

# **Summary Plan Description**

IMPORTANT BENEFITS INFORMATION

## **FRONTIER CWA 1298 Vision Program (“Program”)**

**(formerly referred to as “East Vision Program”)**

*This Summary Plan Description (SPD) is a guide for using the Frontier CWA 1298 Vision Program, a component under the Frontier Communications Health Care Plan No. 505. This SPD replaces the prior Vision SPD and all of its summaries of material modifications.*

*Please keep this SPD for future reference.*

*(Bags 560-566)*

## **IMPORTANT INFORMATION**

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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 SPD is a guide to your Program Benefits. This SPD, together with the SMMs issued for this Program, constitute your SPD for this Program as well as the Frontier Communications Health Care Plan No. 505 (“Plan”) with respect to Benefits provided under this Program. See the “Eligibility and Participation” section for more information about Program eligibility.

Este documento contiene un resumen, en inglés. Si usted tiene dificultad en entender este documento, entre en contacto por favor con Frontier Benefits Service Center, 855-387-2887.

### **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.

### **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 questions regarding your Program Benefits, eligibility or contributions, contact the applicable administrators. Contact information is provided in the “Contact Information” section.

Si usted tiene alguna dificultad en entender cualquier parte de este documento, entre en contacto por favor con el Frontier Benefits Service Center en la seccion de “Contact Information.”

## **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 the 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 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 Frontier Benefits Service Center;
- Change Frontier Benefits Service Center password; and
- 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 can also 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

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### KEY POINTS

- *The Frontier Communications Health Care Plan No. 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 Frontier Communications Health Care Plan No. 505 (Plan) with respect to Benefits under the Frontier CWA 1298 Vision 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 CWA 1298 Vision Program provided under the Frontier Communications Health Care Plan No. 505 (Plan). The Plan incorporates certain welfare plans sponsored by Frontier. 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 Vision Program (Program).

It provides information about eligibility, enrollment, contributions and legal protections for the Program Benefits for Bargained Employees.

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 Ophthalmologist, Optometrist, Optician 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 Vision 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 health care decisions, and they do not determine the type or level of care or Course of Treatment for your personal situation. Only you and your Ophthalmologist, Optometrist, Optician or health care Provider determine the treatment, care and Services appropriate for your situation.

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## **ELIGIBILITY AND PARTICIPATION**

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### **KEY POINTS**

- *If you are a full-time or part-time CWA 1298 Regular Employee eligibility for coverage begins on the first day of the month in which you complete a Term of Employment of six months with a Participating Company.*
- *Eligible Employees: Your Eligible Dependents are your Spouse or Legally Recognized Partner (LRP) and your Dependent Children who satisfy the Program's eligibility requirements.*
- *If you enroll in the Program and use a Video Display Terminal (VDT) as part of your job, you are automatically eligible for VDT Vision Care Benefits.*
- *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 "What Coverage Options are Available" for the level of coverage (e.g. Individual or Family) 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 referred to as CWA 1298.

Special eligibility rules apply to Employees who transfer or change positions under circumstances specified in the 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.

### **Eligible Employees**

If you are an Eligible Employee of a Participating Company, you are eligible for coverage for yourself and your Eligible Dependents as stated in the Eligibility Rules table below. Special eligibility rules apply to rehired Eligible Former Employees. See the "Rehired Eligible Former Employees" section for more information.

