discuss care options and the best treatment plan based on the most appropriate, evidence-based musculoskeletal care.

Carelon Specialty Health- High Tech Radiology Imaging including but not limited to MRI, CT-Scan, PET, Echocardiography and Nuclear Cardiology

If you need **MRI, CT-Scan, PET, Echocardiography and Nuclear Cardiology**, it's important to know that costs can vary quite a bit depending on where you go to receive the service. Carelon does the research for you and makes it available to help you find the right location for your **MRI, CT-Scan, PET, Echocardiography and Nuclear Cardiology**. Here's how the Program works:

- Your doctor calls the number on the back of the ID card to pre-certify your **MRI, CT-Scan, PET, Echocardiography or Nuclear Cardiology** test
- Carelon works with your doctor to help make sure that you are receiving the right test – using evidence-based guidelines
- Carelon also reviews the physician's referral to see if there are other providers in your area that are high quality but have a lower price than the one you were referred to
- If Carelon finds another provider that meets the quality and price criteria, Carelon will give you a call to let you know
- You have the choice – once approved, you can see the radiology provider your doctor suggested OR you can choose to see a provider that Carelon tells you about. Carelon will even help you schedule an appointment with the new provider

No matter which provider you choose, there is no effect on your health care benefits.

Managing Specialty Medications

If You are utilizing a Specialty Drug, our goal is to provide You with access to the most clinically appropriate therapy to meet Your treatment needs. These Drugs are used to treat complicated and chronic conditions, such as cancer, rheumatoid arthritis, multiple sclerosis, and other diseases. Health issues like these can be challenging to manage and we want to assure that You receive safe, effective treatment.

Providing coverage under the best benefit (Pharmacy or medical) is the first step. Specialty medications which You can give to Yourself are best managed under the Pharmacy benefit. Drugs which require a medical professional to give to You will be provided under Your medical benefit.

Anthem also requires precertification for certain specialty Drugs under the medical benefit. This means that a clinical review is required before the Drug is approved. Precertification assures consistent use of effective medications based on our medical policies and treatment guidelines. We also review for correct dose and frequency as well. During this time, our pharmacists will work with Your Physician to incorporate additional dose reduction opportunities that are still clinically appropriate for You. Your Physician will contact us for precertification and provide us with the clinical information needed for us to review the request.

Our final focus is on the setting in which Your treatment may occur. There are multiple options available to You typically selected by Your Physician. Did You know that the outpatient Hospital setting can be 2-3 times more costly than other sites? Receiving care in a lower cost site which can meet Your specific needs can help You and Your Employer save money and can also possibly provide You with more convenient options in which to receive Your Drug treatment. Anthem's Site of Care program requires that Your prescriber provide information on the level of care that You need. You may be redirected to receive Your care in Your Physician's office, an infusion center, or from a home infusion Provider instead of the outpatient Hospital.

All of these approaches work cohesively together to help You with Your medical Specialty Drug needs.

Physical Therapy (PT) Delivered Digitally!

You have access to virtual physical therapy through "**Hinge Health**" to help you overcome pain anytime, anywhere. When you receive PT sessions through Hinge Health, your cost will be \$0, and the number of PT sessions will not go toward the plan maximum number of visits. The program provides all the tools you need to conquer back and joint pain, recover from injuries, prepare for surgery, or stay healthy and pain free:

- A personal physical therapist that guides you through exercise sessions
- A personal health coach that will be available via text, email, or call to help you reach your goals
- Wearable sensors that give live feedback during stretches and exercises

If you don't have pain and are just looking to stay healthy, you can sign up for their free app.

Recommended exercises will be tailored to you based on your job and lifestyle.

For more details and to participate in Hinge Health, call 855-902-2777 or connect via hinge.health/frontier

Gastrointestinal (GI) Care Clinic, Oshi Health

If you are struggling with gastrointestinal (GI) conditions our new virtual GI care clinic through **Oshi Health** can help.

Oshi Health connects you with an integrated care team consisting of GI specialists - board certified gastroenterologists, registered dietitians, GI-specialized behavioral health clinicians and nurse practitioners. Following your Oshi GI provider visit, you will get access to unlimited visits with GI registered dietitians and GI behavioral health providers to help address the root causes of your digestive symptoms.

The program is offered to you and your eligible adult dependents (+18) participating in a Frontier sponsored Anthem medical plan and is **fully paid by Frontier**.

Visit [Oshi Health](#) to learn more about the program, book a free introductory call to learn how Oshi can help you along your journey to GI health, and/or book an appointment for visit.

EXCLUSIONS AND LIMITATIONS

KEY POINTS

- *Certain Services are never covered by the Program.*
- *Other Services are covered only if they are Medically Necessary.*
- *Some Services are covered, but only in certain circumstances or to a limited extent.*

Some state or local laws may restrict the (1) scope of health care services that a Physician may render and/or (2) the scope of health care items that a Physician may prescribe or furnish. In such case, the Medical Option will not cover such health care services or health care items. The Plan (and each applicable Medical Option) does not cover, pay for or reimburse health care services or health care items that are prohibited by state or local law and which are illegally performed, prescribed or furnished in such state or locality.

The Program does not cover certain medical Services or expenses. These are called exclusions. All care must be Medically Necessary to be covered. No Benefits will be provided for Services that are not Medically Necessary in the judgment of the Benefits Administrator.

This section and the Prescription Drug “Exclusions and Limitations” section provide a list of Services and expenses that are not covered. “Services” includes all Services, treatments and supplies (including Durable Medical Equipment) and Prescription Drugs for which Claims are submitted.

This list does not include exclusions for outpatient Prescription Drug expenses. See the Prescription Drug “Exclusions and Limitations” section for a list of Prescription Drug exclusions.

The exclusions in the following list are not intended to be all-inclusive. Even if not included in the following list, a Service would not be covered if it is not a Covered Health Service as described in the “What Is Covered” section. That is because some general categories of expenses, such as eye care, are not paid by the Program except in specific instances, such as a pair of eyeglasses after eye surgery. It is important to check both sections. If you have questions about whether a Service or expense is covered under the Program, contact the applicable Benefits Administrator.

In addition, the Program will not pay for Benefits for any of the Services or expenses described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

General Health Care Exclusions

- Charges for non-treatment purposes, including missed appointments, room or facility reservations, completion of Claim forms or record processing.
- Expenses for Services that exceed the Allowable Charge or any specified limitation or penalty imposed under the Program.
- Claims filed more than one year after the date of Service if the Program is your only medical coverage, or two years after the date of Service if your Claim is coordinated with another coverage that has primary responsibility.
- Expenses for a Covered Person (including Hospital confinement) incurred before the individual was covered under the Program.
- Services resulting from war or intentional armed conflict.
- Services for which a Covered Person is not required to make a payment (such as for professional courtesy) or for which a Covered Person would have no legal obligation to pay in the absence of this or any other similar coverage; for example, Services provided by the federal or any state government or agency or subdivisions thereof.
- Services resulting from a work-related Injury or Illness covered under workers' compensation.

Specific Health Care Exclusions

Alternative Treatments

- Acupuncture.

Dental

- Routine dental care.
- Correction of malposition of the teeth and jaw through dental or orthodontic treatment or treatment of pain in the jaw joint due to deformity, Injury, deficiency or physical condition of the teeth.

Devices and Appliances

- Nondurable medical items whether used for a medical reason or not, including, for example, batteries and battery chargers.
- Post-mastectomy bras.

Foot Care

- Routine foot care, except for persons diagnosed with diabetes.
- Orthopedic shoes are not covered unless for a Child through the age of 12.

Mental Health/Substance Abuse (MH/SA)

- Any nonprescription or over-the-counter drug, supplement or other medicinal treatment.

- Any testing, evaluation, consultation, therapy, Services, supplies or treatment that are covered as benefits under a plan or other coverage that is primary to coverage under the Program. See the “Coordination of Benefits” section for further information on what coverage is primary.
- Any testing, therapy, Service, supply or treatment of organic disorders, dementia and primary neurologic/neurodevelopment/neurocognitive disorders except for associated treatable and acute behavioral manifestations.
- Any testing, evaluations, consultations, therapy, rehabilitation, remedial education, Services, supplies or treatment for developmental disabilities, communication disorders or learning disabilities available from or through the educational system (whether public, parochial or private), and/or required to be made available from or through the educational system pursuant to Public Law 94-142, regardless of whether or not there is any cost to the Covered Person or the Covered Person takes advantage of such testing, rehabilitation, remedial education, Services or treatment.
- Any testing, evaluation, consultation, therapy, Services, supplies or treatment for personal or professional growth and development.
- Any testing, evaluation, consultation, therapy, Services, supplies or treatment relating to employment, regardless of whether Investigational or pre- or post-employment.
- Any testing, therapy, Service, supply or treatment that does not meet national standards for mental health professional practice or that have not been found to be efficacious or beneficial by one or more of the plans or its designees or authorized management entity’s clinical quality or review committees based on a review of peer-reviewed literature and clinical information available.
- Any testing, therapy, Service, supply or treatment provided as a result of any workers’ compensation law or similar legislation or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof (exclusive of Medi-Cal/Medicaid) or caused by the conduct or omission of a third party for which the Covered Person has a claim of damages or relief, unless the Covered Person provides the Program or its designee with a lien against such claim for damages or relief in a form and manner satisfactory to the Program and its designee.
- Any testing, evaluation, consultation, therapy, Services, supplies or treatment provided by the Covered Person’s parent, siblings, Child(ren), current or former Spouse, or current or former Partner.
- Court-ordered psychiatric or substance abuse evaluation, treatment and testing except when the Program or its designee determines that such Services are Medically Necessary for the treatment of a DSM-IV mental health diagnosis according to established clinical criteria and clinical policies of the Program or its designee.
- Custodial Care. Defined as any Services, supplies, care or treatment rendered to a Covered Person who:
 - Is disabled mentally or physically as a result of a DSM-IV-TR (or ICD-9) MH/SA diagnosis and such disability is expected to continue and be prolonged.

- Requires a protected, monitored or controlled environment whether inpatient, outpatient or at home.
- Requires assistance with activities of daily living.
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the Covered Person to function outside the protected, monitored or controlled environment.
- Experimental or Investigational Services, including testing, therapy, Service, supply or treatment defined as an unproven therapy or treatment that may or may not be superior to a current “gold standard” therapy and that meets one or more of the following criteria:
 - Not generally accepted by the medical community as effective and proven.
 - Not recognized by professional medical organizations as conforming to accepted medical practice.
 - Not approved by the FDA or other requisite government body.
 - In clinical trials or needs further study.
 - Rarely used, novel or unknown and lacks authoritative evidence of safety and efficacy.
- Inpatient Prescription Drugs not dispensed as part of the treatment for a DSM-IV mental health diagnosis in the course of a preauthorized covered inpatient Admission.
- Outpatient Prescription Drugs.
- Private duty nursing except when preauthorized by the Program or its designee as Medically Necessary.
- Psychological testing, except when preauthorized as Medically Necessary by the Program or its designee.
- Services, supplies or treatment for or related to education or training for professional licensure, certification, registration or accreditation.
- Treatment or consultations provided via telephone, electronic transmission or other non-in-person modalities, unless determined as Medically Necessary.

Personal Care, Comfort or Convenience

- Supplies, equipment and similar incidentals for personal comfort, including when provided while an inpatient in a Hospital. Examples include:
 - Personal hygiene, comfort and convenience items commonly used for other than medical purposes, such as air conditioners, televisions, telephones, humidifiers or physical fitness equipment.
 - Personal services when you are in the Hospital (TV rentals, telephone charges, guest meals, etc.).

Physical Appearance

- Wigs and wig styling.

Procedures and Treatments

- Autologous blood donation and storage.
- Charges for procedures, treatment methods, drugs or devices determined by the appropriate Benefits Administrator to be Experimental or Investigational. When a Covered Person is enrolled in a clinical trial, this exclusion does not apply to routine patient costs for Services provided in connection with the clinical trial consistent with the coverage provided under the Program that are typically covered for a Covered Person who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Experimental, Investigational or Unproven Service itself; 2) Services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a Service that is inconsistent with the generally accepted and established standards of care for a particular diagnosis otherwise covered under the Program.
- Cosmetic procedures (unless due to accidental Injury or functional impairment from a birth defect or disease, or breast reconstruction surgery as provided by law) as described in the “What Is Covered” section are excluded from coverage.

Provider Services

- Charges or Services rendered by a Physician or other Provider to himself or herself or for Services rendered to his or her immediate family, including parents, Spouse/Partner and Child(ren).
- Services administered by a licensed pastoral counselor to a member of his or her congregation in the course of normal duties as a pastor or minister.

Reproduction

- Charges for semen as part of infertility treatment (including its collection and storage).
- Reversal of a tubal ligation or vasectomy.

Transplants

- Organ or tissue transplants or multiple organ transplants other than those listed in the “What Is Covered” section and *Appendix B* unless determined by the Benefits Administrator to be a proven procedure for the involved diagnoses.

Types of Care

- Charges for weight loss clinics or programs, exercise programs intended to control weight and special foods or diets unless covered as a Preventive Care Service.

Vision

- Expenses covered under the vision programs; and
- Eyeglasses or contact lenses and eye refractions, except for the initial pair of glasses or contact lenses following eye surgery.

All Other Exclusions

- Charges for custodial or respite care, or day care for Child(ren) or adults whether in the home or in a facility.

- Charges for education, training and bed and board while confined in an institution that is mainly a school or other institution for training or a place for the aged, or a nursing home.
- Expenses for Educational therapy (except for applied behavior analysis (ABA) for treatment of autism), marital Counseling and sex therapy.
- Immunizations, unless otherwise specified in the “What Is Covered” section.
- Paternity testing to establish parenthood.
- Private duty nursing unless preauthorized by the Benefits Administrator.
- Tests for premarital or pre-employment examinations.
- Therapeutic massage and general massages, including services provided by a health spa.

IMPORTANT: Omission of a Service or supply from this list does not automatically qualify it as an Eligible Expense under the Program. Contact the Benefits Administrator before you receive care to determine if the item or Service is covered.

If you have a question about a specific Service and whether it is covered under the Program, contact the appropriate Benefits Administrator.

PRESCRIPTION DRUG COVERAGE

KEY POINTS

- *The Prescription Drug Benefit covers many, but not all, Prescription Drugs currently on the market.*
- *The Prescription Drug Benefit level of coverage depends on where you purchase your Prescription Drug and the type of Prescription Drug you receive.*
- *The Retail Prescription Drug Service is used for a short-term prescription supply (up to a 30-day supply).*
- *The Mail Order Prescription Drug Service is used for a long-term prescription supply (generally, up to a 90-day supply).*
- *The Prescription Drug Benefit imposes special rules for filling and refilling prescriptions for Specialty Prescription Drugs.*

Benefits at a Glance

The Program provides coverage of Prescription Drugs through the Prescription Drug Benefit. The Prescription Drug Benefit is administered by the Prescription Drug Benefits Administrator. Eligibility and participation is automatic with your participation in the Company's Self-Funded Options.

The table below gives you the highlights of the Prescription Drug Benefit. In it, you will find summary information about the cost and coverage of Prescription Drugs and other requirements that may affect your Benefits under the Prescription Drug Benefit. In addition, you will find quick references for more information related to the Prescription Drug Benefit.

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Cost and Coverage			
Annual Deductible	Not applicable	Not applicable	Not applicable
Annual Out-of-Pocket Maximum	Individual and Family: \$1,200/\$2,400 <ul style="list-style-type: none"> • Combined with Mail Order Prescription Drug Service. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. Expenses that do not apply to the Annual Out-of-Pocket Maximum:	Not applicable	Individual and Family: \$1,200/\$2,400 <ul style="list-style-type: none"> • Combined with Network Retail Pharmacy. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. Expenses that do not apply to the Annual Out-of-Pocket Maximum:

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
	<ul style="list-style-type: none"> • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy. 		<ul style="list-style-type: none"> • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy.
Supply Limit	Up to a 30-day supply	Up to a 30-day supply	Up to a 90-day supply
Generic Drug	\$12 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	\$24 Co-payment per prescription
Preferred Brand Drug	\$40 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	\$80 Co-payment per prescription
Non-Preferred Brand Drug	\$65 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	\$130 Co-payment per prescription
Co-payment Exceptions	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.
Other Requirements			
Mandatory Generic/Brand Restriction	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.
Mandatory Mail	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	n/a	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Rx Clinical Programs	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.
Specialty Pharmacy	Plan does not provide coverage, if Specialty Medications are filled through Retail Pharmacy. Specialty Prescription Drugs must be filled through the Benefits Administrator's specialty drugs mail order pharmacy (currently Accredo), from the first Fill of any specialty medication.		Specialty Prescription Drugs must be filled through the Benefits Administrator's specialty drugs mail order pharmacy (currently Accredo), from the first Fill of any specialty medication. See the "Specialty Prescription Drug Services" section for additional information.

For more information about the Prescription Drug Benefit, see the "Filling Your Prescriptions" section for more information on the following:

- Retail Prescription Drug Services.
- Mail Order Prescription Drug Services.
- Specialty Prescription Drug Services.
- "Cost Sharing" section for information on how you and the Program share in the cost of your Prescription Drug coverage.
- "What Is Covered" section for a list of Prescription Drug categories that are covered under the Prescription Drug Benefit.
- "What Is Not Covered" section for a list of Prescription Drugs that are **not** covered under the Prescription Drug Benefit.
- "Contact Information" section if you have any specific questions for the Prescription Drug Benefits Administrator.
- "Claims for Benefits" section if your Prescription Drug Benefit is denied in whole or in part.

Cost Sharing

You and the Program share in the cost of your Prescription Drug coverage.

This section describes cost-sharing features that are built into the Program. See the *Benefits at a Glance* table following the "Key Points" section for specific amounts.

Co-payments

Each time you fill a prescription you pay a Co-payment. The amount of your Co-payment depends on the classification of the Prescription Drug you purchase (Generic Drug, Preferred Brand Drug or Non-Preferred Brand Drug) and where you get your prescription filled.

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum limits the amount you pay for Prescription Drugs each year purchased from a Network Retail Pharmacy or through the Mail Order or Specialty Drug Programs. Once you reach your combined Network Retail Pharmacy and Mail Order or Specialty Drug Program Annual Out-of-Pocket Maximum, the Program will pay the full amount of Eligible Expenses you incur for your eligible Prescription Drugs purchased from a Network Retail Pharmacy or through the Mail Order or Specialty Drug Program for the rest of the calendar year.

Once you meet your Out-of-Pocket Maximum, the Program will pay 100% toward the expense that would have applied toward your Out-of-Pocket Maximum. You will still be responsible for any expenses that would not have applied toward the Out-Of-Pocket Maximum.

See the *Benefits at a Glance* table following the “Key Points” section for the applicable cost share information.

Prescription Drug Coverage

Covered and Excluded Medications

The Prescription Drug Program offers coverage of drugs that are:

- Required by federal law to be dispensed with a written prescription and prescribed over-the-counter medications to the extent required by federal law as preventive care.
- Approved by the Food and Drug Administration (FDA).
- Dispensed pursuant to a prescription issued by a Prescriber.
- Dispensed consistent with Evidence-based Medical Guidelines.
- Dispensed subject to the professional judgment of the dispensing Pharmacist according to applicable laws, regulations and limitations.

The Prescription Drug Benefit covers many, but not all, Prescription Drugs currently on the market. The prescription drugs plan participates in the “National Preferred Formulary” (NPF) as defined by the Plan administrator. The NPF includes drugs on a more selective basis, and preserves individual choice and provides the broadest access to clinically effective generic and brand-name drugs. Drugs not included in the NPF offer no added clinical value over other drugs that remain in the NPF. The NPF provides multiple product alternatives for drugs not included in the NPF, including preferred brands and generics (these safe alternatives are based upon guidance from an independent national panel of expert health professionals). New prescription drugs become available every year—and uses for existing prescription drugs often change. The Claims Administrator will review these drugs to determine whether or not they will be covered, and at what level (Preferred or Non-Preferred). The Claims Administrator has the sole authority to determine which drugs are Covered Services.

For information about Prescription Drugs covered under the Prescription Drug Program, see the “What Is Covered” and “What Is Not Covered” subsections of this “Prescription Drug Coverage” section. For information about coverage of a specific Prescription Drug, contact the Prescription Drug Benefits Administrator. See the “Contact Information” section for contact information.

Classification of Prescription Drugs

The Program covers both Generic Drugs and Brand-Name Drugs, with certain restrictions.

Generic Drugs

A Generic Drug is a medication chemically equivalent to a Brand-Name Drug on which the patent has expired.

To maximize your Benefits under the Program, Generic Drugs should be considered.

Brand-Name Drugs

A Brand-Name Drug is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer. The Prescription Drug Program designates these drugs as either Preferred Brand Drugs and Non-Preferred Brand Drugs.

The Prescription Drug Benefits Administrator has developed a *Preferred Drug Benefit Guide* to help you and your Prescriber select medically appropriate drug therapies from various categories of Preferred Brand Drugs and Generic Drugs that may be available. For information about coverage of a specific Prescription Drug, contact the Prescription Drug Benefits Administrator.

The Prescription Drug Benefits Administrator's *Preferred Drug Benefit Guide* is available to you on its website and is updated quarterly.

Note: The Preferred Drug Benefit Guide is subject to change and does not guarantee coverage under the Prescription Drug Program. See the "Contact Information" section for the website address and contact information of the Prescription Drug Benefits Administrator. You may also request a copy from the Prescription Drug Benefits Administrator.

Preferred Brand-Name Drug

A Preferred Brand Drug is a Brand-Name Drug that is included on the Prescription Drug Benefits Administrator's *Preferred Drug Benefit Guide*. Preferred Brand Drugs generally do not have a Generic Drug equivalent. Preferred Brand Drugs have been reviewed and approved by a group of independent, unaffiliated clinical Physicians and Pharmacists based on their proven clinical and cost effectiveness.

Non-Preferred Brand Drug

A Non-Preferred Brand Drug is a Brand-Name Drug that is *not* included on the Prescription Drug Benefits Administrator's *Preferred Drug Benefit Guide* and may or may not have a Generic Drug equivalent. Non-Preferred Brand Drugs generally have the highest Co-payment, and therefore, are generally more expensive.

Brand-Name Drugs Purchased When a Generic Drug Is Available

To reduce costs for both you and the Program, the Prescription Drug Benefits Administrator promotes the use of Generic Drugs whenever possible.

If a Generic Drug is available and you request a Brand-Name Drug instead, you will pay the applicable Generic Drug Co-payment, plus the difference in cost between the Brand-Name Drug and the Generic Drug. This requirement applies even if your Prescriber indicates that a Generic Drug should not be substituted.

Brand-Name Drugs Purchased When a Generic Drug Is Unavailable

If a Generic Drug is unavailable through the Retail Prescription Drug Service or the Mail Order Prescription Drug Service due to a manufacturer's backorder, but the Brand-Name Drug is available, you may request the Brand-Name Drug; however, you are responsible for paying the brand-name Co-payment.

Brand-Name Drugs When Medically Necessary

If a Brand-Name Drug is Medically Necessary, your Prescriber must indicate this on the prescription; otherwise a Generic Drug will be dispensed. Since a Brand-Name Drug is not usually Medically Necessary, the Pharmacist may contact your Prescriber even if the prescription indicates to dispense the Brand-Name Drug. If the Prescriber does not approve the change to a Generic Drug, your prescription will be filled as originally written with the Brand-Name Drug. See the "Cost Sharing" section for cost share information.

Generic/Brand-Name Exception

If you cannot use a Generic Drug, you can ask for a Generic Drug/Brand-Name Drug exception. Eligibility depends on the following:

- The Prescription Drug Benefits Administrator's electronic records show that you have filled prescriptions for all Generic Drug alternatives within the last 90 days.
- Your Prescriber provided written documentation of the name and strength of all Generic Drugs you have tried or considered.
- Your Prescriber certifies that the Brand-Name Drug is the only safe and effective treatment for your condition.

If the Prescription Drug Benefits Administrator approves your request for an exception, it will apply for a 365-day period. This period begins the date your request is approved. You will pay the Co-payment amount that applies to the Preferred or Non-Preferred Brand Drug. You will not be required to pay the additional amount that would otherwise apply when you do not purchase a Generic Drug when available.

If you would like to request an exception, see the *Prescription Drug Benefits Administrator* table in the "Contact Information" section for contact information.

If you cannot use a Preferred Brand Drug, you may ask for a waiver. Eligibility depends on the following:

- The Prescription Drug Benefits Administrator's electronic records show that you have filled prescriptions for all available Generic Drug and Preferred Brand Drug alternatives within the last 90 days, and
- Your Prescriber provides written documentation that the Non-Preferred Brand Drug is the only effective treatment for your condition.

If your request for exception is approved, the Preferred Brand Drug Co-payment will apply for a 365-day period. This period begins the date your request is approved. You will be charged the Preferred Brand Drug Co-payment for the Non-Preferred Brand Drug. You will not be required to pay the additional amount that would otherwise apply when you do not purchase a Preferred Brand Drug when available.

Prescription Drug Benefits Administrator

The Prescription Drug Benefits Administrator manages the Prescription Drug Benefit Program on behalf of the Plan Administrator. The Prescription Drug Benefits Administrator is identified in the “Contact Information” section.

For information about the Plan Administrator’s authority to delegate administrative powers to a third party administrator, see the “Plan Administration” section.

Filling Your Prescriptions

Depending on the type of medication you need and the frequency of filling, you may fill your prescription at a Retail Pharmacy or by using the Mail Order Prescription Drug Service or the Specialty Prescription Drug Service.

The Prescription Drug Benefit consists of the following Services:

- **The Retail Prescription Drug Services:** for short-term, immediate-use medications to treat acute conditions.
- **The Mail Order Prescription Drug Services:** for long-term maintenance medications to treat chronic conditions.
- **The Specialty Prescription Drug Services:** for medications that treat long-term diseases that frequently require coordination of other medical Services, such as nursing and self-administration education.

Retail Prescription Drug Services (For Specialty medications requirement, refer to the Specialty Prescription Drugs Section)

You may fill short-term, immediate-use medications at a Retail Pharmacy (up to a 30-day supply).

Network Pharmacy

The Prescription Drug Benefits Administrator offers a national Network of Pharmacies. Certain Retail Pharmacies have been designated as part of the Network while others are not. For the lowest out-of-pocket costs, you should use a Pharmacy within this Network. To locate a Network Retail Pharmacy in your area, contact the Prescription Drug Benefits Administrator. See the *Prescription Drug Benefits Administrator* table in the “Contact Information” section for contact information.

When you visit a Network Retail Pharmacy, show your Prescription Drug ID card. You pay any applicable cost share. See the “Cost Sharing” section for your cost share requirements. If you don’t show your ID card, the Pharmacist cannot confirm your eligibility, or if there is a question about whether the prescribed medication is covered, you may be required to pay the full retail price for the Prescription Drug and then submit a Claim for Benefits for consideration by the Prescription Drug Benefits Administrator.

To locate a Network Retail Pharmacy, contact the Prescription Drug Benefits Administrator or go online. The Pharmacy Locator System – a web-based and voice-activated system for locating Network Retail Pharmacies within specific ZIP codes – is available to assist in locating Network Retail Pharmacies. See the *Prescription Drug Benefits Administrator* table in the “Contact Information” section for contact information.

Non-Network Pharmacy

In most cases, you will find a Network Retail Pharmacy to meet your Prescription Drug needs. The Network includes thousands of Pharmacies nationwide, including major chains and independent community Pharmacies.

However, if you use a Non-Network Retail Pharmacy, you will pay 100 percent of the Prescription Drug price and you must submit a Claim for Benefits again for consideration by the Prescription Drug Benefits Administrator.

For more information on filing Prescription Drug Claims, see the “Claims for Benefits” section.

Mail Order Prescription Drug Services (For Specialty medications requirement, refer to the Specialty Prescription Drugs Section)

The Mail Order Prescription Drug Service provides a convenient and cost-effective way for you to order up to a 90-day supply of a long-term or maintenance medication to be delivered directly to your home at no additional cost to you. The Mail Order Prescription Drug supply is used to treat a chronic condition such as asthma, diabetes or high blood pressure.

Note: In some cases arrangements have been made that will permit mail orders to be filled at certain Retail Pharmacies such as CVS or Long Drug Retail Pharmacy, subject to the applicable mail order Co-payment. Some restrictions may apply. Contact the Prescription Drug Benefits Administrator for more information. See the Prescription Drug Benefits Administrator table in the “Contact Information” section for contact information.

Filling Initial Prescriptions Under the Mail Order Prescription Drug Service

For information on how to fill your initial mail order prescription, log onto the Prescription Drug Benefits Administrator’s website. See the *Prescription Drug Benefits Administrator* table in the “Contact Information” section for contact information. This site will provide you with information and forms required to submit your Prescription Drug to the Mail Order Prescription Drug Service.