<b>Eligibility Rules</b>	
<b>Eligible Employees</b>	
You are an Eligible Employee if...	You are a Bargained Employee who is classified by your Employer as a full-time or part-time Active Regular Employee in one of the Eligible Employee groups of a Participating Company.
Population Groups	CWA 1298
<b>Dual Enrollment</b>	
Dual Enrollment	<p>While you may be eligible under more than one status (for example, as an Employee, Eligible Former Employee or dependent), the Program allows you to be enrolled under only one status. See the “Dual Enrollment” section for more information.</p> <p>If your eligible former Spouse/LRP is an Employee, you and your eligible former Spouse/LRP are allowed to</p> <ul style="list-style-type: none"> <li>• Enroll Eligible Dependents under the Program, that is, each of you may enroll all Eligible Dependents at the same time, or you may split the Eligible Dependents between you.</li> <li>• Enroll Eligible Dependents under another vision program sponsored by the Company, that is, each of you may enroll all Eligible Dependents at the same time, or you may split the Eligible Dependents between you.</li> </ul> <p><b>IMPORTANT:</b> Under no circumstance are you and your former Spouse/LRP permitted to provide coverage to each other or to dependents who are not eligible to be covered under the Program. See the “Eligible Dependents” section for further information.</p> <p>The rules discussed above also apply to rehired retirees.</p> <p>In addition, as a rehired retiree, you may not be enrolled at the same time as both an Active and retired Employee in this Program or another vision program sponsored by a member of the Frontier Controlled Group.</p>

## **Rehired Eligible Former Employees**

You are considered to be a “Rehired Retiree” (also known as a “rehired Eligible Former Employee”) if:

You are a CWA 1298 Employee of a Participating Company in a position that would otherwise make you eligible for benefits under this Program; and,

At the time of your latest hire, you were eligible for Post-Employment Benefits as an Eligible Former Employee under a program sponsored by Frontier for CWA 1298 Employees.

If you are a Rehired Retiree, the provisions of the Frontier Rehired Eligible Former Employee supplement supersede the rules in this SPD, including but not limited to whether you are eligible for coverage under this or another Program.

Contact the Frontier Benefits Service Center to obtain this supplement. It will be mailed to you at no cost.

## **How to Determine if Your Dependents Are Eligible for This Program**

Review this section to determine if your dependents (e.g., your Spouse/Legally Recognized Partner (LRP) and/or Child) 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 or COBRA continuation coverage, your dependent(s) cannot be enrolled in the Program, unless you are also enrolled. 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**

<b>Eligibility Rules</b>	
<b>Eligible Dependents</b>	
Your dependents who meet the eligibility rule are eligible for Program coverage.	<p>Your Eligible Dependents are:</p> <ul style="list-style-type: none"> <li>• Your Spouse.</li> <li>• Your LRP.</li> <li>• Your unmarried Children* or your Spouse/LRP’s unmarried children who are dependent on you for support (Dependent Child) up to the end of the year in which they reach age 23.</li> <li>• Your unmarried disabled dependent Child(ren)* who is mentally or physically disabled and was mentally or physically disabled before the age of 23. Contact the Frontier Benefits Service Center well before the Child will reach age 23 to start the disability certification process.</li> </ul> <p>* Children include your own child; a child who is placed for adoption in your home; a child you have legally adopted or your stepchild, including the child of your LRP, who resides in your home; and a child for whom either you or your Spouse/LRP is Legal Guardian and who resides in your home.</p>
<p><b><i>Important:</i></b> A physically or mentally disabled dependent adult Child must be certified as an Eligible Dependent for coverage. You can do this by completing the application forms available from the Frontier Benefits Service Center and submitting them for approval to the address on the forms. See the “Disabled Children Eligibility” section for details of the certification process.</p>	

**Dependent Eligibility Verification**

A dependent is not eligible for Program coverage unless he or she satisfies the Program’s Eligible Dependent requirements. The Company has the right to require that you provide documentation establishing the eligibility of the dependents you enroll in the Program. The following process outlines the steps necessary to complete the enrollment of a dependent in the Program.

Determine if your dependent is eligible for Program coverage. Review the “Eligible Dependents” section for the rules that pertain to dependent eligibility.

Call the Frontier Benefits Service Center or access the Frontier Benefits Service Center Web site to enroll your dependent.

Your dependents will be conditionally enrolled and provided Program coverage contingent on your providing documents that verify the dependent’s eligibility for coverage under the Program, if requested.