- **Refilling Prescriptions.** There are several ways to refill your Mail Order Prescription Drug. Contact the Prescription Drug Benefits Administrator for instructions. See the Prescription Drug Benefits Administrator table in the “Contact Information” section for contact information.
- **Fill Limit at Retail.** If your Prescriber prescribes a Maintenance Drug, your use of a Retail Pharmacy to refill the prescription and receive Prescription Drug Benefits is limited. After the first two Fills at a Retail Pharmacy, all prescriptions for Maintenance Drugs must be filled through the Mail Order Prescription Drug Service to be covered under the Prescription Drug Program. Once you reach your Retail Pharmacy limit, Prescription Drug Benefits will not be payable unless you use the Mail Order Prescription Drug Service. Expenses for any Prescription Drugs that are not covered because you did not use the Mail Order Prescription Drug Service will not apply toward any cost sharing requirements. See the “Cost Sharing” section for your cost share requirements.

Note: You do not need to use the Mail Order Prescription Drug Service if you are submitting Claims for Maintenance Drugs obtained from a licensed long-term care facility with a National Association of Board Pharmacies (NABP) number.

IMPORTANT: Prescription Drugs will not be filled or refilled under the Mail Order Prescription Drug Service if any of the following apply:

- (1) The prescription was written more than 12 months before it was filled.
- (2) The time permitted under applicable state law for controlled substances has expired.
- (3) The Prescription Drug is prohibited by applicable law, including state and local laws or regulation.

Pharmacies are required by law to dispense no more than the exact quantity prescribed by the Prescriber. To order refills of a medication, the Prescriber must indicate on the prescription that you can order refills.

Once you purchase a Prescription Drug at a Retail Pharmacy or processing has begun through the Mail Order Prescription Drug Service, it cannot be canceled or returned. Federal and state laws require that returned medications be destroyed and cannot be restocked. As a result, once the Pharmacist has dispensed the drug, the order cannot be canceled and you are responsible for the full Co-payment. The Prescription Drug Benefit covers many, but not all, Prescription Drugs currently on the market. For information about your Prescription Drug cost under the Program, contact the Prescription Drug Benefits Administrator.

Replacement/Early Refill Policy

Under certain conditions, the Program will authorize the Prescription Drug Benefits Administrator to cover the expense of replacing medications (Co-payments will apply). The conditions are outlined below:

- When medications are stolen or destroyed due to fire and a police report is filed.
- In the case of a natural disaster and the medication is destroyed.

Early refills may be authorized in cases when Covered Persons are traveling outside the United States where refills would not be available. Please note this procedure will not apply to certain controlled substances. Contact the Prescription Drug Benefits Administrator for more information about these procedures.

Exclusive Smart90 (For Specialty medications requirement, refer to the Specialty Prescription Drugs Section)

Exclusive Smart90 allows members two 30-day courtesy fills of maintenance medications at any network pharmacy before a member penalty is triggered. Once the member has used their courtesy fills, the member must switch to a 90-day supply at an in-network CVS pharmacy or through the Express Scripts Pharmacy or pay 100% of the prescription cost.

Specialty Prescription Drug Service

Specialty Prescription Drugs, often called biologic or biotech drugs, are high-cost oral, injectable and infused medications that are used to manage complex diseases such as multiple sclerosis, hepatitis and rheumatoid arthritis. In general, you must fill these prescriptions through the Specialty Prescription Drug Service.

Some key characteristics of specialty drugs include:

- Need for frequent dosage adjustments and drug monitoring.
- Cause more severe side effects than traditional drugs.
- Need special storage, handling and/or administration.
- Have a narrow therapeutic range.
- Require periodic laboratory or diagnostic testing.

IMPORTANT: If you are hospitalized, the medications you receive while confined are covered under the medical or MH/SA inpatient Hospital coverage provisions and not under the Prescription Drug Benefit. For medical and MH/SA Benefits information, see the *Benefits at a Glance* table in the “Medical and Mental Health/Substance Abuse (MH/SA) Coverage” section.

Guideline for purchasing Specialty Prescription Drugs

All Specialty medications must be filled through Accredo, Express Scripts (ESI) specialty mail pharmacy, otherwise you will have to pay 100% of the cost of the medication. Specialty medications are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Call 800-803-2523 to speak with a patient-care representative. If you prefer, your doctor can call Accredo at 866-759-1557 to order your prescription.

When filling specialty prescriptions through Accredo, you’ll receive a variety of specialty pharmacy services including:

- **Safe, prompt delivery:** Accredo will schedule and quickly ship all your specialty medicines, including those that require special handling such as temperature-sensitive medicines to your location of choice
- **Personalized care/support- 24/7:** you’ll have access to a team of trained pharmacists and nurses around the clock to answer your questions and assist you in managing your condition
- **Supplemental Supplies:** supplies, such as syringes, needles and sharps containers, will be provided with your medicine
- **Refill reminder:** Accredo will contact you regularly to schedule your next refill and see how your therapy is progressing; for convenience, some specialty medicine refills can be ordered online, through express-scripts.com
- **Drug safety monitoring:** Accredo can access your prescription information on file in all ESI pharmacies to monitor for potential drug interactions and side effects of your medications

- The Specialty Prescription Drug Co-payment is based on the number of days covered by the Fill as follows:

Number of Days Supply	Co-payment Amount
30 days or less	One-third of the applicable Mail Order Co-payment
31 to 60 days	Two-thirds of the applicable Mail Order Co-payment
61 to 90 days	100 percent of the applicable Mail Order Co-payment
If FDA dosing guidelines require more than a 90-day supply	100 percent of the Mail Order Co-payment

For more information about the Specialty Pharmacy Service or Specialty Prescription Drugs, contact the Prescription Drug Benefits Administrator. See the *Prescription Drug Benefits Administrator* table in the “Contact Information” section for contact information.

Specialty Pharmacy Copay Assistance

Certain specialty pharmacy drugs are not one of the ten Essential Health Benefits under the Affordable Care Act, and therefore are not required to be covered by the plan. At the same time, certain drug manufacturers provide financial assistance or coupons to significantly reduce the cost of certain specialty medications.

In order to reduce both the Company’s and participant’s costs for these specialty drugs, the drugs that are part of a manufacturer financial assistance program (the “Program”) will be excluded from coverage under the plan. However, if you enroll in the Program outside of the plan, your out-of-pocket cost after applying the manufacturer financial assistance will be zero. Because the drugs that are part of the Program are excluded from plan coverage, the amount of the manufacturer financial assistance under the Program will not be credited to your deductible or your out-of-pocket maximum. You are also not required to repay any amount of manufacturer financial assistance under the Program.

Most plan participants will not be affected by this change, because they are not taking any of the specialty medications that are part of the Program. There will be approximately 190 specialty medications in 19 therapy classes that will be part of the Program. However, the specialty medications and classes that are part of the Program may change over time.

The plan is partnering with Express-Scripts’ (ESI) “SaveOnSP,” a specialty pharmacy copayment assistance program to manage this Program. For a current list of the specialty medications included in the Program logon to www.saveonsp.com/frontier; To enroll in the Program, call SaveonSP at 1-800-683-1074.

If your physician prescribes you one of these Non-Essential Health Benefits (NEHB) drugs, SaveOnSP will contact you to participate in the plan's copay assistance program. Once you enroll in the available manufacturer copay assistance program and provide SaveOnSP with consent to monitor your pharmacy account, your cost will be \$0.

While it is your choice whether to participate in the Program, if you do not participate in the Program, you will be responsible for the full required coinsurance set by SaveOnSP for the NEHB classification drugs. Logon to www.saveonsp.com/frontier to view the current applicable coinsurance. Further, because the applicable drug is not covered by the plan, any cost you would pay would not be credited to your deductible and out-of-pocket maximum. Additionally, as a result of the NEHB classification, the coinsurance will continue even after you've met your plan's out-of-pocket maximum.

Advanced Utilization Management

Designed to further ensure safe and effective drug use, decrease prescription waste, and ensure members are utilizing the right medications. The program includes:

Prior Authorization – program that helps ensure the appropriate use of selected prescription drugs. This program is designed to prevent improper prescribing or use of certain drugs that may not be the best choice for a health condition. For more information on medication that requires Prior Authorization, visit www.express-scripts.com, or contact Express Scripts customer service department at 800-551-4136. The list of drugs that require Prior Authorization is updated periodically by Express Scripts and subject to change at any time.

A **Quantity Limit** is a limit on the amount of a medication that you can obtain benefits for during a specific period of time. A Quantity Limit identifies the unit or prepackaged quantity for a specific drug that will be covered with one co-payment or per prescription or claim. Quantity limit applies a limit at the drug-specific level and is frequently employed to support appropriate drug use and to reduce costs. Quantity limits are often applied to inhalers, injectables, patches, and other pre-packaged units, and to medications that are prescribed on an "as-needed" basis such as migraine therapy. Most often, Quantity Limits are set on a monthly basis and are based on guideline from the U.S. Food and Drug Administration and pharmaceutical manufacturers.

For more information on medications that have Quantity Limits, contact Express Scripts customer service department at 800-551-4136. The list of drugs that require a Quantity Limit is updated periodically by Express Scripts and subject to change at any time.

Step Therapy Program - From time to time your doctor may prescribe a medication that requires you to first try another therapy before your prescription benefits may be used toward that medication. This process is called Step Therapy. In general, a drug that has a high potential to be over-prescribed or taken for a non-FDA approved use may be required to use Step Therapy. For more information on medication that requires Step Therapy, visit www.express-scripts.com, or contact Express Scripts customer service department at 800-551-4136. The list of drugs that require Step Therapy is updated periodically by Express Scripts and subject to change at any time.

Opioid Management program

Focuses on promoting safe utilization of Opioid medications and preventing opioid overuse. Point of Sale Edit ensures maximum efficiency and effective monitoring of Opioid use:

- Days Supply limit of a first fill of a short acting Opioid
- Prior Authorization on all long acting Opioids if you haven't had a prior fill for a long acting Opioid
- Morphine Equivalent Dose (MED) based quantity limit - as not all opioids are the same, this quantity limit manages the potential over-utilization of opioid medications by tracking the Morphine Equivalent Dose (MED) for each opioid dispensed

The above edits are meant to bypass if member has history of cancer or palliative care.

The program provides member educational letter, physician care alerts outreach and safe Opioid disposal bags to members who may have excess Opioid medications following their first fill.

Pharmacy Choice Can Affect Your Prescription Drug Benefits (Non-Specialty Prescription Drugs)

If you fill a prescription for an eligible Prescription Drug at a Non-Network Retail Pharmacy, you must pay the Pharmacy's full, non-discounted charge and file a Claim for Benefits. The Program reimbursement, if any, will be limited to 25 percent of the Network Retail Cost of the Prescription Drug charge or the applicable Co-payment, whichever is greater.

IMPORTANT: If you purchase a drug at a Non-Network Pharmacy and if the cost of your Prescription Drug is less than the required Co-payment, you will pay the lesser of the required Co-payment or you will pay the actual cost of the Prescription Drug because it is less.

Prescription Drug Benefit Coverage and Medicare Part D

Enrollment in the Medicare Part D Prescription Drug plan may impact your and your dependents' coverage under the Prescription Drug Benefit. For example, if you currently have coverage under the Prescription Drug Benefit and also enroll in a Medicare Part D Prescription Drug plan, the Prescription Drug Benefit under this Program and the Medicare Part D Prescription Drug plan are coordinated. This means that each of the Prescription Drug plans pay a share of the total bill for the medication.

If you are eligible for Medicare, you will receive an Annual Notice of Creditable Coverage. This notice describes whether the Prescription Drug Benefit coverage options available to you pay on average as much as the standard Medicare Prescription Drug coverage. For more information, see the "Medicare Part D" section of this SPD.

For more information about how enrollment in a Medicare Part D Prescription Drug plan will affect coverage under the Prescription Drug Benefit, contact the Prescription Drug Benefits Administrator. See the *Prescription Drug Benefits Administrator* table in the "Contact Information" section for contact information.

What Is Covered

The Prescription Drug Program covers many, but not all, Prescription Drugs currently on the market. The Prescription Drug Program offers coverage of drugs that are:

- Written by a Prescriber;
- Required by federal law to be dispensed with a written prescription or that are covered as preventive care;
- Consistent with Evidence-based Medical Guidelines;
- Approved by the Food and Drug Administration (FDA); and
- Dispensed subject to the professional judgment of the dispensing Pharmacist according to applicable laws, regulations and limitations.

The Prescription Drug Benefits Administrator maintains a published list of covered Prescription Drugs (referred to as the “drug list” or “formulary”) that is updated quarterly and available to you, free of charge, via the internet. The drug list or formulary contains therapeutic categories, Generic and Preferred Brand Drugs, and can be of use in determining which drugs are covered under the Program and which treatment options are available to you and your Prescriber.

For information about coverage of a specific Prescription Drug, contact the Prescription Drug Benefits Administrator. See the table in the “Contact Information” section.

The list that follows identifies categories of Prescription Drugs generally covered under the Program. The list is illustrative and does not guarantee Program coverage.

The Prescription Drug Benefit covers many, but not all, Prescription Drugs currently on the market. The categories listed below generally represent those Prescription Drugs commonly utilized under the Program, but it is not an exhaustive list of therapeutic categories or the drugs within those categories. For information about your Prescription Drugs covered under the Program, see “What Is Covered” and “What Is Not Covered” in this section. For information about a specific Prescription Drug, contact the Prescription Drug Benefits Administrator. See the *Prescription Drug Benefits Administrator* table in the “Contact Information” section for contact information.

Covered Categories	
Anti-Hyperlipidemics	Dermatologicals
Anti-Hypertensives	Penicillin
Beta-Blockers	Analgesics
Anti-Depressants	Anti-Inflammatory
Analgesics and Opioids	Macrolides
Ulcer Drugs	Anti-Asthmatic and Bronchodilator Agents
Diuretics	Hormone Therapies
Thyroid Agents	Contraceptives
Anti-Diabetics	Human Growth Hormones
Calcium Channel Blockers and Regulators	Insulin Drug and Supplies

Personal-Choice Drugs

The Prescription Drug Program does not cover Personal-Choice Drugs. However, you may purchase Personal-Choice Drugs at a discounted price at a Retail Network Pharmacy. You pay the full discounted cost. The amount you pay for Personal-Choice Drugs does not count toward your cost sharing (such as the Annual Deductible or Out-of-Pocket Maximum).

Drugs in the following categories are considered Personal-Choice Drugs. The Prescription Drug Benefits Administrator determines the specific drugs in each of these categories. The list of drugs may change at any time. You should contact the Prescription Drug Benefits Administrator to determine if any drugs have been added to or removed from the list. See the “Contact Information” section for the telephone number and Web address of the Prescription Drug Benefits Administrator.

- Anti-wrinkle agents
- Diet medications
- Erectile dysfunction medications
- Fertility medications that exceed the combined Medical and Prescription Drug \$20,000 lifetime maximum
- Hair-growth agents
- Hair removal agents
- Topical anti-aging agents

Preventive Care Drugs

Preventive care focuses on evaluating your current health status when you are symptom-free and taking the necessary steps to maintain your health. Appropriate Preventive Care Services will vary from person to person based on age, gender and other risk factors, including family history, and include certain Prescription Drugs. Special benefit provisions apply when you receive Prescription Drugs that qualify as Preventive Care Drugs under the Program.

The drugs that are covered by the Program as Preventive Care Drugs are determined by the Prescription Drug Benefits Administrator based on the requirements of the Patient Protection and Affordable Care Act. The medications covered under the Preventive Care Drugs provisions will change from time to time, as new medical evidence emerges and evidence-based recommendations change. The drugs considered Preventive Care Drugs in some circumstances may also be provided for purposes other than routine preventive care. When this occurs, these drugs are not covered as Preventive Care Drugs by the Program. However, they may be covered under other provisions of the Program, subject to applicable cost sharing, including Co-payment, Coinsurance and Annual Deductible.

Preventive Care Drugs currently include:

- Folic acid vitamins prescribed due to Pregnancy.
- Contraceptives approved by the Food and Drug Administration prescribed to keep you from becoming pregnant.
- Aspirin prescribed as heart-attack prevention.

Subject to the following restrictions, when a medication is covered as a Preventive Care Drug and you fill your prescription through a Network Retail Pharmacy or the Mail Order Prescription Drug Service, your medication will be covered without cost sharing, such as Co-payments, Coinsurance or Annual Deductibles, if applicable:

- This provision only applies to certain Generic Drugs and over-the-counter generic medications. Brand-Name Drugs are not covered as Preventive Care Drugs unless the Prescription Drug Benefits Administrator determines that a Generic Drug is not available. If the Prescription Drug Benefits Administrator determines that there is a Generic Drug available and you purchase the Brand-Name Drug, you will pay the difference in price between the Generic and Brand-Name Drug. See the “Brand-Name Drugs Purchased When a Generic Drug Is Available” section for further information.
- A prescription is required.

If you have questions about Preventive Care Drugs, you may contact the Prescription Drugs Benefit Administrator’s customer service at the toll-free number provided on your ID card. You also can check if a medication is a Preventive Care Drug before you fill a prescription by logging onto the Prescription Drug Benefits Administrators website at www.express-scripts.com and checking whether a Co-payment applies or by calling the Prescription Drug Benefits Administrator using the information in the “Contact Information” section.

What Is Not Covered

The Prescription Drug Benefit covers a wide range of prescription medications and related supplies, but it does include some limitations. Listed below are many of the limitations and exclusions that apply to the Prescription Drug Program. If a prescription medication or supply is not specifically excluded under the limitations below, it does not necessarily mean that the prescribed item is covered by the Program. To determine whether a specific prescribed item is covered under the Program, please contact the Prescription Drug Benefits Administrator.

Exclusions and Limitations	
Exclusions and Limitations:	Notes
Allergy serums	
Amounts above the Allowable Charge	
Anti-wrinkle agents	
Any drug or medicine not Medically Necessary for the treatment of your condition	
Any prescription refill in excess of the number of refills specified by the Provider or any refill requested after one year from the Provider’s original order	
Batteries	
Charges for over-the-counter medications and pharmaceutical purchases	Except insulin, Diabetic Supplies, hypodermic needles and syringes prescribed by a Prescriber for use with covered injectables and medications. The Program also covers certain over-the-counter medications that are considered preventive. See the “Preventive Care Drugs” section for more information about preventive medications.
Charges for the administration or injection of any drug	May be covered under Medical. Not covered under the Prescription Drug Program. See the “What Is Covered” subsection in the “Medical and Mental Health/Substance Abuse Coverage” section.
Cosmetic Botox	

Exclusions and Limitations	
Depigmenting Agents	
Diet and weight loss medications	
Drugs in excess of the day supply limit for drugs purchased at a Retail Pharmacy or through the Mail Order Prescription Drug Service	Except for Seasonale, Seasonique or their generic equivalent (Mail Order only). See the Supply Limit in the "Benefits at a Glance" section.
Drugs paid for by any local, state or federal government agency	Except Medicaid programs or where otherwise required by law
Drugs that are not federal legend drugs (that is, over-the-counter drugs)	
Elastic bandages and supports	
Erectile dysfunction medications	
Fertility medications	Not covered in excess of \$20,000 lifetime maximum Benefit (combined with Medical).
Generic Zyban and Chantix	Not covered after two 12-week cycles per year are exhausted
Hair growth stimulants	
Hair removal agents	
Immunization agents, vaccines, biologicals, blood or blood plasma	May be covered under Medical. See the "What Is Covered" subsection in the "Medical and Mental Health/Substance Abuse Coverage" section.
Influenza treatment	Except Tamiflu. Flu shots may be covered under Medical.
Injectable medications that cannot be self-administered	Unless classified as a Specialty Prescription Drug or covered under the Medical portion of the Program. See the "What Is Covered" subsection in the "Medical and Mental Health/Substance Abuse Coverage" section.
Insulin Pumps	May be covered under the Medical portion of the Program. Not covered under the Prescription Drug Program.
Lancet devices	
Maintenance Drugs not purchased through the Prescription Drug Benefits Administrator's Mail Order Program	Except for the first two Fills of a prescription for the Maintenance Drug at a Network Retail Pharmacy
Medical supplies (for example, bandages, braces and splints, appliances, devices, heat lamps and artificial appliances)	
Medication taken or administered to a patient in an institution that operates or houses a facility dispensing pharmaceuticals on its premises (including take-home medication)	
Medications for which the cost is recoverable under any workers' compensation or occupational disease law, state or government agency, or medications for which no charge is made to the participant	
Multiple and nontherapeutic vitamins, dietary supplements and health and beauty aids	
Nutritional dietary supplements administered intravenously or through a gastrointestinal tube	May be covered under Medical. Not covered under the Prescription Drug Program. See the "What Is Covered" subsection in the "Medical and Mental Health/Substance Abuse Coverage" section.
Oral nutritional and diet supplements	Except if classified as preventive medication. See the "Preventive Care Drugs" section for more information about preventive medications.

Exclusions and Limitations	
Ostomy and irrigation supplies	
Over-the-counter topical fluoride products	
Personal-Choice Drugs	Discounts may be available. See the "Personal-Choice Drugs" section for more information.
Prescription devices	Except for covered Diabetic Supplies
Prescriptions for which primary coverage is provided by another plan	See the "Coordination of Benefits" section for information.
Products not requiring a prescription by law	
Respiratory therapy supplies	
Sales or use tax imposed by some states or municipalities or parishes	
Smoking deterrents, including nicotine products such as nicotine gum and nicotine patches	Except for generic Zyban and Chantix and other generic over-the-counter nicotine replacement products such as gum, patches and lozenges. See the "Generic Zyban and Chantix" section in this table.
Specialty Prescription Drugs	Not covered through Retail Pharmacies. See the "Specialty Prescription Drugs" section.
Specialty Prescription Drugs in excess of day supply limit for drugs purchased through the Specialty Prescription Drug Service	Except if the drug is a Specialty Prescription Drug for which the Program allows an extended days' supply. See the "Specialty Prescription Drug Services" section.
Support garments, and other non-medicinal substances, regardless of intended use	
Therapeutic devices or appliances	May be covered under Medical. Not covered under the Prescription Drug Program.
Topical retinoids	For Covered Persons age 26 and older, except with a diagnosis of adult acne.
Vitamins	Except vitamins that require a prescription or if covered as preventive medication. See the "Preventive Care Drugs" section for more information about preventive medications.
Zyban (brand name only)	Diagnosis required for coverage

Some state or local laws may restrict the (1) scope of health care services that a Physician may render and/or (2) the scope of health care items that a Physician may prescribe or furnish. In such case, the Medical Option will not cover such health care services, prescription drugs, or health care items. The Plan (and each applicable Medical Option) does not cover, pay for or reimburse health care services, prescription drugs or health care items that are prohibited by state or local law and which are illegally performed, prescribed or furnished in such state or locality.

In addition to the limitations and exclusions above, the Prescription Drug Program will not cover the following:

- Drugs that do not meet all requirements for coverage under the Prescription Drug Program.
- Drugs labeled "Caution – limited by Federal law to Investigational use" and Experimental drugs, even though a charge is made to the individual. Whether a drug is determined to be Investigational, Experimental or unproven to be safe and effective is within the discretion of the Prescription Drug Benefits Administrator.
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or medication furnished by

any other drug, medical Service, individual or entity for which no charge is made to the Participant.

- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, Skilled Nursing Facility, convalescent Hospital, nursing home or similar institution that operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals. (*Note: these will generally be covered by the Program's medical Benefits.*)
- Any medicine not prescribed by your Prescriber.
- Any prescription refilled in excess of the number of refills specified by the Prescriber or any refill dispenses after one year from the Prescriber's original order.
- Charges for the administration or injection of any drug.

CLAIMS AND APPEALS PROCEDURES

KEY POINTS

- Two types of Claims may be made and appealed under the Program: Claims for Eligibility and Claims for Benefits.
- You must exhaust all Appeals processes offered by the Program before filing a lawsuit.

You, your covered dependents or duly authorized persons have the right under ERISA and the Plan (including the Program) to file a written Claim for Eligibility or Claim for Benefits under the Program.

The following sections describe the procedures used by the Program to process a Claim for Eligibility or a Claim for Benefits, along with your rights and responsibilities. These procedures were designed to comply with the rules of the United States Department of Labor (DOL) concerning a Claim for Eligibility or Claim for Benefits. It is important that you follow these procedures to make sure you receive the full extent of your Benefits under the Program. You may file suit in federal court if you are denied eligibility or Benefits under the Program.

Exhaustion of Administrative Remedies

Before filing any claim (as defined below) in court or in another tribunal with respect to plan, you must first fully exhaust all of your actual or potential rights under the claims procedures by filing an initial claim and then seeking a timely appeal of any denial, including, with respect to a medical claim only, any external appeal that may be available (referred to generally as the exhaustion requirement).

Upon review by any court or other tribunal, this exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible (and any steps necessary to clarify or effect this intent may be taken). For example, the exhaustion requirement shall apply separately to each provider, each date of service, each billed procedure and/or item, each separate claim and each claim within a concurrent care setting and/or course of treatment.

Furthermore, exhaustion may not be excused (1) for failure to respond to a claim unless the purported claimant took steps that were sufficient to make it reasonably clear to the plan administrator that the purported claimant was submitting a claim with respect to the plan, or (2) for failure to fulfill a request for documents unless –

- The claimant is lawfully entitled to receive a copy of the requested document from the plan administrator at the time and in the form requested;
- The claimant requests such documents in a writing that is addressed to and actually received by the plan administrator;

- The plan administrator fails to provide the requested documents within 6 months after the date the request is received, or within such longer period as may be reasonable under the facts and circumstances;
- The claimant took steps that were sufficient to make it reasonably clear to the plan administrator that the claimant was actually entitled to receive the requested documents at the time and in the form requested (i.e., generally the claimant must provide sufficient information to place the plan administrator on notice of a colorable claim for benefits); and
- The documents requested and not provided are material to the determination of one or more colorable claims of which the claimant has informed the plan administrator.

This exhaustion requirement applies: (1) regardless of whether other claims, assertions, allegations, disputes, issues, actions or other matters (including those that a court might consider at the same time) are of greater significance or relevance; (2) to any rights the Plan Administrator may choose to provide in connection with novel claims or in particular situations; (3) regardless of whether the rights are actual or potential; and (4) even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a claim (in which case the Plan Administrator, upon notice of the claim, shall either promptly establish such claims procedures or shall apply or act by analogy to the claims procedures that otherwise apply to claims for benefits).

The Plan Administrator may make special arrangements to consider a claim on a class basis or to address unusual conflicts concerns, and such minimum arrangements in these respects shall be made as are necessary to maximize the extent to which exhaustion is required.

For purposes of this exhaustion requirement, a “claim” is any claim, matter, issue, action, allegation, assertion, or other dispute that involves any one or more of the following:

- The interpretation of the Plan;
- The interpretation of any term or condition of the Plan;
- The interpretation of the Plan (or any of its terms or conditions) in light of applicable law;
- Whether the Plan or any term or condition under the Plan has been validly adopted or put into effect;
- The administration of the Plan;
- Whether the Plan, in whole or in part, has violated any terms, conditions or requirements of ERISA or other applicable law or regulation, regardless of whether such terms, conditions or requirements are, in whole or in part, incorporated into the terms, conditions or requirements of the Plan;

- A request for Plan benefits or an attempt to recover Plan benefits;
- Whether any entity or individual has breached any fiduciary duty; under ERISA or other applicable law;
- Whether any individual or entity is a participant, former participant, Plan beneficiary, former Plan beneficiary or assignee of any of the foregoing; or
- Any claim, matter, issue, action, allegation, assertion or other dispute that (i) is deemed similar to any of the above items by the Plan Administrator, or (ii) relates to the Plan in any way.

Failure to follow this exhaustion requirement means that any claim, action or suit filed in court or other tribunal will generally be dismissed.

IMPORTANT: All of the facts and circumstances of your case will be thoroughly reviewed. If you have completed all of the Claims and Appeals procedures explained in the following sections and your Appeal is denied, you have the right to file suit in federal court if you are denied eligibility to participate or if you are denied Benefits under the Program.

CLAIMS FOR ELIGIBILITY

KEY POINTS

- *If your or your dependent's enrollment in the Program is denied, you may file a written Claim for Eligibility with the Frontier Benefits Service Center.*
- *If your Claim for Eligibility is denied, you may appeal the decision within 180 days of receipt of the denial notice.*

When to File a Claim for Eligibility

If you or your dependents attempt to enroll or participate in the Program and are told you or your dependent is not eligible to enroll or participate in the Program, you may call the Frontier Benefits Service Center to attempt to resolve the issue. If the issue is not resolved to your satisfaction, you may file a written Claim for Eligibility.

IMPORTANT: The Frontier Benefits Service Center should only be contacted for denials related to enrollment or participation in the Program. For Benefit-related situations, you will need to contact the Benefits Administrator. Please see the "Claims for Benefits" section for the Claim for Benefits process.

You are responsible for initiating the Claim for Eligibility process. The Claim for Eligibility process does not begin until you have provided a written Claim, as outlined below.

How to File a Claim for Eligibility

To file a Claim for Eligibility, you must submit your written Claim for Eligibility, along with any documentation that supports your Claim for Eligibility, to the Frontier Benefits Service Center at the address listed in the "Contact Information" section. To submit a Claim for Eligibility you must file a completed Claim, along with any supporting documentation, with the Frontier Benefits Service Center.

You will be notified of the decision within 30 days of the date of your Claim for Eligibility is received, but this period may be extended once (for up to 15 days) if special circumstances require more time to decide your Claim for Eligibility. If this happens, you will receive a written notice of the special circumstances requiring the extra time and when to expect a response.

If the Frontier Benefits Service Center requires additional information from you in order to determine your Claim for Eligibility, you will receive notification and you will have 45 days from the date you receive the notification to provide the information. The Frontier Benefits Service Center's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Frontier Benefits Service Center will decide your Claim within the time remaining in the initial 30-day or extended 45-day review period, whichever applies.

If you do not respond to the request for information, your Claim for Eligibility will be determined based on the available information, but you may appeal this decision.

The following table summarizes the Program's Claim for Eligibility decision time frame:

Activity	Number of Days Allowed	
Frontier Benefits Service Center decides on Claim	30 days	From the date the Frontier Benefits Service Center receives your initial Claim for Eligibility
Time period is extended if Frontier Benefits Service Center determines special circumstances require more time	Up to 15 additional days	After the initial 30-day period
You must provide additional information requested by the Frontier Benefits Service Center	45 days	From the date you receive notice from the Frontier Benefits Service Center stating that additional information is needed

What Happens If Your Claim for Eligibility Is Denied

Your Claim for Eligibility is denied when the Frontier Benefits Service Center sends written notice that denies your Claim for Eligibility in whole or in part or if you do not receive notice of the denial within the time periods described above. A written denial notice will contain:

- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your Claim for Eligibility acceptable and the reason the information is needed.
- A description of the Program’s Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

How to Appeal a Denied Claim for Eligibility

If your Claim for Eligibility is denied and you disagree with the decision, you may appeal the decision by filing a written request for review. To appeal the Claim, you or your authorized representative must file a written Appeal with the Frontier Benefits Service Center within 180 days of receipt of the denial notice. A special form is not required; however, you may contact the Frontier Benefits Service Center and obtain an Appeal form. A service representative also can provide the appropriate address to direct your Appeal.

If you or your authorized representative submit an Appeal of a denied Claim for Eligibility, you or your representative has the right to:

- Send a written statement of the issues and any other comments. Be sure to clearly state any facts and/or reasons you believe should be considered and include any documents, records or other information relating to your Appeal.
- Include any new or additional evidence or materials that support your Appeal. This information must be provided with your written statement when you file your Appeal.
- Request and receive, free of charge, documents relevant to your Claim for Eligibility, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Claim for Eligibility.

- Reasonable access to and copies of all documents, records and other information relevant to your Claim for Eligibility.

Internal Appeals Process

Individuals who were not involved in the initial decision to deny your Claim for Eligibility, will review and decide your Appeal. In the review of your Appeal, the Plan Administrator, or its designee, will not afford deference to the denied Claim.

The Plan Administrator will notify you of its decision within 60 days of the date of receipt of your Appeal. The Plan Administrator can extend this period once (for up to 60 days) if special circumstances require more time to decide your Appeal. If this happens, you will receive a written notice of the special circumstances requiring the extra time and when to expect a response.

The Plan Administrator’s decision on your Appeal will be in writing and will include the specific reasons and references to Program provisions relied on to make the decision. The Plan Administrator’s decision will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your Claim for Eligibility. The Plan Administrator has been delegated the exclusive right to interpret and administer applicable provisions of the Program, and its decisions are conclusive and binding and are not subject to further review under the Program. If your Appeal is denied, it is final and is not subject to further review. However, you may have further rights under ERISA, as described in the “ERISA Rights of Participants and Beneficiaries” section.

The following table summarizes the Program’s Appeal for Eligibility decision time frame:

Activity	Number of Days	
You request a review of a denied Claim for Eligibility	180 days	From receipt of a denial notice
Plan Administrator decides on Appeal	60 days	From the date the Plan Administrator receives your Appeal
Time period is extended if Plan Administrator determines special circumstances require more time	Up to 60 days	After the initial 60-day period

External Review Process for Certain Eligibility Claims

If your Appeal of a denied Claim for Eligibility is denied by the Plan Administrator, there is an opportunity for external review but only in situations that involve rescission of Program coverage. Generally, rescission of Program coverage is the cancellation or discontinuance of your coverage that has retroactive effect, except to the extent it is attributable to failure to timely pay required contributions or due to an act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact. For further description of rescission of coverage, see the “When Coverage Ends” section of this SPD. If you feel a rescission of Program coverage is not properly determined under the Program pursuant to the Claims and Appeals process, see the “External Review” section of the “Claims for Benefits” section for more information on the external Appeal process.

CLAIMS FOR BENEFITS

KEY POINTS

- *A Claim for Benefits is the initial request that is made to the Benefits Administrator by your Provider or by you to receive Benefits under the Program.*
- *You must file your request for payment of Benefits within the time period specified.*
- *Pre-Service and Post-Service Claims are the two different types of Claims for Benefits with different Claims procedures. If all or part of your Claim for Benefits is denied, you can appeal the decision. You must file your Appeal within the time limit.*
- *If your Appeal is denied based on medical judgment and you believe the outcome of your Appeal is unsatisfactory, you can request an external review.*

How to File a Claim for Benefits

You, your covered dependents or an authorized representative have the right under ERISA and the Plan (including the Program) to file a written Claim for Benefits. A Claim for Benefits is the initial request that is made to the Benefits Administrator for Benefits under the Program. In some cases, the initial Claim for Benefits may be filed by the Provider, and in other instances, you have the responsibility to file the initial Claim for Benefits or make certain that the Provider files it on your behalf.

The following are not considered a Claim for Benefits:

- An enrollment or eligibility request. This is considered a Claim for Eligibility. Please see the “Claims for Eligibility” section for more information. But, if your Claim for Benefits is denied on the basis that you are not eligible to participate in the Program, it may be a Claim for Benefits.
- A request to fill a prescription at a Retail Pharmacy. However, you can file a Claim for Benefits for reimbursement of a prescription filled at a Retail Pharmacy if:
 - The Pharmacist cannot verify eligibility.
 - You disagree with your cost-sharing amount.
 - You use a Non-Network Retail Pharmacy.

The following describes the procedures the Program uses to process Claims for Benefits, along with your rights and responsibilities. These Claims for Benefits procedures comply with the rules of the Department of Labor (DOL). It is important that you follow these procedures to make sure that you receive full Program Benefits. This section provides you with information about how and when to file a Claim for Benefits:

- If you receive Services from a Network Provider, Retail Pharmacy, Mail Order Prescription Drug Service or Specialty Drug Program, your Claim for Benefits generally will be filed by the Provider. The Program may choose to pay these Providers directly but this will not constitute

an assignment of health benefits or rights under the Program or a waiver of the Program's anti-assignment rules. You are responsible for meeting the Annual Deductible and for paying Coinsurance or applicable Co-payments to these Providers at the time of Service or when you receive a bill from the Provider. If a Network Provider sends you a bill for the balance owed for any Service (other than an Annual Deductible, Coinsurance or Co-payment), contact the Benefits Administrator.

- If you receive Services from a Non-Network Provider or you fill a prescription at a Non-Network Retail Pharmacy, you are responsible for filing a Claim for Benefits or making sure the Provider submits a Claim for Benefits on your behalf in the required format. See the "Information to Include in Your Claim" section for more details.

Claim Filing Limits

You or your Provider must submit your Claim for Benefits within one year of the date of service or the date the prescription was provided if this Frontier Medical Program is your only medical coverage. If your Claim for Benefits is coordinated with other coverage, such as Medicare, you must submit your Claim within two years of the date of service or the date you receive the prescription. If a Non-Network Provider or a Non-Network Retail Pharmacy submits a Claim for Benefits on your behalf, you are responsible for the timeliness of the Claim for Benefits and these timing requirements still apply. If you or your Provider do not file a Claim for Benefits within this time period, Benefits will be denied or reduced at the Benefits Administrator's discretion. If your Claim for Benefits relates to an inpatient stay, the date of Service is the date your inpatient stay ends.

Information to Include in Your Claim for Benefits

When you file a Claim for Benefits, you must provide certain information as shown in the following table.

Medical Claim Requirements (including MH/SA Claims)	Prescription Drug Claim Requirements
<ul style="list-style-type: none"> • Employee's or former Employee's name and address • Patient's name, age and relationship to the Employee or former Employee • Member number stated on your ID card • Itemized bill from your Provider that includes the following: <ul style="list-style-type: none"> • Patient diagnosis • Date(s) of Service • Procedure code(s) and descriptions of Service(s) rendered • Charge for each Service provided • Service Provider's name, address and tax identification number • Date the Injury or Illness began • Statement that indicates if you are enrolled for other coverage. If so, you must include the name of the other carrier(s) <p>As part of the Claim for Benefits, the Benefits Administrator may require the individual who received Services to have an examination performed by an appropriate agent or independent contractor as often as the Benefits Administrator determines necessary.</p>	<p>You must include all original receipts (including proof of purchase) for your Claim to process. Cash register receipts will only be accepted for Diabetic Supplies. The minimum information required is:</p> <ul style="list-style-type: none"> • Patient name • Date of Fill • Total charge • Prescription number • Metric quantity • Pharmacy name and address • Medicine NDC number • Days supply • Pharmacy NCPDP/NABP number

The Benefits Administrator may ask for additional information to support your Claim for Benefits. If so, you will receive this request in writing.

Payment of Benefits

The Benefits Administrators are responsible for administration of a Claim for Benefits. The Benefits Administrator will make a determination of the Program's applicability to your Claim for Benefits. See the *Benefits Administrator* table in the "Contact Information" section for information about Claim forms and procedures.

The Benefits Administrator will make a Benefit determination as set forth in the "Benefit Determinations" section.

Benefit Determinations

Post-Service Claims

A Post-Service Claim is a Claim for Benefits you or your Provider file after Services have been received. If your Post-Service Claim is denied, the Benefits Administrator will provide you a written notice of its determination within 30 days of receipt of the Claim for Benefits. The Benefits Administrator may extend this period once (for up to 15 days) if it determines that special circumstances require more time to decide your Claim for Benefits. If this happens, you will

receive a written notice of the special circumstances requiring the extra time prior to the lapse of the 30-day period as well as the date by which you should expect a response.

If the Benefits Administrator requires additional information from you in order to determine your Claim for Benefits, you will receive notification prior to the lapse of the 30-day period and you will have 45 days from the date you receive the notification to provide the information. The Benefits Administrator's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Benefits Administrator will decide your Claim for Benefits within 15 days of the date the information is received.

If you do not respond to the request for information, your Claim for Benefits will be determined based on the available information, but you may appeal this decision. If your Claim for Benefits is denied, you will receive a notice explaining the denial and identifying the Program provisions that the denial is based on, as well as the Claim Appeal procedures.

Pre-Service Claims

A Pre-Service Claim is a Claim for Benefits where the Program requires approval of the Benefit in advance of obtaining medical care. If your Pre-Service Claim is submitted properly, the Benefits Administrator will provide written notice of its determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the Claim for Benefits. The Benefits Administrator may extend this period once (for up to 15 days) if it determines that special circumstances require more time to decide your Claim for Benefits. If this happens, you will receive a written notice of the special circumstances requiring the extra time prior to the lapse of the 15-day period as well as the date by which you should expect a response.

If you file a Pre-Service Claim improperly, the Benefits Administrator will notify you of how to correct it within five days of receipt of the Pre-Service Claim.

If the Benefits Administrator requires additional information from you in order to determine your Pre-Service Claim, you will receive notification within 15 days after the Benefits Administrator receives your Pre-Service Claim. You will have 45 days from the date of the notification to provide the information. The Benefits Administrator's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Benefits Administrator will decide your Pre-Service Claim within 15 days of its receipt of the additional information. If your Claim for Benefits is denied, you will receive a notice explaining the denial and identifying the Program provisions that the denial is based on, as well as the Appeal procedures.

If you do not respond to the request for information within the 45-day period, your Claim for Benefits will be decided based on the available information, but you may appeal this decision.

Urgent Care Claims That Require Immediate Action

An Urgent Care Claim is a Claim for Benefits for Services for which the Program requires you to obtain Preauthorization before the Covered Person receives medical care and a delay in receiving the Service could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, cause severe pain that cannot be

adequately managed without the care or treatment that is the subject of the Claim for Benefits. The Benefits Administrator will defer to your attending Provider's determination that your Claim is an Urgent Care Claim within the meaning described above. In these situations:

- The Benefits Administrator will provide written, electronic or verbal notice of the determination as soon as possible, taking into account the medical exigencies, no later than 72 hours after receipt of the Claim.
- If the Benefits Administrator provides notice verbally, a written or electronic confirmation will follow within three days.

If you file an Urgent Care Claim improperly or additional information is necessary to process the Urgent Care Claim, the Benefits Administrator will notify you of how to correct it or of the required information as soon as possible, but not later than 24 hours of receipt of the Urgent Care Claim. You will have 48 hours to provide the requested information.

The Benefits Administrator will notify you of a determination as soon as possible, but no later than 48 hours after the earlier of:

- The receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

If your Urgent Care Claim is denied, you will receive a notice explaining the denial and identifying the Program provisions on which the denial is based, as well as the Appeal procedures.

Concurrent Care Claims

Concurrent Care is a type of Benefit offered under the Program that involves an ongoing Course of Treatment provided over a period of time or a specified number of treatments. A reduction or termination of previously approved Concurrent Care (other than by Program amendment or termination) before the end of the period of time or utilization of the specified number of treatments is an Adverse Benefit Determination for which you may file an Appeal.

The Benefits Administrator will notify you in advance if your previously approved Concurrent Care will be reduced or terminated so that you may file an Appeal before the reduction or termination. Your Concurrent Care will continue to be covered, pending the outcome of the internal Appeal. This means that the Program cannot terminate or reduce Concurrent Care without providing advance notice and the opportunity for review.

If you make a request to extend Concurrent Care at least 24 hours before the end of the approved treatment and your request to extend treatment is an Urgent Care Claim, as defined above, the Benefits Administrator will make a determination within 24 hours of receipt of your request.

If your request for Concurrent Care is not made at least 24 hours before the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the time frames described above. If your Concurrent Care was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new Claim and decided according to Post-Service or Pre-Service Claim time frames, whichever applies.

What Happens If Your Claim for Benefits Is Denied

If your Claim for Benefits is denied in whole or in part, it is an Adverse Benefit Determination. An Adverse Benefit Determination is any denial, reduction or termination of a Benefit, or a failure to provide or make a payment (in whole or in part) for a Benefit, including any based on your eligibility to participate in the Program, a determination that the Service is not a Benefit under the Program, a Network exclusion or other limitation on Benefits under the Program, a determination that a Service is Experimental, Investigational or not Medically Necessary or appropriate. You have the right to appeal any Adverse Benefit Determination under the procedures described below.

If your Claim for Benefits is denied in whole or in part, the Benefits Administrator will provide you with written or electronic notification of the Adverse Benefit Determination that will include:

- Information sufficient to identify the Claim (including the date of Service, the health care Provider, the Claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.

If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.

- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program's terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your Claim for Benefits acceptable and the reason the information is needed.
- A description of the Program's Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

You or your authorized representative can appeal the denied Claim for Benefits within the time limits set forth in this section for the applicable type of Claim. If you wish to appeal a denied Pre-Service Claim or Post-Service Claim, you must contact the applicable Benefits Administrator in writing. You or your Provider may appeal a denied Urgent Care Claim by calling the Benefits Administrator or filing a written Appeal.

Your Appeal must be submitted to the Benefits Administrator within 180 days following receipt of the notice of the denial of your Claim for Benefits or the date your Claim for Benefits is deemed denied.

IMPORTANT: If your Claim for Benefits is denied on the basis of eligibility to enroll or participate in the Program, you should follow these procedures; however, your Appeal must be filed with Plan Administrator (not the Benefits Administrator).

The Appeal will take into account all comments, documents, records and other information you submit relating to the Claim for Benefits, without regard to whether such information was submitted or considered in the initial Benefit determination. If you wish, you or your authorized representative may review the appropriate Plan documents and submit written information supporting your Claim for Benefits to the Benefits Administrator or Plan Administrator.

If you have received Preauthorization for an ongoing Course of Treatment, you will continue to be covered for that Concurrent Care, pending the outcome of the internal Appeal. This means that the Program cannot terminate or reduce any ongoing Course of Treatment without providing advance notice and the opportunity for review.

If the Program fails to meet the time requirements of the internal Claims and Appeals process for your Claim for Benefits, your Claim for Benefits is deemed denied and you may begin an external review request immediately, if applicable, or pursue your Claim for Benefits in a civil action under ERISA.

You have the right to, upon request and free of charge, reasonable access and copies of all documents, records or other information relevant to your Claim for Benefits. You must make this request in writing. You will be able to review your file and present information as part of the Appeal.

The Benefits Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with your Claim, as well as any new or additional rationale to be used in reaching the decision. You will be given this information in advance of the date the notice of final Appeal decision is made to give you a reasonable opportunity to respond.

How to File an Appeal for Benefits

You can file a written Appeal if your Claim is denied (in whole or in part). To file an Appeal, you must send a written summary to the Benefits Administrator with all of the following information:

- Your name
- Patient's name and patient's identification number from his or her medical ID card
- Dates of Service
- Provider's name
- A summary of the issue, including the reason you believe the Claim for Benefits should be paid
- All relevant documents, such as letters, Explanation of Benefits (EOBs) and statements

See the *Benefits Administrator* table in the "Contact Information" section for more information.

The Benefits Administrator will decide your Appeal based on whether the Program provides Benefits for the proposed treatment or procedure and the amount of such Benefits. You and your Provider decide the appropriateness and necessity of pending health Services.

Internal Appeals

Your Appeal will be assigned to a qualified individual or committee who has had no involvement with the denial of your Claim for Benefits. If your Appeal is related to clinical matters, the review

will include a consultation with a health care professional who has appropriate expertise in the field and who was not involved in the denial of your Claim for Benefits. The Benefits Administrator can also seek the expertise of other medical professionals to resolve your Claim. You must consent to this referral and to sharing your pertinent medical information.

Pre-Service and Post-Service Claim Appeals

There are two levels of internal Appeals. You will be provided written or electronic notification of the decision on your Appeal(s) as follows:

- For Appeals of Pre-Service Claims (as defined in the “Claims for Benefits” section), the first-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for Appeal of a denied Claim. If you are not satisfied with the first-level Appeal decision, you have the right to request a second-level Appeal. Your second-level Appeal request must be submitted to the Benefits Administrator in writing within 180 days from receipt of the first-level Appeal decision. The second-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for review of the first-level Appeal decision.
- For Appeals of Post-Service Claims (as defined in the “Claims for Benefits” section), the first-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time, but not later than 30 days from receipt of a request for Appeal of a denied Claim. If you are not satisfied with the first-level Appeal decision, you have the right to request a second-level Appeal. Your second-level Appeal request must be submitted to the Benefits Administrator in writing within 180 days from receipt of the first-level Appeal decision. The second-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time, but not later than 30 days from receipt of a request for review of the first-level Appeal decision.
- For Pre-Service and Post-Service Claim Appeals, the Company has delegated to the Benefits Administrator the exclusive right to interpret and administer the provisions of the Program. The Benefits Administrator’s decisions are conclusive and binding, subject to the external appeals process below, if applicable.

Please note that the Benefits Administrator’s decision is based only on whether or not Benefits are available and the amount of Benefits under the Program for the proposed treatment or procedure. The determination as to whether the pending health Service is necessary or appropriate, any medical decision or what health Service you actually receive is between you and your Physician.

Urgent Care Appeals That Require Immediate Action

An Urgent Care Appeal does not need to be submitted in writing. You or your Provider should call the applicable Benefits Administrator as soon as possible. The Benefits Administrator will provide you with a written or electronic determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours from receipt of your request to Appeal a denied Urgent Care Claim. All necessary information, including the Benefits Administrator’s determination of your Appeal, shall be transmitted between you or your authorized representative

and the Benefits Administrator by telephone, facsimile, or other available similarly expeditious method.

For Urgent Care Appeals, the Plan Administrator has delegated the applicable Benefits Administrator the exclusive right to interpret and administer the provisions of the Program. The Benefits Administrator's decisions are conclusive and binding, subject to the external appeals process below.

If your internal Appeal is denied in whole or in part, the Benefits Administrator will provide you with written or electronic notification of the Adverse Benefit Determination that will include:

- Information sufficient to identify the Claim (including the date of Service, the health care Provider, the Claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your Claim.

If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.

- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program's terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

External Review

If your Appeal is denied, you may file a request for external review of your denied Claim for Eligibility or a denied Claim for Benefits if your Appeal involves:

- Medical judgment (including, but not limited to, a determination based on the Program's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered Benefit; or a determination that a treatment is Experimental or Investigational).
- Rescission of coverage (whether or not the rescission has any effect on any particular Benefit at that time).

A denied Claim for Eligibility based on an individual's failure to meet the requirements for eligibility (e.g. worker classification and similar issues) cannot be the subject of an external review.

If an external review is available, you will receive a notice from the Benefits Administrator. The notice will include instructions for requesting the review. You may request an external review by completing the request for external review that may be obtained from the Benefits Administrator.

Except for approved expedited external review regarding Urgent Care Claims, this external review is available only after you have exhausted the internal Appeals process.

The external review will be made by an Independent Review Organization (IRO) using health care professionals who are not related to the Company and that had no involvement with the decision on the Claim for Benefits or your Appeal. If the Benefits Administrator approves your request for external review, the Benefits Administrator will provide you notice of the identity of the external review organization.

Expedited

You can request an expedited external review of a denied Urgent Care Claim or a denied Appeal of an Urgent Care Claim if the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function. It is also available if the denial involves an inpatient Admission, availability of care, continued stay, a health care item or discharge from a health care facility.

An external review decision is binding on the Program and the Claimant, except to the extent other remedies are available under law. The Program will provide Benefits as determined pursuant to the external review decision without delay, regardless of whether the Program intends to seek judicial review of the external review decision unless and until there is a judicial decision otherwise.

IMPORTANT: You may have additional rights available to you under ERISA, including the right to file a lawsuit in federal court. See “ERISA Rights of Participants and Beneficiaries” for more information.

COORDINATION OF BENEFITS

KEY POINTS

- *Coordination of Benefits (COB) applies when you have health coverage under more than one plan.*
- *The COB rules describe how Program Benefits are determined and which Coverage Plan will pay first.*
- *Special COB rules apply if you are Medicare Eligible, but only if Medicare is Primary.*

Determining Which Plan or Program Pays First

When two or more Coverage Plans pay Benefits, there are rules that determine which plan pays first. The rules for determining the order of payment are as follows:

- A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to the other Coverage Plan. The Primary Coverage Plan pays Benefits as if the Secondary Coverage Plan(s) does not exist.
- The Primary Coverage Plan pays first without regard to what another Coverage Plan may cover. A Secondary Coverage Plan pays after the Primary Coverage Plan and as a result, may reduce the Benefits it pays.
- A Coverage Plan that does not contain a Coordination of Benefits (COB) provision pays first unless the Coverage Plan is group coverage provided to an organization's members that supplements a basic Benefits package and provides coverage in addition to that basic Benefits package. Examples may include major medical coverages that apply after a base Coverage Plan's Hospital and surgical Benefits, and insurance coverages with a closed panel Coverage Plan that provides Non-Network Benefits.
- The following rules describe which Coverage Plan pays Benefits before another Coverage Plan – the first applicable rule is the rule that is used:
 - **Non-dependent or dependent.** The Coverage Plan that covers you as a non-dependent (for example, as an Employee, member, subscriber or Eligible Former Employee) is primary and the Coverage Plan that covers you as a dependent is secondary. However, if you are Medicare Eligible and Medicare is your Primary Coverage Plan, then the Coverage Plan covering you as a member, subscriber, retiree or Eligible Former Employee is secondary and the Coverage Plan that covers you as a dependent is third. If Medicare is your Secondary Coverage Plan, then Medicare is secondary and the Coverage Plan that covers you as a dependent is third, unless Medicare is also secondary to that Coverage Plan.
 - **Active or inactive Employee.** The Coverage Plan that covers you as an Active Employee (not laid off or retired) is primary. This also applies if you are covered under separate plans as a dependent of an Eligible Former Employee and an Employee. If the other Coverage Plan does not have this rule and the Coverage Plans do not agree on the order of Benefits, this rule does not apply. If you are covered under separate plans as an Eligible Former Employee or retiree and as a dependent of an actively employed Spouse, the "non-dependent or dependent" rule described above applies.

- **Continuation coverage.** If you are covered under any federal or state provided right of continuation coverage and also covered under another Coverage Plan, the Coverage Plan covering you as an Employee, member, subscriber, retiree or Eligible Former Employee (or as that person's dependent) is primary and the continuation coverage is secondary. If the other Coverage Plan does not have this rule and the Coverage Plans do not agree on the order of Benefits, this rule does not apply.
- **Longer or shorter length of coverage.** The Coverage Plan that covers you as an Employee, member, subscriber or Eligible Former Employee longest is primary.
- If the preceding rules do not determine the Primary Coverage Plan, the Coverage Plans (as defined in this section) share the Allowable Charges equally. The sum of all Benefits payable from this Program and the Primary Coverage Plan will not exceed actual Allowable Charges incurred.

Special Rules

Even if the Program is your normal primary or secondary health plan, in all events any worker's compensation coverage, the medical or other compensation component of a personal umbrella insurance policy or contract, the medical or other compensation component of any homeowner's/renter's insurance policy or contract, and any group or individual automobile insurance policy or contract (including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, and no-fault automobile insurance coverage) will be the primary plan for accidents and injuries that are covered by, reimbursable by or for which compensation is otherwise payable by the applicable policy or contract. This program will then pay secondary. In addition, for members and dependents covered by no-fault automobile insurance all medical expenses related to an automobile accident must be submitted to the automobile insurance carrier first and the Plan will only pay after the automobile insurance has paid. This Plan is not qualified health coverage for purposes of Michigan law. The program will pay covered expenses only according to the coordination of benefit rules discussed above.

COB for Eligible Dependent Child(ren)

When more than one Coverage Plan covers a Child, the order of Benefits determination is:

- The Coverage Plan of the parent whose birthday is earlier in the year ("birthday rule") is primary if:
 - The parents are married;
 - The parents are not separated (whether or not they ever have been married); or
 - A court decree awards joint custody without specifying who has responsibility to provide health care coverage.
- The Coverage Plan that covers either of the parents longer is primary if both parents have the same birthday.
- The Coverage Plan of the parent who is responsible for a Child's health care expenses or coverage, as specified by the terms of a court decree, is primary if the parent has knowledge

of the terms. This rule applies to Claim determination periods or Plan Years beginning after the Coverage Plan receives notice of the court decree.

How COB Works

When this Program is secondary, it may pay reduced Benefits. When processing a Claim, this Program will:

- Determine the Benefits the Program would pay if it were primary, however, if a negotiated rate applies to the Service, special rules apply to determine the Allowable Charge for the Service under the Program. Contact the Benefits Administrator if you have questions.
- Determine if total Benefits payable (before applying COB rules) under this Program and other Coverage Plans is more than 100 percent of actual Allowable Charges. If so, this Program reduces its Benefits so that the sum of all Benefits payable from this Program and the Primary Coverage Plan do not exceed Allowable Charges incurred.
- COB rules do not apply if you enroll in two or more closed panel Coverage Plans and Benefits are not payable by a closed panel Coverage Plan. For example, COB does not apply if the closed panel Coverage Plan does not pay Benefits because you went to a non-panel provider.
- If you are eligible for Medicare as your primary coverage, this Program reduces its Benefits by the amount Medicare would pay for Medicare enrolled participants. COB with Medicare conforms to all applicable federal statutes and regulations. To the extent allowed by law, if you are Medicare Eligible, this Program assumes you have full Medicare Parts A and B coverage (i.e., Part A hospital insurance, Part B voluntary medical insurance) even if you have not enrolled for Medicare. See the “If You, Your Spouse or Your Dependent Is Eligible for Medicare” section for detailed information on Medicare coverage and its impact on Program Benefits.
- If you are enrolled in Medicare and Medicare is your Primary Coverage, Program Benefits are secondary. Medicare pays first and Program Benefits are reduced by the amount Medicare pays. If you or your dependent is eligible for Medicare as your Primary Coverage, but not enrolled in Medicare, Program Benefits are reduced by the amount Medicare would have paid.
- As an Active Employee or the dependent of an Active Employee, generally this Program pays primary to Medicare, even if you are eligible for and enrolled in Medicare.
- If you are eligible for Medicare as your primary coverage, you are not required to enroll in Medicare Part D for Prescription Drug Benefits. Your Program Prescription Drug Benefits are your primary coverage if you do not enroll in Medicare Part D. If you enroll in Medicare Part D, Medicare will be primary and your Program Benefits will be secondary.
- Payment made under another Coverage Plan may include an amount this Program should have paid. If this occurs, this Program may pay that amount to the organization that made the payment. This Program treats this amount as if it were a Benefit paid and this Program will not have to pay that amount again. The term “payment made” includes providing Services, in which case “payment made” means reasonable cash value of the Services provided.
- If the amount of the payments the Program made is more than it should have paid under this COB provision, the Program may recover the excess. The Program may recover this amount

from one or more of the persons paid, from one or more of the persons for whom the Program paid or any other person or organization that may be responsible for the Benefits or Services provided. The amount of payments made includes the reasonable cash value of any Benefits provided in the form of Services.