If you do not provide the required documentation and, therefore, do not establish your dependent’s eligibility before the stated deadline, your dependent will not be eligible for coverage. Coverage for the dependent will be terminated retroactively to the date the dependent’s Program coverage began.

If coverage is terminated retroactively, your dependent will not be eligible for Benefits under the Program for that period. You may be personally liable for the cost of any Claims incurred by your ineligible dependent. In addition, your dependent will not be eligible for COBRA continuation coverage under the Program.

**IMPORTANT:** Your dependent’s enrollment in the Program is contingent upon verification of dependent eligibility by the Frontier Benefits Service Center.

*Note: Enrollment of an ineligible dependent in the Program constitutes benefits fraud which may result in legal action and financial consequences. If you are an Active Employee, you may be subject to employment disciplinary action, up to and including dismissal.*

### *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 23 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.

### ***Ineligible Dependents***

You must notify the Frontier Benefits Service Center when one of your Eligible Dependents becomes ineligible to continue coverage under the Program. In addition, the ineligible dependent should not continue using his or her coverage after the last day of the month in which he or she becomes ineligible, unless the ineligible dependent is eligible for and elects to continue coverage under COBRA. If the Company pays expenses for this ineligible dependent before the ineligibility is identified, you must reimburse the Company for any Benefits paid after the last day of the month in which the Eligible Dependent becomes ineligible.

For more information on eligibility requirements and for the rules for when an Eligible Dependent becomes ineligible, contact the Frontier Benefits Service Center. See the Frontier Benefits Service Center table in the "Contact Information" section for contact information. The Company reserves the right to request verification of Eligible Dependent status at any time.

*Note: If your dependent does not meet the eligibility requirements of the Program, the Program will not pay any of his or her vision expenses. If the Program has paid vision expenses for an ineligible dependent before the ineligibility is identified, you will be required to reimburse the Program for all such expenses.*

It is expected that the Active Employees covered under the Program will use the Benefits provided according to the terms of the Program. If you attempt to obtain Benefits to which you are not entitled under the terms of the Program (for example, by submitting false information on Claims for Benefits), or if you permit others to obtain Benefits by

fraudulent means (for example, by allowing a Provider to submit Claims for Benefits for services not provided), you may be subject to prosecution and termination of your participation under the Program and you may be subject to disciplinary action, including, but not limited to, dismissal.

### **Audit 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 enrollment individual meets the eligibility criteria, he/she will be disenrolled 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.

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, including retroactively.

### **Dual Enrollment**

The Program may provide coverage for you and your Eligible Dependent as described below. 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 vision 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.

Some Employees have eligible Spouses/Partners who are eligible to cover themselves and their Eligible Dependents under a Company-sponsored vision program. The following describes the coverage opportunities and/or limitations that apply for these individuals:

If your eligible Spouse/Partner is an Employee, you and your eligible Spouse/Partner are allowed to:

Enroll separately and enroll each other and other Eligible Dependents under the Program.

Enroll in separate Programs. Each may enroll all Eligible Dependents at the same time or you may split the Eligible Dependents between two programs. For example, you may enroll in the Program and your Spouse/Partner may enroll in another program sponsored by the Company. You each may enroll all Eligible Dependents or you may cover some Eligible Dependents under the Program and some under another program sponsored by the Company.

Enroll jointly, that is, you may enroll your Spouse/Partner as a dependent (or vice versa) and cover all Eligible Dependents under the Program.

If your eligible former Spouse/former Partner is an Employee, you and your eligible former Spouse/former Partner are allowed to:

Enroll Eligible Dependents under the Program; that is, each of you may enroll all Eligible Dependents at the same time or you may split the Eligible Dependents between you.

Enroll Eligible Dependents under another vision Program sponsored by the Company; that is, each of you may enroll all Eligible Dependents at the same time or you may split the Eligible Dependents between you.

**IMPORTANT:** You and your former Spouse/Partner are not allowed to provide coverage to each other or to dependents who are not eligible to be covered under the Program. See the “Eligible Dependents” section for further information.

## 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](http://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 (including LTD) 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.

## ENROLLMENT AND CHANGES TO YOUR COVERAGE

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### KEY POINTS

- *If you are an Eligible Employee, coverage under the Program is not automatic; you must actively enroll in the Program to receive coverage for yourself and your Eligible Dependents.*
- *As an Eligible Employee, you can enroll in the Program after your date of hire, during Annual Enrollment, after you experience certain change in status events or prospectively, at any time during the year. You may make changes to your existing coverage during the Plan Year as a result of a change in status event.*
- *For more information on enrollment and changes to your coverage, contact the Frontier Benefits Service Center.*

### What Coverage Levels Are Available

The Program offers the following three levels of coverage:

Individual – You enroll only yourself.

Individual + 1\* – You enroll yourself and one Eligible Dependent (such as an eligible Child).

Individual + 2 or more\* – You enroll yourself and two or more Eligible Dependents (such as two eligible Children).

*\* These levels of coverage are also known as Family Coverage.*

See the “Eligible Dependents” section for information about who qualifies as your Eligible Dependent.

### 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 Rules for You**

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 employee on the first day of the month you complete six months of service if you are a Temporary Employee provided you enroll within the 31-day initial enrollment period.

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.
Change-in-Status Enrollment	See the “Change-in-Status Enrollment” section.

### Newly Hired Employee Enrollment

If you are classified by the Company as an Eligible Employee, you may enroll yourself and your Eligible Dependents in Program coverage. You will receive enrollment materials from the Frontier Benefits Service Center shortly after you are hired. You need to follow the instructions provided on how to enroll and you must enroll within the 31 day window period described in your enrollment materials for your coverage to be effective on the first day of the month in which you attain six months Term of Employment. Your enrollment is subject to the before-tax premium option provided under the Frontier Flexible Spending Account (FSA) Plan, any contributions made through payroll deduction will be deducted on a before-tax basis unless you elect otherwise. If you do not elect to enroll you will default to “no coverage.”

### 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 Jan. 1 of the following Plan Year.

**IMPORTANT:** If you have a Change-in-Status Event on or after annual enrollment 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 Jan 1.

You can enroll through 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.

The effective date of the change in coverage is noted in the Enrollment Rules for You table.

If you contribute toward the cost of your vision coverage, any additional required contributions resulting from your prospective enrollment must be paid on an after-tax basis until the first day of the next Plan Year. Refer to the “Before-Tax and After-Tax Contributions” section for more information.

Note: Once you enroll in the Program, you may not drop coverage or elect a lower level of coverage for the remainder of the following two calendar years unless you experience a change in status.

### **Change-in-Status Enrollment**

Circumstances often change. You may get married, welcome a Child to the family, lose benefits under another employer’s vision 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.

You will be eligible to change Program coverage for you and/or your Eligible Dependents during the course of your two-year enrollment period (if you are an Eligible Employee) or the Plan Year (if you are an Eligible Former Employee), provided that:

- The change you make is consistent with the Change-in-Status Event.
- You contact the Frontier Benefits Service Center within the required time period as described in the applicable “Family Status Changes” and the “Change in Employment Classification” section.

See the “Change in Status Events” section for a complete list of change in status events and the changes you are allowed to make if you experience a Change-in-Status Event.

**IMPORTANT:** To be considered a Change-in-Status Event, the event must result in the gain or loss of eligibility or a change in the cost for coverage under either the Program or the vision plan of your Spouse, LRP or dependent.

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. See the “Prospective Enrollment” section and the “Annual Enrollment” section for more information.

### ***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 the timeframes noted below.

You can change your coverage category (for example, changing from individual to individual + 1) during the Plan Year if you have a qualified change in your family status (for example, adoption or marriage). If you are an Eligible Former Employee, this is the only time you will be allowed to change your coverage category during the Plan Year.