IF YOU, YOUR SPOUSE OR YOUR DEPENDENT IS ELIGIBLE FOR MEDICARE

KEY POINTS

- *Eligibility for Medicare may affect your Benefits under the Program (if Medicare is primary)*
- *Certain options are not available to you and/or your Eligible Dependent if Medicare is your primary coverage.*
- *Once you are Medicare Eligible you must enroll in Medicare Parts A and B or your Medical Benefits may be substantially reduced.*

Your Program Benefits are affected when you or your dependent become Medicare Eligible, but only if you are not in current employment status. For the impact on Program Benefits and the steps you must take if you are Medicare Eligible, see the “Medicare Parts A and B” section.

Medicare Parts A and B

Impact of Medicare Parts A and B on Program Benefits

Medicare Parts A and B provide coverage for many of the same expenses as the Program. When an individual is enrolled in both Medicare and a group health plan, federal law determines when Medicare or the Program provides primary coverage. When Medicare coverage is primary, Medicare pays first for these expenses before the Program calculates Benefits. Your Benefits under the Program will be secondary to Medicare for these expenses.

The chart below indicates when Medicare coverage or the Program generally is primary. To verify what coverage will be primary under your circumstances, contact the Centers for Medicare and Medicaid Services. See the “More Information on Medicare” section for contact information.

Circumstances	Additional Conditions	Primary Payer	Secondary Payer
Age-based Medicare entitlement for you or your Spouse or dependent + coverage under the Program due to current active employment status	Employer has 20 or more Employees	Program	Medicare
Age-based Medicare entitlement + coverage under the Program due to former employment status or COBRA	N/A	Medicare	Program
Disability-based Medicare entitlement for you or your Partner or dependent + coverage under the Program due to current active employment status of a family member	Employer has 100 or more Employees	Program	Medicare
Disability-based Medicare entitlement + coverage under the Program due to former employment status or COBRA	N/A	Medicare	Program
End-Stage Renal Disease (ESRD)-based Medicare eligibility or entitlement + coverage under the Program (including coverage due to current active employment status, Eligible Former Employee status or COBRA)	First 30 months of Medicare eligibility or entitlement	Program	Medicare
	After 30 months of Medicare eligibility or entitlement	Medicare	Program

To receive maximum coverage for services that could be covered under Medicare Parts A or B, if Medicare would be primary, you must enroll in Medicare Parts A and B when you first become Medicare Eligible. Once you or your covered dependent become eligible for Medicare as your primary coverage, Benefits payable under the Program will automatically be calculated and paid as secondary to Medicare. The Program will not pay any portion of your expenses that would be payable by Medicare Parts A or B as your primary coverage if you were enrolled. Once you become eligible for Medicare as your primary coverage, Benefits payable under the Program will automatically be reduced by Benefits that would be payable for the same Services under Medicare Parts A and B. This applies whether or not you enroll in Medicare Parts A and B. As a result, to receive maximum coverage for medical Services, you must enroll in both Medicare Parts A and B once you are Medicare Eligible and remain enrolled.

What are the consequences of not enrolling in Medicare when you are eligible, if Medicare would pay as the primary payor (such as for former employees)? Here's an example.

Mike is a Medicare Eligible Former Employee who is enrolled in a Program that has a \$400 individual Annual Deductible and a \$2,000 Annual Out-of-Pocket Maximum, and pays a Benefit of 90 percent once the Annual Deductible is met. The Medicare Part B deductible for the Service is \$162, which counts toward his Program Annual Deductible.

Assume Mike has a covered emergency room visit and receives a bill for \$5,000. He has not yet accumulated any expenses toward the Program Annual Deductible. Since Mike is enrolled in Medicare, here's what happens:

	Mike Pays	Medicare Pays	Program Pays
Medicare Part B Deductible	\$162		
Medicare Part B Coinsurance		\$3,870.40 80% of \$4,838 (\$5,000 expense - \$162 deductible = \$4,838)	
Remaining Program Deductible	\$238 (\$400 Program deductible less \$162 Medicare deductible)		
Program Coinsurance			\$656.64 90% of \$729.60 (\$5,000 - \$162 - \$3,870.40 - \$238 = \$729.60)
Participant Balance	\$72.96 (\$5,000 - \$162 - \$3,870.40 - \$238 - \$656.64)		
TOTAL	\$472.96	\$3,870.40	\$656.64

The Program calculates Benefits as if Mike enrolled in Medicare – even if he didn't do so. If, in fact, Mike didn't enroll, his out-of-pocket costs would be much higher:

	Mike Pays	Medicare Pays	Program Pays
Assumed Medicare Part B Coinsurance		\$3,870.40 80% of \$4,838 (\$5,000 expense - \$162 deductible = \$4,838)	
Program Deductible	\$400		
Program Coinsurance			\$656.64 90% of \$729.60 (\$5,000 - \$3,870.40 - \$400 = \$729.60)
Participant Balance	\$3,943.36 (\$5,000 - \$400 - \$656.64)		
TOTAL	\$4,343.36	\$0	\$656.64

Mike will pay \$4,343.36, and the Program will pay \$656.64. Note that the \$3,870.40 that Medicare would have paid does not count toward meeting the Program Annual Out-of-Pocket Maximum.

Becoming Eligible for Medicare

If within the next six months you or a covered dependent will become Medicare Eligible, either due to age or disability, or are planning to leave your employment, call your Benefits Administrator at the toll-free number on your Program identification card and ask how Medicare eligibility will affect payment of your Program Benefits.

For information regarding your eligibility for Program coverage after you leave employment, call the Frontier Benefits Service Center.

Other Consequences of Not Enrolling in Medicare Part A and Part B

In addition to the impact on Program Benefits, failing to enroll in Medicare Parts A and B when eligible for Medicare as your primary coverage can also impact the cost of your Medicare coverage.

When your Program coverage becomes secondary to Medicare, it is important that you enroll in Medicare Part A and Part B or you could be required to pay more for your monthly Medicare Part B coverage in the future due to Medicare's late enrollment penalties.

For some people, enrollment in Medicare Parts A and B is automatic. For example, enrollment is automatic, but this is not always the case.

There generally is no monthly charge for Medicare Part A coverage; however, the federal government charges a monthly premium for Medicare Part B coverage. While you will have the option to opt out of Medicare Part B and avoid the premium, you should first determine the impact on your Program Benefits as well as your future Medicare Part B Premium, when you do decide to enroll in Medicare.

If you are not automatically enrolled for Part A or Part B, you must enroll when you are first eligible or during a Medicare enrollment period. If you do not enroll during your initial Medicare enrollment period or you opt out of coverage, you may be subject to Medicare late enrollment penalties. These late enrollment penalties do not apply if you are eligible for enrollment during a

Medicare special enrollment period. See the “Medicare Enrollment Periods and Late Enrollment Penalties” and “Medicare Special Enrollment Periods” sections for more information about these penalties and periods.

Medicare Enrollment Periods and Late Enrollment Penalties

When you first become eligible for Medicare Part A, you have an initial enrollment period in which to take action regarding Medicare Part B. Unless you have coverage under a group health plan available through your or your Spouse’s current active employment (or any family member’s active employment if you are eligible for Medicare due to disability), a delay on your part in Medicare Part B enrollment may delay Medicare coverage and result in higher Medicare premiums when you do enroll. This late enrollment penalty is in addition to a reduction in coverage of Medicare-eligible expenses described in the “Consequences of Not Enrolling in Medicare Parts A and B” section. The timing and length of the initial enrollment period vary, depending on the basis of Medicare eligibility. See the “More Information about Medicare” section for assistance with Medicare questions.

Medicare Special Enrollment Period

If you did not enroll in Medicare Part A and/or Medicare Part B when you were first eligible because you are covered under the Program or another group health plan based on your or your Spouse’s or family member’s current employment, you generally can enroll during a Medicare special enrollment period. The timing and length of this period vary. However, to avoid a gap in coverage of your Medicare-eligible expenses, it is important to ensure that you are enrolled in Medicare Parts A and B at the time your active employment ends. Delay also may result in higher Medicare premiums when you do enroll. See the “More Information about Medicare” section for assistance with Medicare questions. See the “Impact of Medicare Parts A and B on Program Benefits” section for information on how a delay in enrollment may affect your coverage of Medicare-eligible expenses.

For special enrollment periods that apply to Medicare Part D for prescription drugs, see the “Enrollment in Medicare Part D” section.

If You Work Past the Age of 65

If you remain Actively at Work with the Company after age 65 and are eligible for Medicare Part A, the Program will provide your primary coverage, and Medicare coverage will be secondary for you and your covered dependents. You may elect Medicare as your primary coverage while you are still working. However, if you elect Medicare as your primary coverage while you are still working, you and your Eligible Dependents will not receive any Benefits from the Program.

If you are Medicare Eligible when you terminate employment and you are enrolled in both the Program and Medicare, Medicare will become your primary medical coverage. If you were not enrolled in Medicare while you were an Active Employee, if you are Medicare Eligible when you terminate employment, Program coverage ceases to be your primary Medical coverage on the first day of the month following your Termination Date. If you were not enrolled in Medicare while you were an Active Employee, you must enroll in Medicare to have Medicare coverage. You may enroll in Medicare after your Termination Date during a Medicare special enrollment period. If your Medicare enrollment is not effective as of the first day of the month following your Termination Date, you will have a gap in coverage of the medical expenses that could have been covered by Medicare. See the “Medicare Special Enrollment Period” section for effective dates of Medicare coverage. You and/or your Spouse should enroll in Medicare Parts A and B before

terminating employment to ensure you have the maximum coverage of your Medicare-eligible expenses.

If You Become Disabled Before the Age of 65

If you are disabled before age 65 and become eligible for Social Security for 24 months based on that disability, you also become eligible for Medicare. If your Company-sponsored coverage is not based on your current employment, to obtain maximum coverage for your Medical expenses that could be covered by Medicare, you must enroll in Medicare Parts A and B as soon as you are eligible. See the “Impact of Medicare Parts A and B on Program Benefits” section for more information.

If Your Dependent Becomes Eligible for Medicare While You Are Actively at Work

If your covered Spouse/Partner or dependent becomes eligible for Medicare while you are receiving medical coverage from a Company-sponsored plan due to your current employment, the Program will provide your covered Spouse/Partner’s or dependent’s primary coverage.

If you are planning to retire or terminate employment and you will be eligible for continued coverage under the Program, your covered dependent should enroll in Medicare before you terminate employment to receive the maximum coverage for your Medicare-eligible expenses. When you have terminated employment but are receiving coverage under the Program for any reason, Medicare will become primary for any covered dependent who is eligible for Medicare. This will affect their Program coverage. See the “Impact of Medicare Parts A and B on Program Benefits,” “Medicare Enrollment Periods and Late Enrollment Periods” and “Medicare Special Enrollment Period” sections for information. You must also notify the Frontier Benefits Service Center of your covered dependent’s Medicare eligibility to ensure that your contributions reflect your covered dependent’s Medicare status.

If end-stage renal disease is the cause of Medicare eligibility for your covered dependent, see the “If You Have End-Stage Renal Disease” section for more information.

If You Have End-Stage Renal Disease (ESRD)

If you or your dependent has ESRD you may be eligible for Medicare before age 65 even if you are not disabled; for example, if you are receiving dialysis or require a kidney transplant.

If you are eligible for Medicare solely on the basis of ESRD and are enrolled in Program coverage, your Program coverage will be primary to Medicare for a period of 30 months, after which Medicare will provide primary coverage, even if you are Actively at Work. This is known as the coordination period.

Enrollment in Medicare Parts A and B is not automatic. You must actively enroll to have coverage. If you or your dependent does not enroll when eligible for Medicare as your primary coverage due to ESRD, Program Benefits will be affected in the same manner as if you became Medicare primary due to age. See the “Impact of Medical Parts A and B on Program Benefits” section for information.

If you have questions regarding Program coverage, contact the Benefits Administrator. If you have questions concerning Medicare coverage, refer to the “Medicare & You” handbook. If you or your dependent is eligible for Medicare, you will receive a copy of this handbook in the mail every year from Medicare.

Medicare Crossover Program

The Medicare crossover program is an electronic Claim-filing service set up by Medicare. This program electronically transmits Medicare Parts A and B Claims processed by Medicare to other group health insurance plans for processing. This eliminates the need for you to send a copy of the Provider's bill and the Explanation of Medicare Benefits (EOB) to your Benefits Administrator when filing a Claim for Benefits.

Once you elect Medicare crossover, you should allow 30-60 days from the set-up date for the crossover to start. Your EOB will indicate whether the Claim was electronically sent to the Benefits Administrator. Until this message appears, you must continue to file secondary Claims with the Benefits Administrator. Once the crossover starts, when Medicare processes a Claim, it is automatically forwarded electronically via the crossover program to the Benefits Administrator for processing. You should allow 30 days for Medicare to process the Claim and to electronically transmit the Claim to the Benefits Administrator for processing.

The Medicare crossover program links Medicare (all states; Washington, D.C.; Guam; Puerto Rico and U.S. Virgin Islands) to the Benefits Administrator.

IMPORTANT: If you do not want to participate in the Medicare crossover program, contact the Benefits Administrator to make your request. Changes in the Medicare crossover program are sent to Medicare, but may take 4-6 weeks before the change becomes effective. Retroactive requests are not available.

More Information on Medicare

Benefits Administrator

If you have questions on how Medicare affects your Program Benefits, contact your Benefits Administrator at the toll-free number on your Program identification card. The Benefits Administrator is available to help you understand how your Medicare and Program Benefits are coordinated and how that affects your Program Benefit as a whole.

Assistance with Medicare Questions

If you need assistance in understanding Medicare's rules and regulations, you may contact Medicare toll-free at **800-MEDICARE (800-633-4227)** or at www.medicare.gov. You can refer to the "Medicare & You" handbook, which is available from Medicare. This handbook will help you understand Medicare.

You may also contact the Social Security Administration toll-free at **800-772-1213** or call your local Social Security Administration office. To find your local Social Security office, call **800-722-1213**. If you have access to the Internet, you may go to www.ssa.gov.

Medicare Enrollment

If you are on COBRA coverage and are eligible for Medicare, Medicare will pay primary and your medical option on COBRA will pay claims secondary, regardless of whether you have enrolled in Medicare.

If you are disabled and you are eligible for Medicare (generally after 24 months of receiving SSA disability benefits), you are also responsible for enrolling in Medicare Part A and Part B, and this Plan will pay your claims secondary, regardless of whether you have enrolled in Medicare.

Therefore, to avoid your overall benefits from being reduced, you must enroll in Medicare Part A and Part B, once you are eligible. If you are already enrolled in Medicare Parts A and B and if you then drop Medicare Parts A and B, your medical option while disabled will still only pay claims secondary. Therefore, dropping Medicare Parts A and B will cause your overall medical benefits to be reduced, as set forth in the above example.

Frontier will not reimburse you or compensate you for failing to enroll in Medicare or dropping your Medicare enrollment when the Plan pays claims secondary as noted above.

You must contact the Social Security office at 1-800-772-1213 to apply for Medicare Part A and Part B. It is not done through the Company. You should also be aware that failure to enroll within the applicable Medicare enrollment period after you or your Dependent become eligible, means that you may have to wait until the following year to enroll and may have to pay higher premiums (that will last for your lifetime) once you do enroll in Medicare. To determine your applicable Medicare enrollment period or if you have any questions regarding Medicare, you should contact your local Social Security Office or review the Medicare and You Handbook at <http://www.medicare.gov>.

MEDICARE PART D

KEY POINTS

- *Medicare Part D is a voluntary Prescription Drug Benefit available to Medicare-Eligible individuals.*
- *Unlike Medicare Parts A & B, as an Active Employee, you are not required to enroll in Medicare Part D when Medicare coverage is primary.*

Coverage Under Medicare Part D

You and your dependents are eligible for Prescription Drug coverage under a Medicare Part D plan if you or your dependents are entitled to benefits under Medicare Part A and/or enrolled in Part B.

All Medicare Part D Prescription Drug plans provide at least a standard level of Prescription Drug coverage set by Medicare. Some plans may offer more Prescription Drug coverage for a higher monthly premium.

You may obtain the Medicare Part D Prescription Drug benefit through two types of private plans:

- You can join a Medicare Part D Prescription Drug plan for Prescription Drug coverage only;
or

- You can join a Medicare Advantage plan that covers both medical Services and Prescription Drugs.

If you are considering joining a Medicare Part D Prescription Drug plan, you should compare your current Program Prescription Drug coverage, including which Prescription Drugs are covered and at what cost, with the coverage and costs of the Medicare Part D plans offering Prescription Drug coverage in your area.

Enrollment in Medicare Part D

Each year, Medicare Part D Prescription Drug plans offer an enrollment opportunity from Oct. 15 through Dec. 7. If you or your dependents are eligible for Medicare Part D, then you are eligible to enroll.

In addition, you and your dependents may be eligible for a two-month special enrollment period to join a Medicare Part D Prescription Drug plan if:

- You or your dependents lose creditable Prescription Drug coverage, through no fault of your own; or
- You or your dependents drop non-creditable Prescription Drug coverage.

If You Enroll in Medicare Part D

If you and your dependents enroll in a Medicare Part D Prescription Drug plan, your coverage under the Program may be affected. For example, if you currently have Prescription Drug coverage under the Program and also enroll in a Medicare Part D Prescription Drug plan, coverage provided under the Program and the Medicare Part D Prescription Drug plan may be coordinated. See the “Coordination of Benefits” section for information on Coordination of Benefits.

In addition, if you decide to enroll in a Medicare Part D Prescription Drug plan and drop your current coverage under the Program, you and your dependents may not be able to get this coverage back.

For more information about how enrollment in a Medicare Part D Prescription Drug plan will affect coverage under the Program, contact the Prescription Drug Benefits Administrator. See the *Prescription Drug Benefits Administrator* table in the “Contact Information” section for contact information.

You Are Not Required to Enroll in Medicare Part D

As an Active Employee, you are not required to enroll in Medicare Part D to continue to obtain Prescription Drug Benefits under the Program; however, your decision to enroll or not to enroll may affect your Medicare Part D premiums in the future.

“Creditable coverage” means that Program Prescription Drug Benefits pay out at least as much as the standard coverage available through a Medicare Part D Prescription Drug plan. “Non-creditable coverage” is Prescription Drug coverage that, on average, does not pay out as much as the standard coverage available through Medicare Part D.

If Prescription Drug coverage under the Program is considered “creditable,” then you may keep Prescription Drug coverage under the Program and not pay a higher Medicare Part D premium if you later decide to join a Medicare Prescription Drug plan.

If Prescription Drug coverage under the Program is considered “non-creditable,” you may pay a higher Medicare Part D premium (a penalty) if you do not enroll in a Medicare Part D Prescription Drug plan when you first become eligible.

If you are eligible for Medicare, you will receive a Creditable Coverage Disclosure Notice annually describing if the Prescription Drug coverage options available to you under the Program are creditable. For more information about whether Prescription Drug coverage under the Program is creditable or non-creditable, contact the Frontier Benefits Service Center.

Reimbursement of Medicare Part D Premiums

You are responsible for the full and timely payment of any Medicare Part D Prescription Drug coverage premiums to the private plan you choose or Medicare. The Program does *not* offer reimbursement of Medicare Part D premiums.

Medicare Part D Low Income Assistance

If you have limited income and resources, extra help paying for Medicare Part D Prescription Drug coverage is available. For information about this extra help:

- You may contact Medicare at **800-MEDICARE (800-633-4227)** or on the Internet at www.medicare.gov.

You may contact the Social Security Administration at **800-772-1213 (TTY 800-325-0778)** or on the Internet at www.socialsecurity.gov.

Creditable Coverage and Late Enrollment Penalties

Creditable Coverage

If you or your dependents are eligible for Medicare and have Prescription Drug coverage through the Program, you may stay in the Program and choose not to enroll in the Medicare Prescription Drug plan. If the Prescription Drug coverage under the Program is at least as good as Medicare Part D Prescription Drug coverage (and therefore considered “creditable coverage”), then you and your dependents can continue to receive Prescription Drug Benefits under the Program and avoid higher Medicare Part D premiums if you or your dependents sign up for Medicare Part D Prescription Drug coverage later. If you are eligible for Medicare, you will be provided with an annual notice informing you whether your coverage is creditable or not.

Late Enrollment Penalties

If you or your dependents drop or lose your current Prescription Drug coverage under the Program and do not enroll in a Medicare Part D Prescription Drug plan within 63 consecutive days after your current Prescription Drug coverage under the Program ends, you may pay a higher Medicare Part D premium (a penalty) to join a Medicare Part D Prescription Drug plan later.

If you or your dependents go 63 consecutive days or longer without creditable Prescription Drug coverage under this Program (or any plan that offers creditable Prescription Drug coverage), your monthly Medicare Part D premium may increase by at least 1 percent of the Medicare Part D base beneficiary premium per month for every month that you are without creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19 percent higher than the Medicare Part D national base premium. You may have to pay this higher Medicare Part D premium (penalty) as long as you have Medicare Part D Prescription Drug coverage. In addition, you may have to wait until the next Medicare Part D annual enrollment period to enroll in a Medicare Part D Prescription Drug plan.

Additional Medicare Contact Information

For More Information About Medicare Part D and This Program

If you have questions about how the Program coordinates Prescription Drug coverage with Medicare Part D, you may contact your Prescription Drug Benefits Administrator at the toll-free number on your identification card.

For More Information About Your Options Under Medicare Part D Prescription Drug Coverage

More detailed information about Medicare Part D Prescription Drug plans is available in the “Medicare & You” handbook. If you or your dependent is eligible for Medicare, you will receive a copy of this handbook in the mail every year from Medicare. You also may be contacted directly by Medicare Part D Prescription Drug plans.

For more information about Medicare Part D Prescription Drug coverage:

- Visit Medicare on the Internet at www.medicare.gov.
- Call your State Health Insurance Assistance Program (refer to the “Helpful Resources & Tools” section of your copy of the “Medicare & You” handbook for the telephone number) for personalized help.
- Call Medicare at **800-MEDICARE (800-633-4227)**. TTY users should call **877-486-2048**.

WHEN COVERAGE ENDS

KEY POINTS

- *Coverage under the Program generally terminates on the last day of the month in which your employment with the Company ends.*
- *Coverage for an eligible Spouse/Partner or Child will end as of the last day of the month, when the Spouse/Partner or Child no longer meets the requirements to be eligible under the Program.*
- *Under certain circumstances, coverage will be continued for a disabled Former Employee and a Disabled Child(ren).*
- *You and your eligible Spouse/Partner and Child(ren) may be able to continue coverage under COBRA in certain circumstances. In some circumstances, continued coverage may be provided after your death for some period of time.*

For Employees

Coverage under the Program will stop on the earliest of the following:

- The last day of the month in which your employment with the Company stops.
- The last day of the month in which you stop being an Eligible Employee.
- Your company is no longer a Participating Company.
- The last day of a period for which contributions for the Cost of Coverage have been made in full, if the contributions for the next period are not made in full when due.
- The day the Program ends.
- The date you fail to cooperate with the Plan Administrator or Benefit Administrator with respect to the administration of benefits.

See the “Extension of Coverage – COBRA” and “Your Conversion Rights” sections for information about what rights you may have to continue coverage.

The remainder of this section describes certain other situations where continued coverage may be available for you and/or your covered dependents.

For Covered Spouse/Partner and Child(ren)

Coverage for your Spouse/Partner, and/or your Child(ren), stops when one of the following occurs:

- Your coverage stops.
- The last day of a period for which contributions for the Cost of Coverage have been made in full if the contributions for the next period are not made in full when due.

Coverage for a Spouse/Partner or Child will stop sooner if one of the following occurs:

- The individual becomes covered as an Employee of the Company under this Program.

- The individual is no longer eligible as defined in the section called “Eligible Dependents.” (Coverage stops on the last day of the month in which the individual is no longer eligible.) Coverage ends for your Child(ren) at the end of the month in which they turn age 26.
- The date you remove the individual from coverage.
- The date the individual fails to cooperate with the Plan Administrator or Benefits Administrator with respect to the administration of benefits.

See the “Extension of Coverage – COBRA,” “Surviving Dependent Coverage” and “Your Conversion Rights” sections for information about what rights you or your dependents may have to continue coverage.

A mentally or physically incapacitated Child’s medical benefit coverage under the Program will not stop due to age. It will continue as long as your dependent’s coverage under the Program continues and the Child continues to meet the conditions described in the sections entitled “Eligible Dependents” and “Certification of Disabled Dependents.”

It is your responsibility to report a change in a spouse’s/partner’s or dependent child’s eligibility. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded. Your Program coverage and your spouse/partner/dependent child’s Program coverage may also be terminated or suspended for engaging in misrepresentation or fraud against the Program, including filing or participating in filing a false, misleading or fraudulent claim for benefits, allowing your ID card to be used by an individual who is not enrolled in the Program, providing false or misleading information regarding a spouse/partner or dependent child, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria.

If You Are Laid Off from Active Employment

If you terminate employment due to a force adjustment or layoff, continued Company contributions to your medical coverage may be available for a limited period (as long as you continue to pay any applicable contribution) in accordance with the layoff provisions of your Company’s collective bargaining agreement. You should refer to your collective bargaining agreement to determine the layoff benefits and what options are available for extended coverage. You may also contact the Frontier Benefits Service Center for assistance with questions.

If You Are Leaving the Company

If you leave the Company, you may be eligible for Post-Employment Benefits under this Program or a program for Eligible Former Employees (Retirees) for your job classification. Please refer to the SPD for Eligible Former Employees (Retirees) for the eligibility and contribution rules that generally apply to Eligible Employees at termination of employment. You should also review this SPD for details including applicable definitions any exceptions that may apply to your specific circumstances. Contact the Frontier Benefits Service Center to request a copy of the applicable SPD. You also may be eligible for COBRA in lieu of the Benefits for Eligible Former Employees.

If Your Active Employment Ends by Reason of Disability

If you are disabled, you may be eligible to continue your (and your Eligible Dependents') coverage under this Program or a program for Eligible Former Employees. See the section entitled "Eligible Former Disabled Employees" for a description of the eligibility requirements applicable to totally disabled former Employees.

If Your Active Employment Ends by Reason of Your Death

If you have a surviving Spouse/Partner and/or Child(ren) covered by the Program as of the date of your death, they will be eligible to elect continuation coverage under COBRA. See the "Extension of Coverage – COBRA," "Surviving Dependent Coverage" and "Your Conversion Rights" sections for information about what rights you or your dependents may have to continue coverage.

In addition, your surviving dependents may be able to obtain continued coverage under the Program for a limited period on the same basis as during your active employment or may be able to continue coverage at their own expense for a period longer than the maximum COBRA coverage period.

Rescission of Coverage

A rescission of your coverage occurs if the coverage is cancelled retroactively except when the termination is for nonpayment. Your coverage can be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice or omission that constitutes fraud; or if you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

You will be provided with 30 calendar days advance notice before your coverage is rescinded. You have the right to request an internal Appeal of a rescission of your coverage. Once the internal Appeal process is exhausted, you may have the additional right to request an independent external review. If you appeal a rescission in coverage, coverage will be maintained pending a resolution of the Appeal to the extent required by law. See the "External Appeals Process for Certain Eligibility Claims" section for information.

EXTENSION OF COVERAGE - COBRA

KEY POINTS

- *COBRA continuation coverage is a temporary extension of group coverage that allows Program participants who have lost coverage due to a Qualifying Event to continue coverage for a period of time.*
- *If you experience a COBRA qualifying event, you must notify the Frontier Benefits Service Center no later than 60 days after the date the event occurs.*
- *If you or your Spouse/Partner and dependent Child(ren) do not elect your COBRA continuation coverage within the 60-day election period, you will lose your right to elect continuation coverage.*
- *Generally, you will be required to pay the entire cost of COBRA continuation coverage.*
- *If you fail to pay the COBRA premium by the due date, your COBRA coverage will end and you will not be able to re-enroll.*

COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer a temporary extension of coverage (called “continuation coverage” or “COBRA” coverage) in certain instances when coverage under the Program would otherwise end. This coverage is available to Employees/Eligible Former Employees and their families who are covered by the Program.

In this section, “you” is defined as the person or persons who lost coverage due to a COBRA or insurance continuation Qualifying Event (the “Qualified Beneficiary”).

The Program is a group health plan subject to this law. You do not have to show that you are insurable to elect COBRA continuation coverage during the election period. However, you will have to pay the entire premium for your COBRA continuation coverage. At the end of the maximum coverage period (described below in this section), you may be allowed to enroll in an individual conversion health plan if it is available under the Program. You will be responsible for paying the premiums for this coverage as required by the individual conversion health plan.

This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive this coverage. This section provides only a summary of your COBRA continuation coverage rights. See the “Your ERISA Rights” section for contact information.

The COBRA Administrator is WageWorks/HealthEquity.

In addition to COBRA continuation coverage, you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. Additional information is provided below.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of group health coverage. It is available when coverage would otherwise end because of a life event known as a Qualifying Event. Specific Qualifying Events are listed later in this section.

After a Qualifying Event occurs and any required notice is provided to the COBRA Administrator, COBRA continuation coverage must be offered to each person who is a Qualified Beneficiary. A Qualified Beneficiary is someone who will lose coverage under the Program because of a Qualifying Event. Only Qualified Beneficiaries may elect to continue their group health coverage under COBRA. Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Depending on the type of Qualifying Event, the following may be considered “Qualifying Beneficiaries” if they are covered under the Program on the day before the Qualifying Event occurs:

- Employees/Eligible Former Employees.
- Spouses/Partners of Employees/Eligible Former Employees.
- Dependent Child(ren) of Employees/Eligible Former Employees.
- Certain newborns, newly adopted Child(ren) and alternate recipients under Qualified Medical Child Support Orders (“QMCSOs”) may also be Qualified Beneficiaries. This is discussed in more detail in the “Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period” section and the “Alternate Recipients Under Qualified Medical Child Support Orders” section.

COBRA continuation coverage is the same coverage that the Program gives to Covered Persons or beneficiaries who are currently participating in the Program and not receiving COBRA continuation coverage. Ordinarily, the COBRA continuation coverage will be the same coverage that you had on the day before the Qualifying Event occurred. But if coverage is changed for similarly situated Active Employees or Eligible Former Employees covered by the Program, or their Spouses/Partners or dependent Child(ren), the COBRA continuation coverage generally will be changed in the same way for the Qualified Beneficiaries on COBRA at the same time.

As a COBRA continuation coverage participant, you will have the same rights under the Program during your COBRA continuation coverage period as other Covered Persons or beneficiaries covered under the Program, including Annual Enrollment and special enrollment rights.

You can find specific information describing the coverage to be continued under the Program elsewhere in this document and in the Plan document. For more information about your rights and obligations under the Program, you can get a copy of the Plan document by requesting it from the Plan Administrator as described in the “Your ERISA Rights” section.

COBRA-Qualifying Events: When Is COBRA Continuation Coverage Available?

Eligible Employee

If you are an Employee covered by the Program, you become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if you lose your coverage under the Program due to one of the following Qualifying Events:

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

Spouse or Partner

If you are the Spouse/Partner of an Employee/Eligible Former Employee covered under the Program, you will become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if you lose your coverage under the Program because of any of the following Qualifying Events:

- Your Spouse/Partner dies.
- Your Spouse's/Partner's employment ends for any reason other than his or her gross misconduct, or your Spouse's/Partner's hours of employment are reduced.
- You become divorced or legally separated from your Spouse, or your legally recognized partnership is dissolved.

IMPORTANT: If you are an Employee/Eligible Former Employee and you eliminate coverage for your Spouse/Partner in anticipation of a divorce or partnership dissolution, and the divorce or partnership dissolution occurs, then the actual divorce or partnership dissolution will be considered a COBRA-qualifying event even though the ex-Spouse/Partner lost coverage earlier. If the ex-Spouse/Partner notifies the Frontier Benefits Service Center within 60 days after the later of the divorce or partnership dissolution or the date coverage terminates under the Program and can establish that the coverage was eliminated earlier in anticipation of the divorce or partnership dissolution, then COBRA continuation coverage may be available for the period after the divorce or partnership dissolution.

- Your Spouse/Partner becomes entitled to Medicare Part A, Part B or both.

Child(ren)

Your Child who is covered by the Program will become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if he or she loses group health coverage under the Program because of any of the following Qualifying Events, or he or she is born to or placed with you for adoption during a period of COBRA continuation coverage and is enrolled in the Program:

- The Employee/Eligible Former Employee-parent dies.
- The Employee/Eligible Former Employee-parent's employment ends for reasons other than gross misconduct, or the Employee/Eligible Former Employee-parent's hours of employment with the Company are reduced.
- The parents' divorce or legal separation or the parents' partnership dissolves.
- The Employee/Eligible Former Employee parent becomes entitled to Medicare Part A, Part B or both.
- The Child ceases to be eligible as a Child under the Program.

FMLA (Active Employee Only)

Special COBRA rules apply if you take FMLA leave and do not return to work at the end of the leave. Failure to return to work at the end of an FMLA leave may constitute a COBRA-qualifying event (i.e., an Employee and the Employee's Spouse/Partner and Child(ren) may elect COBRA continuation coverage). In this case, you and your Spouse/Partner and Child(ren), if any, will be entitled to elect COBRA if both of the following conditions are met:

- They were covered under the Program on the day before the FMLA leave began (or became covered during the FMLA leave).
- They will lose coverage under the Program because you do not return to work at the end of the FMLA leave.

This means that you may be entitled to elect COBRA continuation coverage at the end of a FMLA leave for yourself and your dependents even if coverage under the Program ended during the leave.

If you are on a non-FMLA leave that provides coverage as if you were still an Active Employee, and your employment is terminated during the leave or your coverage ends at the end of the maximum coverage period specified for your leave, you (and your Spouse/Partner and Child(ren)) may elect COBRA coverage to be effective as of the date your coverage would end if you are both:

- Covered under the Program on the day before beginning the leave of absence (LOA).
- Terminated from employment for any reason except gross misconduct or lost your coverage due to the expiration of the maximum coverage period.

If COBRA continuation coverage is elected, the maximum coverage period will begin with the date your coverage would otherwise have ended. See the "How Long Does COBRA Continuation Coverage Last?" section for more information.

Important Notice Obligations

You will only receive notification that COBRA continuation coverage is available to you if you notify the Frontier Benefits Service Center in a timely manner that a Qualifying Event has occurred.

Your Employer's Notice Obligations

When the Qualifying Event is one of the following, Frontier will notify the Frontier Benefits Service Center within 30 days of the Qualifying Event:

- The end of your employment.
- The reduction of your hours of employment.

If your employment ends due to a termination that your Employer determines to have been a result of your gross misconduct, you will receive a notice indicating that you have been determined **not** to be eligible for continuation coverage and why. You may appeal this determination by filing an Appeal with the Benefits Administrator within 60 days after your receipt of this determination. See the "How to File a Claim for Eligibility" section for more information on your right to appeal an adverse eligibility determination under this Program.

Your Notice Obligations

You are responsible for notifying the Frontier Benefits Service Center if your Spouse/Partner or Child loses coverage under the Program as a result of divorce, legal separation, partnership dissolution, or your entitlement for Medicare (Part A or Part B or both), or the Child's loss of eligible status under the Program. Your Spouse/Partner or Child is responsible for notifying the Frontier Benefits Service Center if your Spouse/Partner or Child loses coverage under the Program as a result of your death. You, your Spouse/Partner or Child *must* provide this notice, using the procedures specified in the "COBRA Notice and Election Procedures" section, no later than 60 days after the later of the date the event occurs or the date the Qualified Beneficiary loses or would lose coverage under the Program's terms. This is generally at the end of the month in which the date on which the COBRA-qualifying event occurs (see the "When Coverage Ends" section for more details).

If you, your Spouse/Partner or Child fails to provide this notice to the Frontier Benefits Service Center during this 60-day notice period (using the procedures specified), any Spouse/Partner or Child who loses coverage will not be offered the option to elect continuation coverage. If you, your Spouse/Partner or Child fails to provide this notice to the Frontier Benefits Service Center and if any Claims are mistakenly paid for expenses incurred after the date coverage should have terminated, then you, your Spouse/Partner and Child will be required to reimburse the Program for any Claims so paid.

If the Frontier Benefits Service Center provides the COBRA Administrator (WageWorks/HealthEquity) with timely notice of a Qualifying Event that has caused a loss of coverage for a Spouse/Partner or Child, then the COBRA Administrator (WageWorks/HealthEquity) will send a COBRA Enrollment Notice to the last known address of the individual who has lost coverage. The COBRA Administrator (WageWorks/HealthEquity) will also notify you (the Employee/Eligible Former Employee), your Spouse/Partner and Child of the right to elect continuation coverage after the administrator receives notice of either of the following events that results in a loss of coverage:

- Employee's termination of employment (other than for gross misconduct)
- Reduction in the Employee's hours

COBRA Notice and Election Procedures

All COBRA notices must be provided to the Frontier Benefits Service Center within the time frames and methods specified in this section.

Important COBRA Notice and Election Procedures

You must provide all required notices (or make your COBRA election) no later than the last day of the required notice period (or election period). You can do this by placing a telephone call to the COBRA Administrator at the telephone number in the "Contact Information" section of this SPD or subsequent summaries of material modifications. You must speak to a service associate at the time of the call. Written or electronic communications or calls to other telephone numbers will not meet your obligation to provide this notice.

When you call to provide notice or elect coverage, you must provide the name and address of the Employee/Eligible Former Employee covered under the Program and the name(s) and address(es) of the Qualified Beneficiary(ies) affected. If your notice concerns a Qualifying Event, you also must include the name of the Qualifying Event or second Qualifying Event, if applicable, as well as the date the event(s) happened. If your notice concerns the disability of a Qualified Beneficiary, you also must include the name of the disabled Qualified Beneficiary, the date when the Qualified Beneficiary became disabled and the date the Social Security Administration made its determination. You may be required to provide documentation to support eligibility.

Electing COBRA Continuation Coverage

Once you inform the Frontier Benefits Service Center that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. If you elect COBRA continuation coverage in a timely fashion, COBRA continuation coverage will begin on the date that the Program coverage would otherwise have been lost.

In order to elect COBRA continuation coverage (if you are entitled to do so), you and/or your Spouse/Partner and Child(ren) must complete and return the form within 60 days after the later of:

- The date you and/or your dependents lose coverage; or
- The date you and/or your covered dependents are notified of your right to continue coverage (the date on the COBRA Enrollment Notice).

If you or your Spouse/Partner and Child(ren) do not elect continuation coverage within this 60-day election period using the procedure described in the "COBRA Notice and Election Procedures" section above, you will lose your right to elect continuation coverage.

However, as described in the "Surviving Spouse/Partner and Child(ren)" section, when you or a Child is eligible for extended coverage during a leave of absence or after termination of employment and the extended coverage runs concurrently with COBRA continuation coverage, you will automatically be enrolled in COBRA continuation coverage for the duration of your eligibility for extended coverage. At the end of your extended coverage, you may continue COBRA continuation coverage for the remainder of your eligible period (if any), by paying the required COBRA premiums. See the "Company Extended Coverage" section for more information.

If you reject COBRA continuation coverage during the election period, you may change that decision and enroll anytime until the end of the election period, using the required election procedure.

In most cases, a single COBRA election form and notice will be provided to the Employee/Eligible Former Employee and any eligible Spouse/Partner and Child(ren) or, in the case of an election provided only to the Spouse/Partner and Child(ren), a single election form

and notice will be provided to the Spouse/Partner. However, each Qualified Beneficiary has an independent right to elect continuation coverage. For example, both you and your Spouse/Partner may elect continuation coverage, or only one of you may choose to elect continuation coverage. In addition, each eligible Child may elect coverage, even if one or both of you do not. Parents may elect to continue coverage on behalf of their Child(ren).

Even if you have other health coverage or are enrolled in Medicare benefits on or before the date COBRA is elected, you are entitled to elect COBRA continuation coverage. However, as discussed below, a Qualified Beneficiary's eligibility for COBRA continuation coverage will end if, after electing COBRA, he or she becomes covered under another employer-sponsored group health plan or program or enrolled in Medicare. If this occurs, the other Qualified Beneficiaries may still elect COBRA continuation coverage.

When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or by calling 1-800-318-2596.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out-of-pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

Paying for COBRA Continuation Coverage

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount may not exceed 102 percent of the cost to the group health plan (including both Employee/Eligible Former Employee and Employer contributions) for coverage of a similarly situated Covered Person or beneficiary who is not receiving COBRA continuation coverage (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent). Your election notice from WageWorks/HealthEquity will include the cost of COBRA continuation coverage. In some circumstances, when you or your dependents are receiving Company Extended Coverage, the Company will make contributions toward the applicable COBRA premium. See the "When Coverage Ends" section for more information. The amount of your COBRA premium may change from time to time during your period of COBRA coverage, for example, upon annual changes in the cost of group health plan coverage or if you elect changes in your coverage. You will be notified of any COBRA premium changes.

When you elect COBRA, you will receive an initial bill. You must make your first payment for COBRA continuation coverage no later than 45 days after the date of your election. The amount of your required first payment will be stated on your initial bill. It will include the cost of COBRA continuation coverage from the date coverage begins through the end of the month following the month in which the bill is issued. Claims for payment of Benefits under the Program may not be processed and paid until you have elected COBRA continuation coverage and made the first payment. **Any Benefits paid during this period will be retroactively canceled if you do not**

elect COBRA or if coverage is canceled because you do not make timely payments. Bills for subsequent coverage will be issued monthly.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. The maximum duration for COBRA continuation coverage is described in this section. COBRA continuation coverage can end before the end of the maximum coverage period for several reasons that are described in the “Termination of COBRA Coverage Before the End of the Maximum Coverage Period” section.

COBRA Events	
Event	Length of Coverage
If you leave the Company (for reasons other than gross misconduct)	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you no longer meet the eligibility requirements	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you are on a military leave	Coverage for you and your dependents may last for up to 24 months
If you die	Coverage for your dependents may last for up to 36 months
If you and your Spouse divorce or become legally separated or Partner requirements are no longer met	Coverage for your Spouse, Partner and/or Eligible Dependent Child(ren) may last for up to 36 months**
If a Child loses dependent status	Coverage for that dependent Child may last for up to 36 months**
If you are laid off	Coverage for you and your dependents may last for up to 18 months*
If you fail to return to work at the end of your family medical leave	Coverage for you and your dependents may last for up to 18 months*
<p><i>*An 18-month continuation period may be extended. For more information, see the “18 Months (Extended Under Certain Circumstances)” section below.</i></p> <p><i>**If you do not call or provide written notice within 60 days after the event, COBRA continuation rights will be lost for that event.</i></p>	

18 Months (Extended Under Certain Circumstances)

When the Qualifying Event is the end of employment or reduction in hours, COBRA continuation coverage for you, your Spouse/Partner or Child, as applicable, can last for up to 18 months from the date of termination of employment or reduction in hours. There are three ways this 18-month period of COBRA continuation coverage can be extended:

- Disability Extension.** An 11-month extension of coverage may be available if any of the Qualified Beneficiaries in your family become disabled. All of the Qualified Beneficiaries who have elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them is qualified under this rule. The Social Security Administration (SSA) must formally determine under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the Qualified Beneficiary was disabled at some time prior to or during the first 60 days of COBRA continuation

coverage. You must notify WageWorks/HealthEquity of this fact, using the notification procedure identified in the “COBRA Notice and Election Procedures” section. **You must provide this notification within 60 days after the later of the SSA’s determination or the beginning of COBRA coverage and before the end of the first 18 months of COBRA continuation coverage.** The disabled individual does not need to enroll for coverage in order for the other Qualified Beneficiary family members to be covered. In the event the disabled party does not continue COBRA, only 102 percent of the premium may be charged for months 19 through 29. If the disabled party does continue COBRA, 150 percent of the premium will be charged for months 19 through 29. **If notice of the disability is not provided within the required period using the required procedure, there will be no disability extension of COBRA continuation coverage for any Qualified Beneficiary.** If the Qualified Beneficiary is determined by the SSA to no longer be disabled, you must notify WageWorks/HealthEquity within 30 days after the SSA’s determination. This is accomplished by using the notice procedure identified in the “COBRA Notice and Election Procedures” section. COBRA continuation coverage for all Qualified Beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA’s determination that the Qualified Beneficiary is no longer disabled, provided it is after the initial 18-month period. The Program reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all Benefits paid after the first day of the month that is more than 30 days after the SSA’s determination.

- **Second Qualifying Event.** An extension of up to 18 months of COBRA continuation coverage will be available to Spouses/Partners and Child(ren) who elect COBRA continuation coverage if a second Qualifying Event occurs during the 18-month or 29- month coverage period following an Employee’s termination of employment or reduction in hours. The maximum amount of continuation coverage available when a second Qualifying Event occurs is 36 months. The second Qualifying Event must be an event that would provide a 36-month continuation coverage period, such as the death of a covered Employee/Eligible Former Employee or a Child ceasing to be eligible for coverage. For the extension period to apply, notice of the second Qualifying Event must be provided to WageWorks/HealthEquity no later than the 60th day after the later of the date of the second Qualifying Event or the date coverage would otherwise end, using the notification procedure specified in the “COBRA Notice and Election Procedures” section. **If the notice procedure is not followed or notice is not given within the required period, then there will be no extension of COBRA continuation coverage due to a second Qualifying Event.**
- **Medicare extension for Spouse/Partner and Child(ren).** If a COBRA-qualifying event that is a termination of employment or a reduction of hours occurs within 18 months after the Employee becomes entitled to Medicare then the maximum coverage period for the Spouse/Partner and eligible Child(ren) will end three years after the date the Employee became entitled to Medicare (but the covered Employee’s maximum coverage period will remain 18 months).

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage for the Employee/Eligible Former Employee, Spouse/Partner and/or Child(ren) will automatically terminate when any one of the following six events occurs before the end of the maximum coverage period:

- The premium for the Qualified Beneficiary's COBRA continuation coverage is not paid in full within the allowable grace period.
- After electing COBRA continuation coverage, you (the Employee/Eligible Former Employee, Spouse/Partner or Child) become covered under another group health plan/program (as an Employee or otherwise). This rule applies only to the Qualified Beneficiary who becomes covered by another group health plan/program.
- After electing COBRA continuation coverage, you (the Employee/Eligible Former Employee, Spouse/Partner or Child) become enrolled in Medicare. This will apply only to the person who becomes enrolled in Medicare.
- During a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, however, continuation coverage will not end until the month that begins more than 30 days after the determination.
- If for any reason, other than a COBRA-qualifying event, the Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).
- The Company no longer provides group health coverage to any of its Employees.

Information About Other Individuals Who May Become Eligible for COBRA Continuation Coverage

Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period

A Child born to, adopted by or placed for adoption with you during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary if you are a Qualified Beneficiary and have elected continuation coverage for yourself. The Child's COBRA continuation coverage begins when the Child is enrolled in the Program, whether through special enrollment, Prospective or Annual Enrollment. It lasts for as long as COBRA continuation coverage lasts for your other family members. To be enrolled in the Program, the Child must satisfy the otherwise-applicable eligibility requirements (for example, age).

Annual Enrollment Rights and HIPAA Special Enrollment Rights

If you elect COBRA, you will be given the same opportunity available to similarly situated Active Employees to change your coverage options or to add or eliminate coverage for dependents at Annual Enrollment. In addition, the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA continuation coverage certain rights to add coverage for Eligible Dependents if that person acquires a new dependent (through marriage, birth, adoption or placement for adoption) or if an Eligible Dependent declines coverage because of other coverage and later loses that coverage as a result of certain qualifying reasons. Except for certain Child(ren) described in the "Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period" section above, dependents who are enrolled in a special enrollment or Annual Enrollment do not become Qualified Beneficiaries. Their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under Qualified Medical Child Support Orders

If you have a Child that is receiving Benefits under the Program pursuant to a Qualified Medical Child Support Order received by the Frontier Benefits Service Center during your (the

Employee's/Eligible Former Employee's) period of employment with the Company, he or she is entitled to the same rights under COBRA as an eligible Child of yours, regardless of whether that Child would otherwise be considered eligible (other than on account of age).

When You Must Notify Us About Changes Affecting Your Coverage

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the **addresses of family members**. While you are an Active Employee, your address in the system of the Frontier Benefits Service Center will be used to send COBRA notices. Contact the Frontier Benefits Service Center to update your home address.

Also, for all participants, if your **marital status changes** or if a **covered Child ceases to be eligible for coverage** under the Program terms, you, your Spouse/Partner or Child must promptly notify the Frontier Benefits Service Center to remove that person from your coverage. You also must provide the appropriate mailing address for mailing your Spouse's/Partner's or Child's COBRA notice. Such notification is necessary to protect COBRA rights for your Spouse/Partner and Child(ren). In addition, you must notify us if a disabled Employee or family member is determined to **no longer be disabled**. Once your dependent is enrolled in COBRA, he or she must promptly report any **address changes** to the Frontier Benefits Service Center.

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage

early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

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

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

If you have questions about your right to coverage, contact the COBRA Administrator.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-

3272. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov

For More Information

Contact the Frontier Benefits Service Center if you, your Spouse/Partner or Child(ren) have any questions about this section or COBRA. You also may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of regional and district EBSA offices are available online at www.dol.gov/ebsa (EBSA's website).

Contact Information

For contact information for the COBRA Administrator, see the "Contact Information" section. For contact information for the Plan Administrator, see the *Other Plan Information* table in the "Plan Information" section.

Surviving Dependent Coverage

If you are enrolled in the Program as of your date of death, medical coverage for your enrolled dependents will continue through the end of the month and continued coverage under Company Extended Coverage (CEC) will be available after that, under the same terms that would have applied if you remained alive, subject to their continued eligibility and payment of required contributions. Company contributions toward the Cost of Coverage will be available for up to six months for your surviving Spouse/Partner and other dependents who are enrolled under CEC. See the "Surviving Dependents" subsection in the "Contribution" section for more information on surviving dependent contributions.

After eligibility for COBRA ends, unless COBRA coverage is lost due to nonpayment of required contributions or voluntary termination of coverage, your surviving Spouse/Partner may continue medical coverage for himself or herself and any dependent Child(ren) who were enrolled for medical coverage at the time of your death, provided they have remained eligible for CEC and paid all applicable premiums. Your surviving Spouse/Partner may continue medical coverage for your dependent Child(ren) until they no longer qualify as dependents under the Program or your surviving Spouse/Partner is no longer covered.

If your surviving Spouse/Partner decides to terminate Program coverage for any reason or is terminated from coverage because of not having paid the required contribution, he or she will not be permitted to re-enroll in medical coverage. If your surviving Spouse/Partner declines coverage under this extended option at the time it is offered, he or she will not be permitted to elect medical coverage at a later date. Once enrolled in this extended option, your surviving Spouse/Partner may not enroll new dependents.

Surviving dependent CEC coverage will terminate for all covered survivors at the end of the month in which the surviving Spouse/Partner:

- Fails to make the required contributions.
- Drops the coverage on himself or herself.
- Dies.
- Marries; or forms a legally recognized partnership.

The following additional conditions apply to this extended coverage:

- Surviving dependent CEC is available if you die while on a leave of absence or short-term disability.
- Surviving dependent CEC is not available if you die while receiving severance payments.
- Surviving Spouses, LRPs or Child(ren) cannot add new dependents during this Company Extended Coverage (CEC) period.

IMPORTANT: To report a death, call the Frontier Benefits Service Center listed in the “Contact Information” section. Please have information regarding the deceased available when you call, such as name and Social Security number.

WHAT HAPPENS WHEN YOU LEAVE THE COMPANY

Active Program coverage for you and your covered dependents continues through the end of the month in which your employment terminates. If eligible for Post-Employment Benefits, your Post-Employment Benefits will be subject to provisions that apply to Eligible Former Employees unless you elect COBRA continuation coverage under your active Program coverage. Information concerning your options as a former Employee are available from the Frontier Benefits Service Center.

Post-Employment Coverage

The Frontier Benefits Service Center will send you information regarding Post-Employment Benefits and required monthly contributions. Contact the Service Center if you do not receive this statement within two weeks of your employment Termination Date or if you would like to make any changes to your coverage.

If you are eligible for Post-Employment Benefits, your coverage will begin on the first day of the month following your employment Termination Date, subject to the payment of any required contributions. For example, if you terminate employment on June 15, the effective date for Post-Employment Benefits is July 1. See the “When Coverage Ends” section for more information.

There is a separate SPD for your post-employment coverage Program benefits. You will receive a copy of your post-employment SPD either electronically or by mail. You can also access a copy of your SPD through the Frontier Benefits Service Center.

Steps You Must Take to Ensure Coverage Continuation	
Within two weeks of your termination of employment	Look for information from the Frontier Benefits Service Center; call if you do not receive it.
Within 31 days of receipt of information	Enroll for Post-Employment Benefits available to Eligible Former Employees, if applicable.
Within 31 days of enrollment for Post-Employment Benefits available to Eligible Former Employees	Submit payment for any required contributions.
Within 60 days of your active Program coverage end date or receipt of COBRA Enrollment Notice, whichever is later	Elect COBRA coverage, if applicable.
Within 45 days of electing COBRA coverage	Submit payment for COBRA coverage.
Ongoing	<ul style="list-style-type: none"> • Submit payments by the payment due date. • Promptly report your address change. • Promptly report any Change-in-Status Events • See the “Contact Information” section for contact information.

Dependent Coverage

If you are eligible for Post-Employment Benefits, you may cover your Eligible Dependents who were enrolled in active Program coverage at the time you terminated employment, subject to

dependent eligibility requirements and payment of any required contributions. If you acquire a new dependent after you terminate employment, contact the Frontier Benefits Service Center to find out if your new dependent is eligible for coverage. The Frontier Benefits Service Center will advise you of the steps you must take to enroll your new dependent, if eligible, and any additional cost you must pay for coverage of your new Eligible Dependent.

Annual Deductible Credit

If the medical option you were covered under as an Active Employee does not change when you terminate employment and begin your Post-Employment Benefits, you will receive credit for any amounts applied to your Annual Deductible as an Active Employee for the remainder of the calendar year in which you retire. Your Annual Deductible will begin anew on Jan. 1 of the following year.

If the post-employment medical option you are covered under is different than the medical option you were covered under as an Active Employee, you will not receive any Annual Deductible credit. You will be subject to the full Annual Deductible amount that applies to your Post-Employment Benefits.

Enrollment in Medicare

Eligibility for Medicare may affect your Benefits under the Program. Once you or your covered dependent is Medicare Eligible or will become eligible soon, it is important to understand how the Program works with Medicare and to notify the Frontier Benefits Service Center. See the "If You, Your Spouse or Your Dependent is Eligible for Medicare" section for details.

COBRA Coverage in Lieu of Post-Employment Benefits

Upon your termination of employment from the Company, you will receive a COBRA enrollment notice. As an alternative to Post-Employment Benefits for Eligible Former Employees, you may choose to continue your active Program coverage by electing COBRA coverage, as provided by federal law. Eligibility for COBRA coverage does not affect your eligibility for Post-Employment Benefits for Eligible Former Employees. However, if you elect COBRA coverage, you may not commence your Post-Employment Benefits for Eligible Former Employees until such time as COBRA coverage ends. Once COBRA coverage ends, you may enroll in Post-Employment Benefits for Eligible Former Employees. See the "Extension of Coverage – COBRA" section for more information.

Extension of Benefits

When coverage ends, the Program generally pays no further Benefits, unless a Covered Person is in the Hospital at that time. In that case, the hospitalized individual will continue to receive Medical Benefits only for the current Hospital services and only for the specific condition being treated at the time coverage terminated. This extension of Medical Benefits is provided subject to all applicable provisions of the Program. After the extension, all Medical Benefits cease, unless you are eligible for post-employment or COBRA continuation coverage.

PLAN ADMINISTRATION

KEY POINTS

- *The Plan is administered by the Plan Administrator, who has full authority and discretion to administer, interpret and enforce the terms of the Plan, and who may delegate that authority and discretion to other entities or individuals. The Plan Sponsor has the right to amend or terminate the Plan at any time.*
- *You must exhaust your Claims and Appeals rights under the Program before bringing a court action for Benefits.*
- *There are time limits for filing an action for Benefits under the Program.*
- *It is very important that you keep the Plan informed of any changes in your mailing address, contact information and family status changes.*

Plan Administrator

The Plan Administrator is the named fiduciary of the Plan, including all component Programs, and has the power and duty to do all things necessary to carry out the terms of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, to resolve any ambiguity in the terms of the Plan, to make findings of fact, to determine the rights and status of you and others under the Plan, to decide and resolve disputes under the Plan and to delegate all or a part of this discretion to third parties. To the extent permitted by law, such interpretations, findings, determinations and decisions are final, conclusive and binding on all persons for all purposes of the Plan.

If the Plan Administrator fails to strictly enforce any provision of the Plan in a given instance, it will not be construed as a waiver of that provision in any later case. The Plan Administrator reserves the right to strictly enforce each and every Plan provision at any time without regard to its prior actions and decisions, the similarity of the circumstances or the number of occurrences.

The Plan Administrator has the authority and discretion to settle or compromise any Claim against the Plan based on the likelihood of a successful outcome as compared with the cost of contesting such Claim. The Plan Administrator also has the authority and discretion to pursue, relinquish or settle any Claim of the Plan against any person. No person may rely on the actions of the Plan Administrator regarding Claims by or against the Plan in connection with any subsequent matter.

Coverage under the Program will be determined solely according to the terms of the Program and the applicable facts. Only the duly authorized acts of the Plan Administrator are valid under the Program. You may not rely on any oral statement of any person regarding the Program and may not rely on any written statement of any person unless that person is authorized to provide the statement by the Plan Administrator and **one** of the following applies:

- The statement is an official decision of the Plan Administrator to an individual whose eligibility for enrollment, participation or payment of Benefits under the Program is in dispute.
- The statement constitutes a duly authorized interpretation of an ambiguous or doubtful term of the Program.

- The statement constitutes the issuance of a rule, regulation or policy under the Program and applies to all participants.
- The statement communicates an amendment to the Program and applies to all participants.

Administration

The Plan Administrator has contracted with third parties for certain functions including, but not limited to, the processing of Benefits and related thereto. In carrying out these functions, these third party administrators have been delegated responsibility and discretion for interpreting the provisions of the Program, making findings of fact, determining the rights and status of you and others under the Program and deciding disputes under the Program. The *Plan Information* table indicates the functions performed by a third party contractor, as well as the name, address and telephone number of each contractor.

Nondiscrimination in Benefits

The federal tax and other laws prohibit discrimination in favor of highly compensated participants or key Employees with regard to some of the Benefits offered under the Program. The Plan Administrator may restrict the amount of nontaxable Benefits provided to key Employees or highly compensated participants and their covered dependents so that these nondiscrimination requirements are satisfied.

Benefits provided under the Program will not discriminate in any of the following ways:

- On the basis of any health factor, including evidence of insurability.
- As to eligibility for Benefits on the basis of a health factor.
- On the basis of premiums or contributions for similarly situated individuals.

Amendment or Termination of the Plan or Program

Frontier intends to continue the Program described within this SPD but reserves the right to amend or terminate the Program and eliminate Benefits under the Program at any time.

In addition, your Participating Company (or the Participating Company from which you terminated employment) reserves the right to terminate its participation in the Program. In any such event, you and other Program participants may not be eligible to receive Benefits as described in this SPD and you may lose Benefits coverage. However, no amendment or termination of the Program will diminish or eliminate any Claim for any Benefits to which you may have become entitled prior to the termination or amendment, unless the termination or amendment is necessary for the Program to comply with the law.

Although no Program amendment or termination will affect your right to any Benefits to which you are already entitled, this does not mean that you or any other Active or Eligible Former Employee will acquire a lifetime right to any Benefits under the Program, or to eligibility for coverage under the Program or to the continuation of the Program merely by reason of the fact that the Program was in effect during your employment or at the time you received Benefits under the Program or at any time thereafter.

Limitation of Rights

Participation in the Program does not give you a right to remain employed with Frontier.

Legal Action Against the Plan

Any claim filed in court (or any other tribunal) by or on behalf of a claimant with respect to this plan must be brought within the applicable timeframe that relates to the claim listed as follows:

- Any claim relating to the alleged wrongful denial of plan benefits (in whole or in part) must be brought within 18 months of the applicable appeal determination date that applies to the plan benefit; and
- Any other claim not covered above (including a claim relating to an alleged interference or violation of ERISA-protected rights or any that is characterized as a fiduciary breach), must be brought and filed within two years of the earlier of (1) the date when the claimant has actual or constructive knowledge of the acts or failures to act that are alleged to give rise to the claim, or (2) the date when the benefit was first paid, provided or denied.

The “appeal determination date” is the later of (1) the date the final appeal is denied or (2) if applicable, the date that the final external review is denied.

Any claim not filed or brought within the aforementioned timeframes shall be null and void.

Any claim or action relating to the Plan (including claims for eligibility, benefits or other matters) must only be brought or filed in the United States District Court for the District of Connecticut.

You Must Notify Us of Address Changes, Dependent Status Changes and Disability Status Changes

In order to protect your rights under the Program and those of your family members, it is vitally important that you keep the Plan Administrator informed of any changes in your mailing address and those of any covered family members who do not live with you. While you are an Active Employee, your address in the system of the Frontier Benefits Service Center will be used to send important Program information to you and your covered dependents, including COBRA notices, should your coverage end because of a Qualifying Event such as termination of employment or reduction of hours.

Also, for all participants, if your marital status changes, you must promptly report the change to the Frontier Benefits Service Center. If you have any changes in your dependents, such as the birth or death of a Child, a covered Child ceases to be eligible under the Program terms because of reaching the maximum age limit under the Program or a Child is placed with you for adoption, you must report these changes to the Program’s Frontier Benefits Service Center.

Where eligibility of a dependent is lost through divorce or other loss of eligibility, you, your Spouse/Partner or dependent must promptly notify the Frontier Benefits Service Center to remove that dependent from your coverage and provide the appropriate mailing address for mailing the affected dependent’s COBRA notice. Such notification is necessary to protect COBRA rights for your Spouse/Partner or dependent Child who is affected by the loss of coverage. Failure to keep the Frontier Benefits Service Center advised of changes in your marital status, dependents, mailing address and contact information may result in the permanent loss of significant Benefits rights.

EXAMPLE: Joseph Employee lives at 123 Main Street, Our Town, USA, and is covered under the Program. Employee moves to 456 Broadway, Our Town, USA, but does not notify the Plan of his new address. Three months later, Employee quits to seek other employment. The Program's COBRA Administrator sends Employee's COBRA notice and election materials to his last known address at 123 Main Street, Our Town, USA. Employee does not receive the COBRA materials and does not elect COBRA continuation coverage. Six months later, Employee has a serious health condition and incurs substantial medical expenses. Employee inquires with the Plan Administrator about COBRA continuation coverage. Employee has no COBRA rights because the COBRA Administrator of the Plan sent his COBRA notice and election form to the last known address in its files, and Employee did not elect COBRA continuation coverage within 60 days. Employee's COBRA rights have extinguished, and he cannot obtain health coverage through the Program.

Plan Information

This section provides you with important information about the Plan. The following *Other Plan Information* table provides you important administrative details including:

- **Plan Administrative Information.** The Plan can be identified by a specific name and identification number that is on file with the U.S. Department of Labor. The Other Plan Information table provides this official Plan name, the name of the Program addressed in this SPD, the Plan identification number, Plan Year and certain details on Plan records.
- **Important Entities and Addresses.** Situations may occur that require you to contact (in writing or by telephone) a specific administrative entity related to the Plan. Details throughout this SPD explain instances when the entities identified in the Other Plan Information table are important to a process related to the Plan.
- **Plan Funding.** In most instances, the Plan shares in the Cost of Coverage under the Program. The Other Plan Information table provides details on how the Plan funds the Cost of Coverage.
- **External Review Process.** The external review process is available for review of certain Adverse Benefit Determinations and Rescissions of Coverage. This process utilizes an Independent Review Organization (IRO). Information regarding the availability of the external review process and arrangements with IROs is provided in this table.
- **Collective Bargaining Procedures (if applicable).** Certain Programs contain provisions maintained pursuant to a collective bargaining agreement. The Other Plan Information table provides information on how to obtain copies of the collective bargaining agreement.

The text immediately after the table provides information regarding the arrangements by the Plan Administrator with various third parties to provide Services to the Plan, including Benefits Administration and eligibility and enrollment functions. Please see the applicable *Benefits Administrator* table in the "Contact Information" section for contact information for these third parties.

Other Plan Information	
Plan Name	Frontier Communications Health Care Plan
Program Name	CWA 1298 Employee Medical Program
Plan Number	505
Plan Sponsor/Employer Identification Number (EIN)	Frontier Communications Parent, Inc. EIN: #86-2359749
Plan Administrator	Frontier Communications Parent, Inc. Attn: Plan Administrator 2 Washington Street Norwalk, CT 06854 Frontier.Benefits.Team@ftr.com
Name and Address of Employer	Frontier Communications Parent, Inc. 2 Washington Street Norwalk, CT 06854 Frontier.Benefits.Team@ftr.com
Agent for Service of Legal Process	Frontier Communications Parent, Inc. Attn: General Counsel 2 Washington Street Norwalk, CT 06854
Type of Plan	The Plan is an employee welfare benefit plan providing medical benefits
Plan Year	Jan. 1 through Dec. 31
Plan Funding	Benefits are paid from the Company's general assets; both the employer and the employee make contributions.
External Review	The Benefits Administrator has engaged at least three Independent Review Organizations (IROs) for the purpose of providing external review of Adverse Benefit Determinations and final Adverse Benefit Determinations under the Program's External Review Process policy. External review is available with respect to Claims for Eligibility involving rescission of coverage and Claims for Benefits involving medical judgment. When you request external review under the Program's external review procedure, you will be provided with the name and contact information for the IRO which has been assigned to review your Claim. A copy of the Program's External Review Process policy will be provided to you by the Benefits Administrator upon request at no cost to you.
Plan Records	All Program records are kept on a calendar year basis beginning on Jan. 1 and ending on Dec. 31.
Collectively Bargained Plan	With respect to certain Eligible Employees, the Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries whose rights are governed by such collective bargaining agreement upon written request to the Plan Administrator and also is available for examination by participants and beneficiaries as specified under Department of Labor Regulations Section 2520.104b-30.

Other Plan Information	
Frontier Benefits Service Center	Frontier Benefits Service Center Empyrean http://www.frontierbenefitscenter.com Phone: 855-387-2887 (Monday through Friday, 9:00 a.m. to 6:00 p.m., Eastern Time)

Type of Administration and Payment of Benefits

Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with the Program, as described below. Benefits under the Company Self-Funded Option(s) are paid by Frontier. The Benefits Administrators below do not insure Benefits provided under the Program.

Medical (including Mental Health/Substance Abuse “MH/SA”) Benefits Administrator

The Plan Administrator administers Claims and Appeals for medical and MH/SA Benefits under the Company Self-Funded Option(s) on a contract basis with Anthem Blue Cross and Blue Shield. The Benefits Administrator has discretionary authority to interpret the provisions of the Company Self-Funded Option(s) and to determine entitlement to medical and MH/SA Benefits. Benefits are payable only if the Benefits Administrator determines they are payable.

Prescription Drug Benefits Administrator

The Plan Administrator administers Claims and Appeals for Prescription Drug Benefits under the Company Self-Funded Option(s) on a contract basis with ESI. The Plan Administrator has discretionary authority to interpret the provisions of the Company Self-Funded Option(s) and to determine entitlement to Prescription Drug Benefits.

Frontier Benefits Service Center

The Plan Administrator administers enrollment, eligibility, and monthly contributions under the Program provisions, including the determination of initial Claims for Eligibility (through the Frontier Benefits Service Center). The Plan Administrator determines final Appeals from the denial of a Claim for Eligibility. Refer to the chart above for contact information.

Plan Administration

The plan administrator shall determine the administration of this Plan (or portions thereof), and such administration may occur in any United States location regardless of:

- The location or residence of the applicable claims administrator, plan administrator, healthcare provider, employee and/or dependent;
- The location in which the service was performed, the supply was provided, the item was procured or the expense was incurred;
- The location or residence of the Company; and
- The location in which any other plan benefits may be administered.

The determination made by the plan administrator above may be made at any time including after the Plan benefit was rendered, provided, procured or incurred. The plan administrator may determine what portions of the plan may be administered in different locations. Any ambiguity or conflict in the plan records that relate to a determination by the plan administrator of the location in

which a plan benefit is administered shall be resolved by the plan administrator making a new determination which may be retroactive and/or prospective in its sole discretion.

Request for Plan-Related Documents

A participant or beneficiary may authorize a third-party to request and receive plan-related documents (which shall include the summary plan description, the annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated), provided that the authorization –

- Is in writing,
- Clearly states that the third party is authorized to request and receive plan-related documents on behalf of the participant or beneficiary,
- Is signed by the participant or beneficiary, and
- Is notarized by a notary public.

Requests for plan-related documents pursuant to a court order or by an attorney representing a participant or beneficiary are not required to satisfy the above requirements.

Any request for plan-related documents shall not be considered valid unless and until the request is received by the plan administrator.

Appointing a third party to request and/or receive plan-related documents is not the same thing as appointing an authorized representative to act on your behalf for purposes of claims and appeals. If you want to appoint someone to act as your authorized representative for purposes of claims and appeals, you must follow the procedures described under the heading “Authorized Representative” elsewhere in this SPD.

RIGHT OF RECOVERY AND SUBROGATION

Right of Reimbursement

If you or one of your dependents suffers a loss or injury caused by the actions or omissions of a third party, that third party may be responsible for paying your medical expenses. For this purpose, a “party” means any individual, entity, person or other party responsible for causing the loss or injury to you or your dependent and any entity responsible for making any payment to you or your dependents due to your or your dependent’s accident, injury or illness, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner’s/renter’s insurance, personal umbrella coverage, Workers’ Compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC). For purposes of any applicable coordination of benefits rules, a third party shall pay primary and the plan shall pay secondary. Any amounts paid or received from or on behalf of a third party are referred to as third party proceeds.

For example, if you are injured in a car accident, the person who caused the accident (and the person’s insurer) are the third parties and may be responsible for paying for your injury-related expenses. You and your dependent will be required to provide the plan or its

agents information concerning any claim or lawsuit you or your dependents may have against a third party for injury caused by that party. You or your dependent must also provide the plan or its agents any documents or information relevant to the protection of the plan's rights of reimbursement.

You may be asked to sign a repayment agreement as a condition for receiving benefits under the plan. If the agreement is not signed or you fail to cooperate with the Claims Administrator, you will lose your benefits related to the accident/injury/illness. If you do not cooperate, the Claims Administrator may terminate your injury-related benefits from and after a certain date even if your injury-related benefits were approved before that date. The plan is not required to enter into a reimbursement agreement. Entering into a reimbursement agreement and the terms and conditions thereof are within the sole discretion of the Claims Administrator (or plan administrator). Rather, in order to recover any third party proceeds, the plan may, in its sole discretion, reduce and/or offset the payment of current and future plan benefits (in whole or in part) relating to you and/or any dependent by the amount of the third party proceeds and may initiate actions to collect prior plan benefits that were paid. The reduction and/or offset of current and/or future plan benefits (in whole or in part) shall be accomplished by the Claims Administrator or plan administrator (in its sole discretion) as a right of administrative set off without the need to initiate any legal action or proceeding. The plan may reduce and/or offset plan benefits from and after a designated date, even if plan benefits were not reduced and/or not offset prior to a designated date.

If you decide to sue the person who caused the accident/injury/illness, you must inform the Company. The plan may initiate legal action against you or your dependent (or anyone else holding the third-party proceeds, such as a legal representative or trust) to collect the third party proceeds and may take any other actions (even if not set forth in this section) to protect the plan's right of reimbursement.

If you receive any type of payment, reimbursement or legal recovery from the third-party or an insurer (referred to as third party proceeds), you are obligated to reimburse the plan for:

- Any benefits or expenses that the plan paid for the accident/injury/illness;
- Any projected benefits or expenses the plan will pay in the future with respect to the accident/injury/illness; plus
- Any related legal and collection costs the plan incurred.

Your obligation to reimburse the plan exists for any legal recovery that relates to an accident, injury or illness for which the plan paid benefits (including any amounts used to pay your legal fees), even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for medical expenses. The plan's reimbursement shall not be reduced by any legal or attorney costs or fees you may incur in obtaining the third-party proceeds, unless and only to the extent such reduction is allowed by a signed reimbursement agreement.

In addition, the right of full and unreduced reimbursement shall also apply even if the rights of the plan are separated and treated as not resolved in the judgment, settlement, verdict or insurance proceeds (but in this case, the plan's rights shall be assigned to you to the extent reimbursement is actually received out of the recovery). The plan's right to receive

any payment, reimbursement or recovery discussed in this section supersedes and has priority over your and your dependent's right to receive any payment, reimbursement and recovery and supersedes any applicable state laws that otherwise may directly or indirectly conflict with the provisions of this section.

In order to recover any reimbursement, payment, overpayment or excess payment to which the plan has a right of reimbursement as provided above, you and your dependents, as a condition of receiving benefits under the plan, grant to the plan the following rights:

- A first priority equitable lien against the third-party proceeds (i.e., any settlement, verdict, insurance proceeds or other amounts) received by you or your dependents from or on behalf of any third-party that may be responsible for an illness, injury or condition for which the plan incurred expenses or paid benefits. The amount of the lien is equal to the amount of prior and future benefits paid by the plan.
- The right to impose a constructive trust on the third-party proceeds (i.e., any settlement, verdict, insurance or other amounts) awarded, transferred or paid by or on behalf of a third party to you or your dependents and any other person or entity holding the proceeds, including a legal representative or trust.
- The right of administrative set-off against current and/or future plan benefits without the need to bring any legal action or proceeding.
- The right to bring any legal action or proceeding to enforce the above rights in any court of competent jurisdiction as the plan may elect, and upon receiving benefits under the plan, you and your dependents hereby submit to each jurisdiction regardless of your current or future residence.

Third party proceeds held directly or indirectly by you or a dependent are intangible assets of the plan and are held by you or a dependent in a constructive trust for the benefit of the plan. Any participant or dependent who directly or indirectly holds or exercises any control over third-party proceeds is an ERISA fiduciary with respect to the third-party proceeds and must hold the third party proceeds for the exclusive benefit of the plan. A legal representative is an ERISA fiduciary solely with respect to his or her direct or indirect control of third-party proceeds and not with respect to his or her legal representation of you and/or a dependent.

The plan's right of reimbursement shall apply without regard to any equitable defenses that a third party, participant and/or dependent asserts or may be entitled to assert, including any defense of unjust enrichment. ERISA preempts any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plan's right of reimbursement. Neither the make whole doctrine nor the common fund doctrine apply to the plan.

For purposes of this section, "you" and "your" includes your spouse/partner/dependents, your agent and any agent of the foregoing, your attorney and any attorney of the foregoing and your estate and any estate of the foregoing.

Right of Subrogation

When another party is legally responsible or agrees to compensate you for an accident, illness or injury for which the plan has paid benefits, the plan has the same rights ("right of subrogation") that you have against the party. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or

responsible for making any payment to you due to your injury, illness or condition, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, Workers' Compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., supplemental policies).

The plan's rights of subrogation shall supersede any applicable state laws that otherwise may directly or indirectly conflict with the plan's right of subrogation.

In addition, the plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you have been fully compensated. If you enter into litigation or settlement with another party, the plan's right of subrogation will still apply.

The provisions set forth above under "Reimbursing the Plan" shall fully apply under this section as well.

Recovery of Excess Payments and Overpayments

The plan has the right to recover excess payments from any individual (including you, your dependents and a provider), insurance company or other entity or organization to whom the excess payments were made—or to withhold payment (in whole or in part) on current and/or future benefits or offset current and/or future benefits to the extent of the excess payment until the excess payment is recovered. Whenever payments have been made based on inaccurate, misleading or fraudulent information provided by you or your dependent, the plan will exercise all available legal rights to recover the excess payment, including its right to withhold payment (in whole or in part) on current and/or future benefits or offset current and/or future benefits to the extent of the excess payment until the excess payment is recovered. Any reduction and/or offset of current and/or future plan benefits (in whole or in part) shall be accomplished by the Claims Administrator or plan administrator (in its sole discretion) as a right of administrative set off without the need to initiate any legal action or proceeding.

An excess payment includes:

- Any "overpayment" includes – (1) any payment of plan benefits received by or on behalf of yourself or a dependent, which you or a dependent are not entitled to under the terms of the Plan;
- Any payment of plan benefits received by or on behalf of yourself or a dependent, which is in excess of the amount necessary to satisfy the requirements of this plan;
- Any additional payment of plan benefits to or on behalf of a healthcare provider, where the plan has previously paid plan benefits to or on behalf of yourself or your dependent and you or the dependent has failed to remit all or a portion of the previous payment(s) to the provider.
- Any legal costs, attorneys' fees and court costs incurred as a result of or relating to collecting the excess payment.

In addition to the above, the plan may also reduce future payments to the provider by the amount of the overpayment. These future payments may involve this plan or other health plans that are administered by the carrier. Under this process, the carrier reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this plan are subject to this same process when the carrier recovers overpayments for other plans administered by the carrier.

ERISA RIGHTS OF PARTICIPANTS AND BENEFICIARIES

KEY POINTS

- *ERISA is a federal law that provides certain rights and protections to all participants.*
- *The persons who are responsible for the operation of the Plan have a duty to act prudently and in the interest of the Plan and their beneficiaries.*
- *No one may fire or discriminate against you for exercising your rights under ERISA.*

Your ERISA Rights

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

- Receive information about your Plan and Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the EBSA.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (SAR).
- Continue group health plan coverage in certain situations.
- You may have the right to continue health care coverage for yourself, Spouse/Partner or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (see the "Extension of Coverage – COBRA" section). You, your Spouse/Partner or your covered dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Benefits that is denied or ignored, in whole or in part, and you have exhausted all applicable administrative remedies under the Plan, you may file suit in state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance With Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER PROGRAM INFORMATION

KEY POINTS

- *This section describes various laws that may impact your right to Program Benefits.*
- *Some laws provide specific Program eligibility rights.*
- *Other laws provide specific Program coverage rights, such as coverage for mastectomy, childbirth and Mental Health/Substance Abuse Services.*
- *Certain laws protect the privacy and security of your protected health information.*

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that requires a group health benefits plan to provide parity between Mental Health/Substance Abuse (MH/SA) benefits and medical and surgical benefits.

Wherever the Program provides MH/SA Services, coverage will generally be provided to the same extent as medical and surgical Services. This means the Program:

- May not apply more restrictive financial or treatment limitations on Benefits for MH/SA Services when compared to Benefits for medical and surgical Services.
- May not apply more restrictive annual or lifetime maximum dollar limits on MH/SA Services than are applied to medical and surgical Services.
- Must cover Non-Network Benefits for MH/SA Services to the same extent as Non-Network Benefits for medical and surgical Services.

However, the Program may apply cost-containment methods as long as those methods are consistent with parity requirements under federal law. Common cost-containment methods for MH/SA Services may include the following:

- Cost sharing: Co-payments, Coinsurance and Annual Deductibles
- Limitations on the number of office visits or inpatient/outpatient days
- The terms and conditions of the amount, duration or scope of Benefits

Federal guidelines for MH/SA Services as required under the MHPAEA are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to MHPAEA or MH/SA Services, please see the applicable *Benefits Administrator* table in the “Contact Information” section for contact information.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), as amended, is a federal law intended to extend health care benefits and coverage to most Americans by 2014.

The PPACA, sometimes referred to as Health Care Reform or the Affordable Care Act (ACA), imposes new mandates on both insurers and employers who provide group health benefits to their employees and their dependents. These mandates have been gradually phased in and include the following:

- Coverage of adult children up to age 26;
- Coverage of certain preventive health services;
- External review of adverse Claim for Eligibility determinations relating to rescission and Claims for Benefits involving medical judgment;
- Enhanced benefits communication materials;
- Elimination of annual and lifetime dollar limits on essential health benefits and prohibition of pre-existing condition requirements for certain participants;
- Provision of certain coverage to participants in clinical trials (as described above); and
- A prohibition on the use of health factors, medical condition or history, Claim experience, genetic information, disability or evidence of insurability in eligibility rules.

Federal guidelines for certain health care benefits and coverage as required under the PPACA are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to PPACA or mandated health care benefits and coverage, please see the applicable *Benefits Administrator* table in the “Contact Information” section for contact information.

Qualified Medical Child Support Orders

The Program extends Benefits to an Employee’s noncustodial Child, as required by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court or agency order that does both of the following:

- Meets all applicable legal requirements for qualification.
- Creates, recognizes or assigns to a Child of an Employee (alternative recipient) the right to receive health benefit coverage under the Program.

An alternative recipient is any Child of a participant who is recognized by a medical child support order as having a right to enrollment under a participant’s program for group health benefits.

A medical child support order has to satisfy certain specific conditions to be qualified. The Frontier Benefits Service Center will notify you if the Company receives a medical child support order that applies to you and will provide you a copy of the Program’s procedures used for determining whether the medical child support order is qualified. A medical child support order will generally not be considered to be qualified if it requires the Program to provide certain benefits or options that are not otherwise provided by the Program. Participants and beneficiaries can obtain, free of charge, a copy of such procedures from the Frontier Benefits Service Center.

If the Frontier Benefits Service Center determines the order to be qualified, your Child named in the order will be eligible for coverage as required by the order. You must then enroll the Child in the Program and pay any applicable contributions for coverage of the Child. If a QMCSO is

issued for your Child and you are eligible but not participating in the Program at that time, you must enroll yourself and your Child in the Program and pay any applicable contributions.

Federal guidelines for medical child support orders as required under ERISA are continually evolving, however, the Program and its Frontier Benefits Service Center are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to a QMCSO, please see the Frontier Benefits Service Center table in the “Contact Information” section for contact information.

Your Conversion Rights

Conversion to an individual coverage policy may be available to you and your Eligible Dependents whose coverage under the Program ends.

Contact the Benefits Administrator to determine if you have any conversion rights and, if so, the deadline for electing this. Typically when conversion rights exist, you must apply for and pay the premium amount for conversion coverage within 31 days of the end of your coverage under the Program. If you fail to meet the 31-day deadline, you may lose your right to conversion coverage. Please note: you are responsible for any conversion fee associated with your conversion coverage.

You can also elect coverage through the Marketplace. Please visit www.healthcare.gov for more information.

To determine the availability of conversion coverage under the Program, contact your Benefits Administrator. See the *Benefits Administrator* table in the “Contact Information” section for contact information.

Data Privacy

The Company and its benefit plans collect and maintain certain personal information that may include your name, home address, telephone number, date of birth, Social Security number or other government or employer-issued identification number, hire/rehire data, salary and other compensation, benefit plan elections, citizenship, job title, work status, marital status, dependent names and beneficiaries (collectively “Personal Data”) when you participate in the benefit plans. Authorized employees of the Company may use, process and/or transfer Personal Data to implement, administer and/or manage your participation in the benefit plans. The Company and benefit plans may further use, process, analyze and/or transfer Personal Data for the administration, management, and/or modification of the benefit plans and/or to comply with any applicable laws and regulations. Personal Data is retained by the Company and the benefit plans in accordance with business, legal and regulatory requirements.

The Company and its benefit plans maintain technical, administrative and physical safeguards designed to protect Personal Data. The Company and its benefit plans may share and/or transfer Personal Data, in electronic or other format, to third parties including but not limited to the benefit plans’ service providers. Such third parties assist in the implementation, administration and/or management of the benefit plans and your and your elected family members’ participation in the benefit plans. Third parties retained by the Company and benefit plans may use the Personal Data as authorized by the Company and benefit plans to provide the requested services. These third parties may be located throughout the world, including the United States, and they may publish their own policies that govern their privacy and security practices. We encourage you to review the privacy policies or notices provided by such third parties (if any).

To the extent your Personal Data includes health information for a Company sponsored health plan, see the terms of the HIPAA Privacy Notice for additional details.

Protecting the Privacy of Your Protected Health Information – Notice of HIPAA Privacy Rights

HIPAA provides you with certain rights in connection with the privacy of your health information. The Program will not use or disclose your protected health information (PHI) for purposes other than treatment, payment or Program administrative functions without your written authorization as required by federal law. The Program routinely discloses PHI to insurance companies, Benefits Administrators and other contracted health operations services such as those who verify Benefits or conduct audits. All PHI used, requested or disclosed is limited to the minimum amount necessary to accomplish the intended purpose of the Program and its administration.

The Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. If you would like a copy of the Plan's Notice, it is located in the Frontier Communications Required Health Care Notice Package or can be obtained by calling the Frontier Benefits Service Center.

If you have a complaint about the way your personal health information is handled by Frontier or the Benefits Administrator, you are encouraged to share your complaint with Frontier by contacting the Frontier Benefits Service Center at 855-387-2887. Frontier is committed to trying to resolve your concerns about the privacy of your personal information. Additional rights that you may have are described in the Privacy Notice.

No Assignment of Rights and Benefits

Your rights and benefits under a medical option are personal to you and your enrolled family members and they cannot be assigned, sold or transferred (in whole or in part) to any person, including your health care provider. The only exception is under a qualified medical child support order. For this purpose, your plan rights and benefits include, without limitation, the right to file an administrative appeal (whether directly or derivatively), the right to sue following a denied administrative appeal and any other plan rights and benefits, whether actual or potential. Any purported assignments of rights and/or benefits under the plan will be void and will not apply to the plan. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed to anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by you, an enrolled family member, the plan, the plan administrator or a claims administrator; and

- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Limited Authorization of Payments and Health Care Provider Agreements

To the extent allowed by the claims administrator, you may authorize your claims administrator to make payments directly to a health care provider for covered services. Further, even without such authorization, a claims administrator may make direct payments to a health care provider for covered services according to the claims administrator's rules and procedures at the applicable time. Authorization of payments to a health care provider or direct payments to a health care provider are not assignments of benefits. Even though you may authorize a health care provider to receive a payment or reimbursement of covered services and even though a claims administrator may pay a health care provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a health care provider cause the provider to become a plan participant or plan beneficiary (or assignee of a participant or beneficiary) under ERISA.

In addition, sometimes your health care provider requests that you sign various agreements and other documentation as a condition of receiving health care services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider but that do not include the plan administrator or the Company) are not binding on and will have no legal effect whatsoever on any terms, conditions or requirements of the plan or any claims administrator. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed for anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by you, an enrolled family member, the plan, the plan administrator or a claims administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Authorized Representative Rules

If you need to appoint an authorized representative for purposes of an internal claim or appeal for health and welfare benefits or for purposes of an external appeal for medical benefit claims, you must follow the rules and procedures of the applicable Claims Administrator for such claim or appeal. To the extent a Claims Administrator has no rules or procedures, then the rules and procedures of this section will apply.

If you need to appoint any authorized representative for any purpose other than as listed in the prior paragraph, your appointment of an authorized representative must:

- Be in writing and dated,
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative,
- Be signed by you, and must be notarized by a notary public, and
- Satisfy any other legal requirement applicable to appointments under state or federal law.

A plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

IMPORTANT NOTICES ABOUT YOUR BENEFITS

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) is a federal law prohibiting discrimination against an Employee, dependent or Spouse on the basis of an individual's genetic information. Genetic information is defined as information about an individual's genetics based on genetic tests of an individual's family members or information about the manifestation of a disease or disorder within an individual's family. Genetic information includes any request for or receipt of genetic services (including genetic testing, counseling or education), or participation in clinical research that includes such services, by the individual or family member.

Federal guidelines related to GINA are constantly evolving, however, the Program is making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to the use of your genetic information or GINA, please see the *Benefits Administrator* table in the "Contact Information" section for contact information.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

An individual who is receiving mastectomy-related Benefits under this Program and who elects breast reconstruction in connection with the mastectomy will receive coverage for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to give a symmetrical appearance, any needed prostheses and coverage for treatment of physical complications of all stages of the mastectomy, including lymphedema. This coverage is subject to any Annual Deductible, Co-payment or Coinsurance percentage levels applicable to other medical and surgical Benefits provided under the Program.

If you have any questions with respect to WHCRA or mastectomy-related Benefits, please see the *Benefits Administrator* table in the "Contact Information" section for contact information.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage under the Program, but are unable to afford the premiums, some states have premium-assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that participates in CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are **not** currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **877-KIDS NOW (877-543-7669)** or **insurekidsnow.gov** to find out how to apply.
- If you qualify, you can ask the state if it has a Medicaid or CHIP program that might help you pay the contributions for health coverage under the Program.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Program is required to permit you and your dependents to enroll in the

Program — as long as you and your dependents are eligible, but not already enrolled in the Program. This is called a “special enrollment” opportunity in the Program, but you must request coverage within 60 days of being determined eligible for premium assistance.

Alternatively, if you and your dependents are eligible, but not enrolled in the Program, and you lose your eligibility for premium assistance under Medicaid or CHIP, you are entitled to a “special enrollment” opportunity in the Program, but you must request coverage within 60 days of losing eligibility for premium assistance.

Federal guidelines related to premium assistance are constantly evolving, however, the Program is making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to premium assistance, please see the Frontier Benefits Service Center table in the “Contact Information” section for contact information.

For information on which states have a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/ebsa 866-444-EBSA (866-444-3272)	U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services www.cms.hhs.gov 877-267-2323 (choose option 4), ext. 61565
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Newborns’ and Mothers’ Health Protection Act

To the extent this Program provides Benefits for Hospital lengths of stay in connection with childbirth, the Program will cover the minimum length of stay required for deliveries (i.e., a 48-hour Hospital stay after a vaginal delivery or a 96-hour stay following a delivery by Cesarean section). The mother’s or newborn’s attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by federal law. No Provider authorization is required from the Program or any Benefits Administrator for prescribing a length of stay less than 48 or 96 hours. This coverage is subject to any applicable Annual Deductible, Co-payment or Coinsurance percentage levels.

Federal guidelines for minimum Hospital stays related to childbirth as required under Newborns’ and Mothers’ Health Protection Act (NMHPA) are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to NMHPA or Hospital stays related to childbirth, please see the *Benefits Administrator* table in the “Contact Information” section for contact information.

Your Rights & Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn’t be charged more than your plan’s copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, the federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

CONTACT INFORMATION

Contact Information	
Benefits Administrator	
Name	AnthemBlue Cross and Blue Shield
Type	Medical
Services Provided	Medical & MH//SA Benefits Administration
Benefits Administrator Contact Numbers	
Domestic Phone Number	1-866-236-4368
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	Anthem BlueCross and BlueShield 370 Bassett Road North Haven, CT 06473 Tel: 1-866-236-4368

Contact Information	
Benefits Administrator	
Name	Express Scripts
Type	Prescription Drugs
Services Provided	Prescription Drug Administrator
Benefits Administrator Contact Numbers	
Domestic Phone Number	800-551-4136
Benefits Administrator Hours of Operation	
Hours of Operation	Service Center: Staffed 24 hours per day, 7 days per week.
Website	www.express-scripts.com
Claims	
Claims Information	Claim forms and/or mail-service order forms are available via the website or by phone.

Contact Information	
Claims Regular	Express Scripts P.O. Box 650322 Dallas, TX 75265-0322
Appeals	
Appeals Regular	Express Scripts P.O. Box 650322 Dallas, TX 75265-0322

Contact Information	
Vendor	
Name	Frontier Benefits Service Center (Empyrean)
Type	Eligibility and Enrollment
Services Provided	Responsible for eligibility, enrollment, contributions, billing, election changes, questions
Vendor Contact Numbers	
Domestic Phone Number	855-387-2887
Vendor Hours of Operation	
Hours of Operation	Monday through Friday 9:00 a.m. to 6:00 p.m., Eastern Time
Vendor Web	
Website	www.frontierbenefitscenter.com
Vendor Mailing Address	
Mailing Address Information	Frontier Benefits Service Center c/o Empyrean PO Box 2607 Bellaire, TX 77402

Contact Information	
Vendor	
Name	WageWorks/HealthEquity
Type	Eligibility and Enrollment
Services Provided	COBRA eligibility and enrollment
Vendor Contact Numbers	
Domestic Phone Number	866-747-0039
Vendor Hours of Operation	
Hours of Operation	Monday through Friday 9:00 a.m. to 6:00 p.m., Eastern Time
Vendor Web	
Website	www.WageWorks.com

DEFINITIONS

Active Employee. An Employee who is on a Participating Company's active payroll, regardless of whether such Employee is currently receiving pay.

Actively at Work. A time when an Employee is actually working for the Company on a regular basis at the Employee's customary place of employment, receiving short-term disability benefits under a Company-sponsored disability plan, or is on a leave of absence (LOA) that provides for continued coverage, but only for the period of continued coverage while on the LOA.

Admission. The period of time between an entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the patient leaves or is discharged from the Hospital or Skilled Nursing Facility.

Adverse Benefit Determination. A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a Program Benefit, including any such denial, reduction, termination of, or failure to provide or make a payment that is based on a determination of a Covered Person's eligibility to participate in the Program.

Allowable Amount or Allowable Charge. The dollar amount which is the basis on which Benefits for Eligible Expenses are calculated as determined by the applicable Benefits Administrator for a Covered Health Service. The Program will not pay Benefits toward any amount above the Allowable Charge for a Covered Health Service. See the "Allowable Charges for Eligible Expenses" section for additional information.

Alternate Care. Care provided under the terms of an Alternate Care Plan developed by the Benefits Administrator in lieu of or to avoid a potentially more costly alternative. Alternate Care does not extend or create coverage for Services that are otherwise specifically excluded. See the "Alternate Care" subsection of the "What Is Covered" section for additional information.

Alternate Care Plan. A Course of Treatment developed by a Benefits Administrator that meets the definition of Alternate Care. See the "What Is Covered" section for more information.

Alternative Facility. A health care facility that is not a Hospital and that provides Covered Health Services on an outpatient basis, as permitted by law. The facility must be duly licensed by the appropriate state and local authority to provide such Services.

Ambulance Services. A transportation vehicle (air or ground) designed and equipped to be capable of transporting individuals with Emergency Medical Conditions. The vehicle must comply with state or local laws governing the licensing and certification of an emergency medical transportation vehicle.

Annual Deductible. The amount of money you must first pay out of pocket each calendar year for Covered Health Services before the Program begins to pay Benefits that are subject to a Deductible. See the "Cost Sharing" subsection of the "Medical Benefits" and "Prescription Drug Coverage" sections for information.

Annual Enrollment. The period specified by the Company during which Eligible Employees, Eligible Former Employees and COBRA participants may make changes to their coverage (including coverage options and enrolled dependents) under the Program. See the "Annual Enrollment" section for additional information.

Annual Maximum. The maximum dollar amount the Program will reimburse in a calendar year for certain nonessential health Benefits.

Annual Out-of-Pocket Maximum. The maximum amount of the Allowable Charges for Eligible Expenses that you will pay out of pocket for Covered Health Services each calendar year that account toward the applicable Annual Out-of-Pocket Maximum. See the “Cost Sharing” subsection of the “Medical Benefits” and “Prescription Drug Coverage” sections for information.

Appeal. A written request for the review of an Adverse Benefit Determination or a denial of a Claim for Eligibility under the formal process outlined in the Program for a Claim for Eligibility or Claim for Benefits, as applicable. See the “Claims Procedure” section for more information.

Bargained Employee. Either: (1) an Employee whose job title and classification is included in a collective bargaining agreement between a Participating Company and a union, or (2) an Employee whose job title and classification have been excluded from a collective bargaining agreement represented by the union, but for whom the Company provides the same Benefits provided to Employees included in a collective bargaining agreement between the union and the Participating Company.

Benefit Maximum. See the “Benefits at a Glance” and “What Is Covered” sections for Benefit information, including any Benefit Maximums and other Benefit limitations.

Benefits. Payments for Covered Health Services that are available under the Program. The availability of Benefits is subject to the terms, conditions, limitations and exclusions of the Program.

Benefits Administrator. Any third party, insurance company or other organization or individual to which the Company or the Plan Administrator has delegated the duty to process and/or review Claims for Benefits under the Program. Benefits administrator may also be referred to as the claims administrator.

Brand-Name Drug. Medication sold by a pharmaceutical company under a trademark-protected name. Brand-name medications can only be produced and sold by the company that holds the patent for the drug.

Calculation Year. The calendar year immediately preceding the Plan Year the Program Premium Equivalent Rate will be in effect.

Change-in-Status Event. Certain life events such as marriage, birth of a Child, loss of benefits under another employer’s medical plan, or going on an LOA that under the terms of the Program trigger the ability to change your enrollment under the Program. See the “Enrollment and Changes to Your Coverage” section for information.

Child(ren). See the “Eligible Dependents” section for the definition of Child(ren).

Claim. A Claim for Benefits or a Claim for Eligibility.

Claim for Benefits. A request for Benefits from the Plan that is made by the claimant or their representative in accordance with the Plan’s established procedures for filing a Claim for Benefits and includes both Pre-Service and Post-Service Claims.

Claim for Eligibility. A written request for eligibility or enrollment sent to the address specified by the Frontier Benefits Service Center following a denial of enrollment that has not been resolved informally.

Claims Administrator. See the definition of Benefits Administrator.

COBRA. The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) as enacted April 7, 1986, and as subsequently amended from time to time. Any reference to COBRA shall be deemed to include any applicable regulations and rulings. See the “Extension of Coverage – COBRA” section for information.

Code. The Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings.

Coinsurance. The percentage of the Allowable Charge that you pay for Covered Health Services. Other cost-sharing requirements may apply. See the “Cost Sharing” subsection for more information.

Common Law Marriage. A marriage occurring in a state or foreign country recognizing common-law marriages and satisfying applicable state or foreign requirements to be considered married under common law in such state or foreign country.

Company. Frontier Communications Parent, Inc and its subsidiaries and affiliates that participate in the Plan, or any successor or successors thereof.

Company Extended Coverage or CEC. Continued coverage under the Program that may be available to you or your dependents in limited circumstances. For more information, see the “When Coverage Ends” section.

Company Self-Funded Option. A coverage option under the Program, the Benefits under which are not funded through insurance.

Complications of Pregnancy. Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not complications of pregnancy.

Congenital Anomaly. A condition or conditions that is present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits (COB). The method of determining which health plan pays a plan participant’s Claims first (primary), which pays second (secondary) and, in some cases, which pays third (tertiary), when the participant has coverage under more than one health plan. See the “Coordination of Benefits” section and the “If You Have Other Group Health Insurance” subsection of the “If You, Your Spouse or Your Dependent is Eligible for Medicare” section for more information.

Co-pay (Co-payment). The specific fixed dollar amount (for example \$15) you pay for certain Covered Health Services under the Program. See the “Benefits at a Glance” subsection of the “What Is Covered” and “Prescription Drug Coverage” sections for cost-sharing information.

Cost-effective. In connection with Durable Medical Equipment and prosthetic devices, the least expensive equipment that performs the necessary function.

Cost of Coverage. The total cost to the Plan to provide Benefits under the Program. With respect to the Company Self-Funded Options, it is the Company Self-Funded Premium Equivalent Rate. See these specific definitions for more information.

Counseling. A therapeutic clinical process based on face-to-face interaction between a Covered Person and/or a Covered Person’s family and a Practitioner and/or other persons with similar

clinical conditions for the purpose of identifying the Covered Person's problems and needs, setting goals and interventions, resolving problems and promoting new behaviors.

Course of Treatment. The continuous treatment of a person for a condition.

Coverage Plan. See the "Coordination of Benefits" section.

Covered Health Services. Services, supplies (including Durable Medical Equipment) and Prescription Drugs provided for the purpose of preventing, diagnosing or treating an Illness or Injury, Mental Illness, substance abuse or their symptoms that are determined by the Benefits Administrator to be Medically Necessary and included in the "What Is Covered" section and not excluded under the "Exclusions and Limitations" section. To be considered a Covered Health Service, it must be provided:

- When the Program is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this SPD; and
- Only when the person who receives Services is a Covered Person and meets all eligibility requirements specified in the Program.

Covered Person. Either the Eligible Employee, Eligible Former Employee or an Eligible Dependent if, and only if, the individual is enrolled under the Program. References to "you" and "your" throughout this SPD, except with respect to eligibility and enrollment, are references to a Covered Person. See the "Eligibility and Participation" section for eligibility provisions.

Custodial Care. Services that:

- Are non-health related Services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating).
- Are health-related Services that do not seek to cure or that are provided during periods when the medical condition of the patient who requires the Service is not changing.
- Do not require continued administration by trained medical personnel to be delivered safely and effectively.

Daily Charge. The charges for Room and Board from a facility such as a Hospital.

Designated Network Provider. A Provider, including a facility, chosen by the Benefits Administrator as a preferred Provider for certain specialized Services. These may include, for example, organ transplants, cancer treatment, congenital heart disease, kidney treatment and neonatal care. See the "What Is Covered" section for more information on Designated Network Providers and limitations available under the Program.

Diabetic Supplies. Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin diabetes prescribed by a Prescriber. Examples of equipment and supplies include lancets, test strips (blood or urine), insulin syringes and glucometers for all categories of diabetes listed.

Diagnostic Services. Professional Services rendered for the diagnosis of your symptoms and that are directed toward evaluation or progress of a condition, disease or Injury.

Disabled Child(ren). Your Child who is over the age of 26 and meets the requirements to be eligible for Program coverage due to disability. See the “Eligible Dependents” section for more information.

Domestic Partner. Your partner of the same gender:

- Who resides in the same household as you;
- Who is at least 18 years old, mentally competent to enter into a valid contract, unrelated to you and not legally married to anyone;
- With whom you have a close and committed personal relationship and there is no other such relationship with any other person;
- With whom you share responsibility for each other’s welfare and financial obligations; and
- Who was enrolled as your dependent in the Program on the day before you became eligible for coverage under the Program.

Dual Enrollment. See the “Dual Enrollment” section for more information.

Durable Medical Equipment (DME). Medical equipment that:

- Is ordered by a Physician.
- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose for treatment of an Illness, Injury or their symptoms.
- Is generally not useful to a person in the absence of an Illness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Dependent. An individual who is eligible to participate in the Program as described in the “Eligible Dependents” section.

Eligible Employee. An Employee who satisfies the conditions for eligibility to participate in the Program set forth in the “Eligibility and Participation” section.

Eligible Expenses. The expenses for Covered Health Services that are eligible for consideration for payment of Benefits under the Program. Benefits paid under the Program are based on the Allowable Amount of Eligible Expenses determined by the Benefits Administrator.

Emergency Facility. The emergency department of a Hospital, an acute care facility, or any other medical facility capable of providing Emergency Services, or treatment to Stabilize a patient with an Emergency Medical Condition.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to (i) place the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) result in the serious impairment to bodily functions; or (iii) lead to serious failure of any bodily organ or part to function properly.

Emergency Services. With respect to an Emergency Medical Condition, Emergency Services include:

- A medical screening examination that is within the capability of the emergency department of a Hospital, including related Services routinely available to the emergency department to evaluate the condition.
- Further medical examination and treatment that is within the capabilities of the staff and facilities available at the Hospital, as are required to stabilize the patient.

Employee. Any individual, other than a leased employee or Nonresident Alien Employed Outside the United States, who is carried on the payroll records of a Participating Company as a common law employee and who receives a regular and stated compensation, other than a pension or retainer, from that company, in exchange for services rendered to that Participating Company.

- For purposes of the preceding sentence, the term “leased employee” refers to any
- individual who is a leased employee within the meaning of Section 414(n)(2) of the Code; and
- The term “Employee” does not include any individual:
 - Who is rendering services to a Participating Company pursuant to a contract, arrangement or understanding either purportedly (i) as an independent contractor, or (ii) as an employee of an agency, leasing organization or any other such company that is outside of the Frontier Controlled Group and is providing services to a Participating Company; or
 - Who is treated by an agency, leasing organization or any other such company that is outside of the Frontier Controlled Group as an employee of such agency, leasing organization or other such company while rendering services to a Participating Company, even if such individual is later determined (by judicial action or otherwise) to have been a common law employee of a Participating Company rather than an independent contractor or an employee of such agency, leasing organization or other such company.
- For purposes of this definition, a “Nonresident Alien Employed Outside the United States” is any individual who receives no earned income (within the meaning of Section 11(d)(2) of the Code) from any Participating Company that constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code).

Employer. The Frontier Controlled Group member that issues your paycheck/that pays you.

ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time. Any reference to any section of ERISA shall be deemed to include any applicable regulations and rulings.

Essential Health Benefits. Health benefits determined by the Benefits Administrator pursuant to the Patient Protection and Affordable Care Act to be “Essential”. Generally Services under the following categories are considered to be Essential Health Benefits under the Patient Protection and Affordable Care Act: Ambulatory patient Services; Emergency Services, hospitalization; maternity and newborn care, mental health and substance abuse Services; certain Prescription Drugs (see the prescription drug section later in this SPD); rehabilitative and habilitative Services

and devices; laboratory Services; preventive and wellness Services and chronic disease management; and pediatric Services, including oral and vision care.

Evidence-based Medical Guidelines. Guidelines the United States Task Force on Preventive Care provides with respect to determination of covered Preventive Care Services under the Patient Protection and Affordable Care Act.

Expense Incurred. The actual billed cost for a Service or procedure; except when the Provider has contracted directly or indirectly or negotiated with the Benefits Administrator for a different amount.

Experimental or Investigational Services. Any procedures, drugs, devices, Services and/or supplies that (1) are provided or performed in special settings for research purposes or under a controlled environment and are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

Explanation of Benefits (EOB). A statement you receive after a Benefits Administrator has processed your Claim for Benefits and there is an amount for which you are responsible. The EOB shows the expenses submitted for payment, the Allowable Charge for Eligible Expenses, the amount of Benefits payable and any amounts you must pay.

Extended Care Facility. An institution, other than a Hospital, that is accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare and is licensed to provide medical Services in a state. To be covered under the Program, the Extended Care Facility must provide direct medical treatment, have a professional nursing staff and operate under the supervision of a Physician. In addition, the facility must not be primarily a place for rest, the aged, Custodial Care or for the treatment of a mental health or substance abuse condition. An Extended Care Facility may operate under other names, such as Skilled Nursing Facility, convalescent facility, intermediate care facility, sub-acute care facility or rehabilitation facility.

Family Coverage. Coverage for a Covered Person and more than one dependent as described in the “Levels of Coverage” section.

FDA. The U.S. Food and Drug Administration (FDA). A federal regulatory agency that collects and analyzes data about medications to determine if they are safe for manufacture and sale to consumers.

Fill. The dispensing of a prescription medication.

FMLA. The Family and Medical Leave Act of 1993, as amended from time to time.

Frontier Controlled Group. Frontier Controlled Group includes any of the following:

- A corporation that is a member of the controlled group of corporations within the meaning of section 414(b) of the Code of which the Company is a member.
- Trade or business (whether or not incorporated) with which the Company is under common control as defined in section 414(c) of the Code.

- Other entity is required to be aggregated with the Company and treated as a single employer under section 414(o) of the Code.

Generic Drug. A drug that is equivalent to a Brand-Name Drug in that it uses the same active ingredients as a Brand-Name Drug and works the same way in the body. Generic Drugs are developed when the patent of a brand-name medicine expires permitting other drug manufacturers to make and sell the same medicine. This medicine is sold under its chemical or “generic” name. Generic equivalent drugs use the same active ingredients as Brand-Name Drugs and work the same way in the body. The FDA requires that Generic Drugs must be as high quality, strong, pure and stable as brand-name medicines.

Health Care Network (HCN). The group of Providers of health care Services that have an agreement in effect with the Benefits Administrator or an affiliate (directly or through one or more other organizations) who have agreed to participate in the HCN that the Benefits Administrator makes available for use by the Program. The term Health Care Network was previously referred to as the Point-of-Service Network.

Health Care Network (HCN) Coverage. The coverage option available under the Program that generally provides a different level of Benefits for Services performed by Network and Non-Network Providers. See the definition of Health Care Network (HCN).

HIPAA. The Health Income Portability and Accountability Act of 1996 (HIPAA), as amended from time to time including any applicable regulations and rulings.

Home Health Care. Treatment prescribed in writing by a Physician for the care of a Covered Person’s Injury or Illness in the person’s home.

Home Health Care Agency. A public or private agency that specializes in giving nursing and other therapeutic Services in the Covered Person’s home, including skilled nursing care, therapist, home visits, nutrition therapy and medical supplies prescribed by a Physician. An approved Home Health Care Agency must be licensed by a state department or agency having authority over home health care agencies.

Home Health Care Plan. A plan of Home Health Care treatment established and approved in writing by a Physician. The Physician must certify that Services of the patient receiving Home Health Care is Medically Necessary.

Hospice. An organization licensed according to state laws to provide care to terminally ill patients. A Hospice may be either an agency that performs Services in a patient’s home or a hospice facility the patient is admitted.

Hospice Care Program. A Hospice Care Program is:

- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families.
- A program that provides palliative and supportive medical, nursing and other health Services through home or inpatient care during the Illness.
- A program for persons who have a terminal Illness and for the families of those persons.

Hospital. A facility that is:

- Licensed as a general acute care hospital by the state in which it is located, accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and Medicare-certified.
- Provides 24-hour nursing Services by registered nurses (RNs) on duty or on call.
- Provides Services under the supervision of a staff of one or more Physicians to diagnose and treat ill or injured patients hospitalized for surgical, medical, or MH/SA conditions.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Illness. A disorder of the body or mind, and pregnancy. Pregnancy shall include normal delivery, cesarean section, miscarriage, abortion, or any complications resulting from Pregnancy.

Injury. Bodily damage from trauma other than Illness, including all related conditions and recurrent symptoms.

Investigational Services. See the definition of Experimental or Investigational Services.

Legally Recognized Partner (LRP). Any individual:

- Who is a Registered Domestic Partner, or
- With whom an Eligible Employee or Eligible Former Employee has entered into a same-gender relationship pursuant to and in accordance with state or local law, such as marriage, civil union or other legally recognized arrangement that provides similar legal benefits, protections and responsibilities under state law to those afforded to a Spouse.

Mail Order Prescription Drug Program. The purchase of Prescription Drugs using the Prescription Drug Benefits Administrator's mail order processing program according to the terms of the Program.

Maintenance Drug. A drug that is generally prescribed for chronic or long-term medical conditions, including but not limited to, diabetes or high cholesterol. The designation of a Maintenance Drug is determined by your Prescription Drug Benefits Administrator.

Maximum Allowed Amount For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Provider's fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to You. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator's website at www.anthem.com.

Member Services is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

Medicaid. The program providing health care benefits under Title XIX of the Social Security Act of 1965, as amended.

Medical Benefits. Amounts paid for:

- The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.
- Amounts paid for transportation primarily for and essential to medical care referred to in the first bullet.

Medical Necessity. See the definition of Medically Necessary.

Medically Necessary. See the "Medically Necessary" section for a definition and details regarding how the Benefits Administrator determines Medically Necessary Covered Health Services, including examples of what is Medically Necessary and what is not considered Medically Necessary.

Medicare. The insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare Advantage. Coverage under Medicare Part C.

Medicare Allowable (MA). The amount Medicare will consider eligible for determining Medicare benefits.

Medicare Eligible. You are eligible for Medicare as your primary coverage over the Program if you were to enroll in Medicare. See the “If You, Your Spouse or Your Dependent Are Eligible for Medicare” section for information.

Medicare Part D. The Part D (Voluntary Prescription Drug Benefit) of the insurance program established by Title XVIII of the United States Social Security Act, as amended, 42 U.S.C. Sections 1394, et seq.

Mental Health Services. Outpatient and inpatient Services to diagnose and treat mental disorders listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association (Manual); however the fact that a condition is listed in the Manual does not mean that treatment for the condition is a Covered Health Service under the Program.

Mental Illness. A condition that meets either of the following two requirements:

- It is classified as a mental illness in the latest edition of the International Classification of Disease of the United States Department of Health and Human Services; or
- It is a condition generally accepted by the health care professionals in the United States as one that requires psychiatric treatment and responds to such treatment.

MH/SA. The abbreviation for Mental Health/Substance Abuse.

MHPAEA. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Negotiated Rate. The agreed-upon payment for a Covered Health Service between the applicable Benefits Administrator and the Provider.

Network. The group of Providers of health care Services that have an agreement in effect with the applicable Benefits Administrator or an affiliate (directly or through one or more other organizations) which the Benefits Administrator makes available for use by the Program.

Network Area. The area determined by the Benefits Administrator to meet the requirements for availability of Network Providers. See the “How Network Areas are Determined” section for more information.

Network Benefits. Benefits for Covered Health Services that are provided by a Network Provider. See the “Network Benefits” subsection in the “Network Coverage” section for medical and MH/SA information.

Network Provider. A Provider who has contracted to participate in the applicable Benefits Administrator’s Network available under the Program. Also referred to as In-Network Provider or preferred Provider.

Network Retail Cost. The cost to the Program of a Prescription Drug, including the Co-payment, if the medication was purchased by a Covered Person, using the Covered Person’s Prescription Drug card, at a Network Retail Pharmacy.

Network Retail Pharmacy. A Retail Pharmacy that is in the Prescription Drug Benefits Administrator's Network of participating Retail Pharmacies and has a participating agreement in effect with your Prescription Drug Benefits Administrator.

Non-Network Provider. A Provider who has not contracted to participate in the applicable Benefits Administrator's Network available under the Program.

Non-Network Benefits. Benefits for Covered Health Services that are provided by a Non-Network Provider. See the "Non-Network Coverage" section for a description of Non-Network Benefits provided under the Program.

Non-Network Retail Pharmacy. A Retail Pharmacy that is not in the Prescription Drug Benefits Administrator's Network of participating retail Pharmacies available under the Program.

Non-Preferred Brand Drug. A Brand-Name Drug that is not on or has an alternative on the Prescription Drug Benefits Administrator's Preferred Drug Benefit Guide. There may or may not be a Generic Drug equivalent.

Notification. A written or oral notice provided by you, your Provider or your representative to the applicable Benefits Administrator using the procedure specified by the Benefits Administrator. See the "Notification and Preauthorization Requirements" section for information and a list of Covered Health Services that require Notification.

Nurse-Midwife. A person certified to practice as a Nurse-Midwife, who is licensed as a registered nurse by a board of nursing and has completed a state-approved program for the preparation of Nurse-Midwives.

Occupational Therapy. Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include Educational training or Services designed and adapted to develop a physical function.

Out-of-Pocket Maximum. See the definition of Annual Out-of-Pocket Maximum.

Outpatient Care. Health Services provided to a Covered Person who is not admitted to a facility as an inpatient (overnight). These Services may be provided in a variety of settings, including a Physician's office, clinic, the patient's home or Hospital outpatient department. Outpatient Care is often Hospital treatment that does not necessitate an overnight stay (for example, one-day surgicenters).

Outside Network Area or ONA. The geographic area outside of the Network Area for the Program.

See the "Outside Network Area (ONA) Coverage" section for information.

Participating Company. Any Frontier Controlled Group member that has elected to participate in the Program subject to approval by the Plan Sponsor.

Partner. Your Legally Recognized Partner (LRP) or, if eligible and enrolled in the Program, your Domestic Partner. See the definitions of Legally Recognized Partner and Domestic Partner for information.

Pharmacist. A person licensed to dispense Prescription Drugs under the laws of the state in which he or she practices.

Pharmacy. An establishment licensed by the state it is located in to dispense Prescription Drugs prescribed by an authorized licensed provider.

Physical Therapy. The treatment of a disease, Injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include Educational training or Services designed and adapted to develop a physical function.

Physician. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) licensed to practice medicine in all its branches, prescribe and dispense all drugs and perform all surgery under applicable laws of the place where treatment is rendered.

Plan. The Frontier Communications Health Care Plan.

Plan Year. The calendar year beginning Jan. 1 and ending Dec. 31.

Post-Employment Benefits. Program coverage (excluding COBRA) made available to a former Employee who meets eligibility requirements for continued Program coverage after the Employee terminates employment. See the “What Happens When You Leave The Company” section for information.

PPACA. The Patient Protection and Affordable Care Act, as amended, including any applicable regulations and rulings. See the “Patient Protection and Affordable Care Act” section for information.

Practitioner. An individual who meets all of the following:

- The Practitioner is one of the following:
 - Podiatrist
 - Chiropractor
 - Psychologist or clinical psychologist with Ph.D. degree
 - Dentist
 - Optometrist
 - Nurse-Midwife
- The Practitioner is qualified and duly licensed or certified to practice in the state in which care is provided
- Operating within the scope of that Practitioner’s license
- In addition, if the individual meets the above, a Practitioner may include an individual from the following list, but only when, in addition to meeting the above requirements of this definition, the patient has been referred to the Practitioner by a Physician or by the Benefits Administrator:
 - Registered physical therapist
 - Clinical social worker with master’s degree (MSW)
 - Marriage, family and child counselor

- Substance Abuse counselor
- Speech pathologist
- Audiologist
- Occupational therapist
- Dispensing optician
- Nurse practitioner
- Physician assistant
- An individual who holds a Master of Science in Nursing, a clinical nurse specialist or an individual certified in psychology and credentialed by the Benefits Administrator, but only when the patient has been referred to the Practitioner by the Benefits Administrator.

Preauthorization. Written or oral approval of a Covered Health Service received from the applicable Benefits Administrator before the Covered Health Service is delivered. See the “Notification and Preauthorization Requirements” section for information and a list of Covered Health Services requiring Preauthorization.

Preferred Brand Drug. A Brand-Name Drug that is included on the Prescription Drug Program Benefits Administrator’s Preferred Drug Benefit Guide.

Preferred Drug Benefit Guide. A guide that identifies the U.S. Food and Drug Administration-approved drugs that the Prescription Drug Benefits Administrator’s panel of doctors and pharmacists has determined to be as safe and effective and generally more cost-effective than Non-Preferred Brand Drugs. The Preferred Drug Benefit Guide is generally revised on a quarterly basis and may change throughout the Plan Year.

Pregnancy. The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body, usually, but not always in the uterus, and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Pregnancy Care. All of the following:

- Prenatal care
- Postnatal care
- Childbirth
- Any complications associated with Pregnancy

Premium Equivalent Rate. The projected average cost of a Company Self-Funded Option for a specified tier, such as “Individual” or “Individual + 1.”

Premium Rate. See the definition of Applicable Premium Rate.

Prescriber. A health care Practitioner licensed or authorized by law to issue an order for a Prescription Drug.

Prescription Drug. A drug or medicine approved by the United States Food and Drug Administration for general use by the public, requiring a prescription by a licensed Pharmacist or Physician.

Prescription Drug Benefit. Payments for outpatient Prescription Drugs that are available under the Program.

Preventive Care Drugs. Medications that are required under the Patient Protection and Affordable Care Act (PPACA) and associated regulations and guidance to be covered as preventive care as determined by the Prescription Drug Benefits Administrator. See the “Preventive Care Drugs” section for more information.

Preventive Care Services. Services that are determined by the Benefits Administrator to provide preventive care and are identified as preventive care in the Benefits Administrator’s preventive care policy, including at a minimum Services required to be covered as preventive care under the Patient Protection and Affordable Care Act (PPACA) and associated regulations and guidance. See the “Preventive Care Services” section for more information.

Primary Subscriber. An Active Employee, Eligible Former Employee, or surviving Spouse/Partner/dependent who is eligible and enrolled for coverage. A Primary Subscriber is not an Active Employee, Eligible Former Employee, or surviving Spouse/Partner/dependent who is covered as a dependent on another Active Employee’s, Eligible Former Employee’s, or surviving Spouse/Partner/dependent’s coverage.

Prior Authorization. A process by which the Benefits Administrator reviews requests for Covered Health Services before the Service is provided.

Program. The component part of the Plan providing Benefits for Covered Health Services to enrolled eligible individuals under the specified terms and conditions. See the “Using this Summary Plan Description” section for information.

Prospective Enrollment. The ability to drop or add coverage outside of Annual Enrollment or a Change-in-Status Event. See the “Prospective Enrollment” section for information.

Provider. Any health care institution or Physician or Practitioner licensed to render health care Services and practicing within the scope of that license.

Qualified Beneficiary. A Covered Person losing coverage under the Program who is eligible to elect COBRA continuation coverage. See the “Extension of Coverage – COBRA” section for more information.

Qualified Medical Child Support Order (QMCSO). See the “Qualified Medical Child Support Order” section for a definition and requirements.

Qualifying Event. An event such as loss of your job, reduction of your hours, death of a covered Employee or former Employee, divorce, or loss of eligibility as a Dependent, that results in the loss of coverage under the Program and gives rise to a right to elect COBRA continuation coverage. See the “Extension of Coverage – COBRA” section for more information.

Registered Domestic Partner (RDP). Any individual with whom an Employee or Eligible Former Employee has entered into a domestic partnership that has been registered with a governmental body pursuant to state or local law authorizing such registration and such relationship has not terminated. You may be asked to provide a copy of the domestic partner registration and other evidence that you continue to meet the requirements of the applicable registry and that the registered domestic partnership has not ended. See the “Dependent Eligibility Verification” section for information for dependent enrollment and verification of dependent eligibility.

Regular Employee. An individual who is classified as a Regular Employee by a Participating Company.

Retail Pharmacy. A place where Prescription Drugs are dispensed and provided to the Covered Person at point of sale.

Retail Prescription Drug Service. A Service administered by the Prescription Drug Benefits Administrator that provides up to a 30-day supply and is used for short-term, immediate-use medications.

Semi-private Room. A room with two or more beds.

Service or Services. Any of the following: medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices (including Durable Medical Equipment) and Prescription Drugs.

Skilled Nursing Facility. An institution licensed under state and local laws and regulations to operate as a Skilled Nursing Facility. Services include room and board in semi-private accommodations. Nursing Services must be supported by an approved treatment plan that leads to rehabilitation and an increased ability to function.

Specialty Pharmacy. A Pharmacy designated by the Prescription Drug Benefits Administrator for filling prescriptions for Specialty Prescription Drugs and providing associated Pharmacy management Services.

Specialty Prescription Drug Service. A Service administered by the Prescription Drug Benefits Administrator that provides Specialty Prescription Drugs.

Specialty Prescription Drugs. Drugs used in the management of certain chronic diseases, are often injectable or infused, treat complex and typically less common conditions, require complex Pharmacy management and frequently require coordination of Services.

Speech Therapist. An individual licensed to evaluate and treat speech impairments.

Speech Therapy. The treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and that is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include Educational training or Services designed and adapted to develop a physical function unless otherwise specifically provided for under the Program.

Spinal Treatment. The detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to distortion, misalignment or subluxation of or in the vertebral column.

Spouse. The person to whom you are legally married, including through Common Law Marriage, under applicable state or foreign law. Civil unions are not considered marriages for this purpose.

Stabilize. (A) The term “stabilized” refers to: (i) with respect to an Emergency Medical Condition other than a pregnant woman having contractions, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, (ii) with respect to a pregnant woman having contractions, that the woman has delivered (including the placenta).

(B) The term “to stabilize” refers to medical treatment of the condition as may be necessary to assure that the individual’s condition is stabilized.

Substance Abuse Services. Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Summary Plan Description (SPD). Each of the Program descriptions that are required by Section 102 of ERISA that provide a summary of the medical and prescription drug Benefits under the Program.

Temporary Employee. An individual who is classified as a “Temporary Employee” by a Participating Company.

Term of Employment. A period of employment of an Employee in the service of one or more members of the Frontier Controlled Group, as determined in accordance with the pension benefit plan the Employee participates in as of termination of employment.

Termination Date. The day immediately following an Employee’s last day on active payroll.

Unproven Service. Services that are not consistent with conclusions of prevailing medical research that demonstrate that the health Service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared with each other and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared with a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.) Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Illness or condition (one that is likely to cause death within one year of the request for treatment), the Benefits Administrator may, in its discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Illness or condition. For this to take place, the Benefits Administrator must determine that the procedure or treatment is promising, but unproven, and that the Service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Claim. Claim for treatment where a delay could seriously jeopardize the life or health of the patient or the ability to regain maximum function. Such a Claim is also one involving a condition that would, in the opinion of a Physician, Provider or Practitioner with knowledge of the condition subject the patient to severe pain that cannot be adequately managed without the care or treatment that is related to the Claim.

Urgent Care Facility. A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Illness, Injury, or the onset of acute or severe symptoms.

APPENDIX A: CHANGE-IN-STATUS EVENTS

Change-in-Status Events

The following provides further clarification on the Change-in-Status Events and actions you are able to take during those Change-in-Status Events.

If one of the events listed below allows you to enroll mid-year in a Marketplace plan, you may be allowed to drop your Program coverage and enroll in a Marketplace plan. However, your new coverage must be effective beginning on the date following the last day of coverage under this Plan. For additional information, you should call the Frontier Benefits Service Center

Change in Legal Marital or Partnership Status

You may change your enrollment if you experience a marriage, partnership, divorce, death of Spouse/Partner, termination of partnership, legal separation or legal annulment. Marriage will generally trigger a HIPAA special enrollment right in addition to your right to a change in enrollment.

For specific information about dependent eligibility, see the “Eligible Dependent” information detailed in the “Eligibility and Participation” section.

Change in Legal Marital or Partnership Status	Changes Permitted	Notes
Marriage or Partnership	AD, AS, C, DD, E, W	E, AD, AS: For newly eligible Spouse/Partner and any dependent Child(ren) of Employee or new Spouse/Partner. DD, W: Only if coverage is effective under new Spouse/Partner’s medical plan.
Death of Spouse/Partner’	AD, C, DD, DS, E	E, AD: Only if you lose coverage under your Spouse/Partner’s medical plan. DD: Only if other dependent loses coverage under your Spouse/Partner’s medical plan.
Divorce, Legal Separation, Legal Annulment or Dissolution of Partnership	AD, C, DD, DS, E	E, AD: Only if you or your dependent loses coverage under your Spouse/Partner’s medical plan. DD: Only if dependent loses coverage under your Spouse/Partner’s medical plan.

Change in Number of Dependents or Dependent Eligibility

You may change your enrollment if your dependent experiences a gain or loss of dependent status including birth, adoption, placement for adoption and death. Gaining a dependent will also trigger HIPAA special enrollment rights in addition to a change in enrollment.

Change in Number of Child Dependent(s)	Changes Permitted	Notes
Birth, Adoption or Placement for Adoption	AD, AS, C, E, W, DD, DS	W: Only if medical coverage is effective under your Spouse/Partner’s medical plan.

Death of Child Dependent'	DD	You may only drop the deceased dependent.
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***If a Dependent Dies**

If your dependent dies, you must notify the Fidelity Service Center at 800-416-2363. Although you are not required to notify the Fidelity Service Center within a specified period of time after the death of your dependent, please contact the Center as soon as possible to initiate the appropriate changes to your Program coverage.

Dependent Satisfies or Ceases to Satisfy Dependent Eligibility Requirements

In addition to birth and adoption, there are other Change-in-Status Events that may affect your dependent's eligibility under the Program and permit you to enroll the dependent. This applies to both your Spouse and Child dependents. There are many events which affect a dependent's eligibility under the Program including circumstances where a dependent:

- Reaches the maximum age for adult dependent Child coverage under the Program.
- Loses eligibility as a Spouse or dependent Child under the terms of the Program.
- Becomes your legal dependent.
- Becomes your certified disabled dependent Child.

Change in Dependent Status	Changes Permitted	Notes
Gain of Dependent Status	AD, AS, C, E, W	E, AD, AS: For the dependent only. W: Only if there is a gain of coverage under another health plan.
Loss of Dependent Status	DD, DS	May only drop coverage for the newly ineligible dependent.

Change in Employee's Employment Status

You may change your enrollment if you experience a change in employment that affects your eligibility under the Program including: termination of employment, commencement of employment, strike or lockout, commencement of an unpaid LOA, termination of an unpaid LOA, change in worksite that constitutes a change in employment status.

IMPORTANT:

(1) A change in employment status generally does not apply unless benefit eligibility under the Program is affected as a result of the event.

(2) A change in financial circumstance (for example, a pay reduction) is not considered a change in employment status unless it affects eligibility under the Program.

Change in Employee Employment Status	Changes Permitted	Notes
Gain of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	AD, AS, E	Only if eligibility for medical coverage option is gained.
Loss of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	W	
Employee Commences Strike or Lockout Resulting in a Change in Benefit Eligibility	W	Participants must lose eligibility and coverage.
Employee Returns From Strike or Lockout Resulting in a Change in Benefit Eligibility	AD, AS, E, W	
Employee Rehires Within 30 Days of Termination	Reinstate prior enrollment	No change permitted unless there is another permissible status change within that 30 day period.
Employee Rehires After 30 Days Following Termination	AD, AS, E	You may enroll and make new enrollment choices.

Change in Spouse's or Dependent's Employment Status

You may change your enrollment if your Spouse/Partner or dependent experiences a gain or loss of eligibility for medical coverage under another employer's plan as a result of a change in their employment status. Your change in enrollment for that individual under the Program must correspond with their specific Change-in-Status Event.

For example, if your dependent loses eligibility under his employer's medical plan due to a reduction of hours, you could change your enrollment to add him to your Program coverage. However, you could not change your election to drop all coverage under the Program.

Change in Spouse/Partner or Dependent's Employment Status	Changes Permitted	Notes
Gain of Employment	DD, DS, W	Enrollment changes under the Program are only permitted for you, your Spouse/Partner or dependent who gain coverage under another employer's medical plan.
Loss of Employment Spouse	AD, AS, C, E	AD, AS, E: Only with respect to you, your Spouse/Partner or dependent who lose coverage under another employer's medical plan.
Change in Work Schedule that Triggers a Loss of Eligibility Under their Employer's Medical Plan	AD, AS, C, E	AD, AS, E: Only with respect to the individual who lost coverage under another employer's plan.
Change in Work Schedule that Triggers a Gain of Eligibility under their Employer's Medical Plan	DD, DS, W, C	Only with respect to the individual who gains coverage under another employer's plan.
Spouse/Partner or Dependent Commences a Strike or Lockout	AD, AS, C', E	'Only if there is a loss in coverage consistent with the event.
Spouse/Partner or Dependent Returns from a Strike or Lockout	C', DD, DS, W	'Only if there is a loss in coverage consistent with the event.

Change in Residence

If you experience a change of residence that affects eligibility under the Program, you are permitted to make an enrollment change. For example, you may change your option enrollment if, as a result of a move, you are no longer eligible for the medical benefit option under the Program.

Change in Benefit Coverage	Changes Permitted	Notes
Relocation Triggers Gain in Eligibility	AD, AS, E	
Relocation Triggers Gain in Medical Benefit Option Availability	AD, AS, E, C	Only if eligibility for coverage option is gained.
Relocation Triggers Loss in Eligibility	C, W, DD, DS	
Relocation Triggers a Loss of Medical Benefit Option Availability	C, W, DD, DS	Only if eligibility for coverage option is lost.

Change in Benefit Coverage Under Another Employer's Plan

You may change your enrollment to add or drop medical coverage for you, your Spouse/Partner or dependent if any of you gain or lose coverage under another employer's medical plan.

Change in Residence	Changes Permitted	Notes
Gain of Medical Coverage under Another Employer's Plan	DD, DS, C, W	
Loss of Medical Coverage under Another Employer's Medical Plan	AD, AS, C, E	AD, AS: Only with respect to the Spouse/Partner or dependent who lost coverage under another employer's medical plan.
Spouse/Partner or Dependent's Annual Enrollment Does Not Correspond with the Program's Annual Enrollment Period	AD, AS, C*, DD, DS, E, W *Only if there is a loss of coverage	AD, AS, DD, DS, E, W: Changes are permitted that reflect corresponding changes in non-Frontier Spouse/Partner or dependent's medical plan.
You Gain Eligibility Under Another Employer's Medical Benefit Plan(s)	DD, DS, W	If Employee, Spouse/Partner and/or dependent coverage under other employer's medical plan is effective.
You Lose Eligibility Under Another Employer's Medical Benefit Plan(s)	AD, AS, C, E	

Loss of Coverage Under a Government or Educational Institution

You may change your enrollment if you experience a loss of group health coverage sponsored by an educational or governmental institution (for example: student health coverage provided by a university, coverage due to military service or certain Indian tribal programs, etc.).

IMPORTANT: There is no change in enrollment permitted for a gain of coverage from a government or educational institution. However, there are special rules for a gain or loss of Medicaid or state sponsored Children's Health Insurance Program (CHIP) coverage. See the "Change in Medicaid and CHIP Coverage" section below.

Loss of Educational or Governmental Institutional Coverage	Changes Permitted	Notes
Your Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, C, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.
Spouse/Partner or Dependent's Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, C, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance

You may change your enrollment if you experience a gain or loss of Medicaid coverage or premium assistance provided under a state sponsored CHIP program.

*Note: This Change-in-Status Event permits an extended enrollment period of **60 days** from the date of the event.*

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance	Changes Permitted	Notes
Your Gain of Medicaid Coverage or CHIP Premium Assistance	W, C, E, AD, AS	
Your Spouse/Partner or Dependent's Gain of Medicaid Coverage or CHIP Premium Assistance	DD, DS, C, W	
Your Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, C, E, W, DD, DS	
Your Spouse/Partner or Dependent's Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, C, E, W, DD, DS	

Change in Cost

You may change your enrollment if you experience a significant increase or decrease in your portion of the cost of your medical option under the Program during a period of coverage.

You may also change your enrollment if your Spouse/Partner or dependent experiences a significant increase or decrease in the cost of another employer's medical plan.

Enrollment changes may include revoking existing coverage and enrollment in a similar alternative coverage or waiving coverage altogether.

If the cost of a medical option significantly decreases, eligible individuals who have not enrolled in the Program may enroll. Those already enrolled in the Program may change their current medical option to the option with the lower cost.

If there is an insignificant increase or decrease in the cost of your current medical option, Frontier may automatically adjust your enrollment contributions to reflect the minor change in cost and you will not be permitted to change your medical coverage.

Change in Cost	Changes Permitted	Notes
Significant Increase in Cost of Your Medical Benefit Option	AS, AD, C*, DD, DS, E, W *Only if Company contributions cease	May change enrollment to match cost increase OR W and AD, AS, E: Another medical benefit option providing similar coverage OR W, DD, DS: If no other medical benefit option provides similar coverage
Significant Decrease in Cost of Your Medical Benefit Option	AS, AD, DD, DS, E, W	May change enrollment to match the cost decrease OR W, DD, DS: Current option and AD, AS, E: Drop other medical benefit option and add the medical benefit option with decreased cost
Increase in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, C*, E	*Only if Company contributions cease
Decrease in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	
You, your Spouse/Partner or Dependent Experience a Complete Loss of Medical Plan Subsidy from Another Employer	C, E, AD, AS	

Change in Coverage Under Another Employer's Plan

You may make an enrollment change if you experience a change under another employer's plan (including a plan of your Spouse's or Dependent's employer) if the enrollment change is on account of and corresponds with the change and the other plan permits its participants to make an enrollment change.

Change in Enrollment Under Another Employer's Plan	Changes Permitted	Notes
Increase in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	If coverage under other employer's plan is effective.
Decrease in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, C*, E	AD, AS, E: If coverage under another employer's plan is decreased or dropped. *Only if Company contributions cease

Addition or Significant Improvement of Benefit Plan Option

You may change your enrollment if the Program adds a new medical benefit option or significantly improves an existing medical benefit option; the Plan Administrator may permit you to enroll in the new or improved medical benefit option.

If a medical option is added or significantly improves, eligible individuals who have not enrolled in the Program may enroll.

If an addition or significant improvement is made under your Spouse/Partner or dependent's medical plan, you may change your enrollment under the Program consistent with those changes.

Addition or Significant Improvement of Benefit Plan Option	Changes Permitted	Notes
Addition or Significant Improvement of a Program Medical Benefit Option	AD, AS, DD, DS, E, W	DD, DS, W then AD, AS, E: May drop current medical benefit option and elect the new or significantly improved medical benefit option. AD, AS: If previously enrolled in a medical benefit option, you may elect the new or significantly improved medical benefit option.
Addition or Significant Improvement of Medical Benefit Option to Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	Only if coverage under another employer's plan is effective.

Significant Curtailment of Coverage (With or Without Loss of Coverage)

You may change your enrollment if you experience a significant curtailment of coverage under the Program during a period of coverage. In this case, you may change your enrollment for an existing medical benefit option even if there is no loss of coverage. An enrollment may be changed to a different medical benefit option or, in some cases, drop coverage if no similar coverage option is available under the Program.

Coverage is "significantly curtailed" only if there is an overall reduction in coverage provided under the Program that reduces coverage generally.

Significant Curtailment of Coverage	Changes Permitted	Notes
Significant Curtailment or Termination of Coverage With or Without a Loss of Coverage	C, DD, DS, W	
Significant Curtailment or Termination of Spouse/Partner or Dependent Coverage under Another Employer's Medical Benefit Plan	AD, AS, C, E	You may only change your election if there is a loss of coverage and no similar coverage is available under another employer's plan.

Medicare or Medicaid

If you, your Spouse/Partner, or dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Program. Similarly, if you, your Spouse/Partner or your dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to enroll or increase that person's coverage under the Program.

Change Due to Medicare or Medicaid	Changes Permitted	Notes
You Gain Medicare or Medicaid Coverage	C, W	
You Lose Medicare or Medicaid Coverage	AD, AS, C, E	
Spouse/Partner Gains Medicare or Medicaid Coverage	DD, DS	If Spouse/Partner or dependent enrolls in Medicare or Medicaid coverage.
Spouse/Partner Loses Medicare or Medicaid Coverage	C, E, AD, AS	AD, AS, E: If Spouse/Partner or dependent loses Medicare or Medicaid coverage.

Leave of Absence (LOA)

You may change your enrollment if you, your Spouse/Partner or dependent begin or return from an LOA.

Common LOAs that trigger the right to a change in enrollment are: federal Family and Medical Leave Act (FMLA), state family and medical leave, federal military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), unpaid personal leave, etc.

Change Due to LOA	Changes Permitted	Notes
You Begin an LOA	DD, DS, W	Whether paid or unpaid whether FMLA or non-FMLA.
You return from an LOA	AD, AS, E	Whether paid or unpaid whether FMLA or non-FMLA.
Spouse/Partner or Dependent Begin an Unpaid LOA (including a FMLA leave) Resulting in a Loss of Eligibility under Another Employer's Medical benefit plan	AD, AS, C, E	AD, AS, E: Only with respect to Employee, Spouse/Partner who lost coverage under another employer's plan.
Spouse/Partner or Dependent Returns from an Unpaid LOA (including a FMLA leave) Resulting in a Gain of Eligibility Under Another Employer's Medical Benefit Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gains coverage under another employer's plan.
Spouse/Partner or Dependent Starts an Unpaid LOA (Non-FMLA) Without a Change in Eligibility under Another Employer's Plan	AD, AS, E	Only with respect to you, your Spouse/Partner who loses coverage under another employer's plan.
Spouse/Partner or Dependent Returns from an Unpaid LOA (Non-FMLA) Without Change in Eligibility Under Another Employer's Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gain you, your Spouse/Partner's coverage under another employer's plan.

Judgments, Orders and Decrees

If a judgment, court order or judicial decree resulting from a divorce, legal separation, annulment or change in legal custody requires medical coverage for your Spouse/Partner or dependent, you (or in some cases, the Program) may make a change to your enrollment to meet the legal obligation. While the judgment order or decree will cause you to be able to make the change in enrollment, it will not cause a Spouse or dependent to be eligible for coverage.

In addition, coverage may be dropped for the dependent if another person (e.g. your former Spouse) is required to cover the dependent.

Note: This enrollment change does not apply to voluntary changes in responsibility for medical coverage of a dependent between ex-Spouses.

Change in Coverage Under a Judgment, Order or Decree	Changes Permitted	Notes
QMCSO or Court Order Requiring You to Cover a Dependent	AD, C	
QMCSO or Court Order Requiring Another Individual to Cover Your Dependent	DD	
Expiration or Termination of a QMCSO or Court Order	W, DD, C	

Change in COBRA Continuation Coverage

Change in COBRA Continuation Coverage	Changes Permitted	Notes
Mid-Year Expiration of Maximum Coverage Period of COBRA Continuation Coverage Under Another Employer's Group Health Plan	AD, AS, C, E	You must exhaust the maximum COBRA coverage period available to you in order to make this change in enrollment. In general, you will not be permitted to make this change if your COBRA continuation coverage is terminated by you or your COBRA continuation coverage Provider before the maximum period of coverage.

Change Due to Enrollment in Qualified Health Plan Purchased through Marketplace

Change in Coverage Marketplace Enrollment	Changes Permitted	Notes
Employee may revoke coverage for employee, Spouse, and Dependents, so long as the revocation corresponds to intended enrollment of employee, Spouse, and Dependents in Exchange coverage that is effective no later than the day after the last day of employer-provided coverage.	DD, DS, W	No change permitted for Excepted benefit coverage (Dental/Vision)

Status Change Codes:

E	Enroll yourself and/or your Eligible Dependent under the Program
AS	Add your Spouse/Partner to medical coverage under the Program
DS	Drop medical coverage for your Spouse/Partner under the Program
AD	Add your Eligible Dependent(s) to medical coverage under the Program
DD	Drop medical coverage for your dependent under the Program

W	Waive or terminate your medical coverage enrollment under the Program
C	Change medical coverage options under the Program

APPENDIX B: SPECIAL BENEFITS ADMINISTRATOR OFFERING

The Benefits Administrator offers a special program that may help reduce your out-of-pocket costs. This program is unique to the Benefits Administrator and a similar program may or may not be available through different Benefits Administrators. The Organ and Tissue Transplant Services Program offers you access to facility Services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures.

This section includes detailed information about the Organ and Tissue Transplant Services Program. Coverage and offerings through this Program depend on your particular situation at the time you utilize the Program. If you have questions with respect to how the Program works, see the Benefits Administrator table in the "Contact Information" section for contact information.

Organ and Tissue Transplant Services

IMPORTANT: Please read this section in its entirety. Requirements for Preauthorization and coverage for recipients and donors are explained as they relate to the covered transplants. Failure to follow guidelines explained in this section may cause a delay or denial of coverage. If you have questions concerning coverage under this Program, contact the Benefits Administrator at the telephone number on your ID card.

Benefits are available for the following transplants:

- Bone Marrow
- Cornea*
- Heart**
- Heart/lung**
- Heart Valve
- Kidney
- Lung**
- Liver**
- Muscular-skeletal
- Pancreas**
- Pancreas/kidney**
- Parathyroid

**Benefits are also available for cornea transplants. You are not required to notify the Benefits Administrator of a cornea transplant nor is the cornea transplant required to be performed at a Designated Network Provider.*

***Inpatient and Outpatient Facility Services (including evaluation for transplant, organ procurement and donor searches) for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplantation procedures must be ordered by a Provider and communicated to the Benefits Administrator by telephone before your transplant surgery has been scheduled. This will ensure*

that the Hospital you plan to use for your transplant surgery is approved by the Benefits Administrator as a location with an approved Organ and Tissue Transplant Services Program. Note: No Benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Benefits Administrator's approved Organ and Tissue Transplant Services Program.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Benefits Administrator to be a proven procedure for the involved diagnoses. Benefits related to the above transplants will be provided for:

- Inpatient and Outpatient Covered Health Services related to the transplant surgery;
- Evaluation, preparation and delivery of the donor organ;
- Removal of the organ from the donor; and
- Transportation of the donor organ to the location of the transplant surgery. *Note: Benefits will be limited to the transportation of the donor organ in the United States or Canada.*

Coverage for Donor and Recipient Services

Benefits are available to the donor and the recipient as follows:

- If both the donor and recipient have coverage, each will have their benefits paid by their own program.
- If you are the recipient of the transplant and the donor for the transplant has no coverage from any other source, the Benefits described in this SPD will be provided to both you and the donor. In this case, payments made for the donor will be charged against your Benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the Benefits described in this SPD will be provided for you. However, no Benefits will be provided for the recipient.

Transportation and Lodging

The Benefits Administrator will provide a \$50 per day/per person Benefit, as well as travel and lodging arrangements, for the patient and a companion (two companions if the patient is a dependent Child under the age of 26) if your place of residency is more than 50 miles from the Hospital where the transplant will be performed.

In addition to the other exclusions included in the "Exclusions and Limitations" section transportation and lodging Benefits are not provided for the following:

- Cardiac rehabilitation Services (when not provided to the transplant recipient immediately following transplant surgery and discharge from the Hospital).
- Travel time and related expenses required by the Provider.
- Drugs that do not have approval from the Food and Drug Administration.
- Storage fees.

- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified.
- Meals.