Changes to your coverage as a result of a qualified family status change other than a change on account of death must be made within 31 days of the change in status event for the change in coverage to be effective retroactive to the date the event occurred. If you are an Eligible Former Employee and you do not make changes within this amount of time, you must wait until the next Annual Enrollment period or subsequent change in status event to make a change in coverage.

The Frontier Benefits Service Center will advise you as to which changes are permissible. If you do not provide the notification within the time frames noted above, your coverage change will become effective on the first day of the month following the date you contact the Frontier Benefits Service Center.

If you lose a dependent as a result of death, you must notify the Frontier Benefits Service Center at **855-387-2887**. If you lose a dependent as a result of loss of eligibility (for example, through divorce or marriage of your Child), you must notify the Frontier Benefits Service Center. Although you are not required to notify the Frontier Benefits Service Center within a specified period of time after your dependent’s death, you should contact the Center as soon as possible to initiate the appropriate changes to your Program coverage. Changes resulting from loss of eligibility under the Program will always be made retroactively to the date of loss of eligibility. Generally, the date of loss of eligibility is the last day of the month during which the event that caused the loss of eligibility occurred. There is no retroactive refund to the date of the event for any required contributions, and your ineligible dependent will not have coverage under the Program after the date on which eligibility is lost.

If any contributions are adjusted as a result of your change in status event, the new contributions are effective the first day of the month following the date you contact the Frontier Benefits Service Center to request the change in your coverage. However, if

you are an Active Employee making before-tax contributions for your vision coverage pursuant to your Company FSA plan, the amount of your before-tax contributions will not change, even if the required contributions for your new coverage are more or less, unless your change in status event also is a qualified status change under your Company FSA plan. Refer to the “Before-Tax and After-Tax Contributions” section for more information on before-tax and after-tax contributions. Although generally similar, not all Change-in-Status Events under the Program are considered qualified status changes under your Company FSA plan. See your Company FSA SPD for a description and list of events that are considered qualified status changes.

### ***The Effective Date of Your Change In Status Enrollment***

It is very important that you notify the Frontier Benefits Service Center 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. See the Frontier Benefits Service Center table in the “Contact Information” section for contact information.

As noted above, your change in enrollment request is subject to review by the Frontier Benefits Service Center. 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 the Dependent Eligibility Verification Process. Therefore, it is especially important to submit the necessary documents that prove eligibility for your dependent in a timely manner. 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 and documentation 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. For information about how your specific enrollment change may affect the amount of your contributions, contact the Frontier Benefits Service Center.

**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.

### ***Change in Employment Classification***

If your employment classification changes, such as going from part-time to full-time status, it may affect your vision coverage. In addition, if the number of hours you are scheduled to work changes, you may be required to contribute to the cost of your coverage or your current contribution may be waived, depending on the increase or decrease in the number of hours you are scheduled to work.

## **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* of 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.

## LEAVE OF ABSENCE

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### 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 the 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 the 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 date 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.

This is a brief overview of the provisions of USERRA. For information concerning coverage for Employees who are absent from employment by reason of service in the Uniformed Services and their Eligible Dependents, contact the Frontier Benefits Service Center. See the Frontier Benefits Service Center table for contact information.

### **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 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. 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 don't 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 continuation coverage will begin on the earlier of:

The date your FMLA leave ends if you don't return to active employment.

The date you notify the Company that you do not intend to return after the end of your FMLA leave.

## WHEN COVERAGE ENDS

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### 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 ends (including by reason of death or retirement).

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.

See the “Extension of Coverage – COBRA” section 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(ren) 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.”

See the “Extension of Coverage – COBRA” section for information about what rights you or your dependents may have to continue coverage.

A mentally or physically incapacitated Child’s benefit coverage under the Program 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.”

### **If You Are Laid Off From Active Employment**

If you terminate employment due to a force adjustment or layoff, continued Company contributions to your coverage may be available for a limited period (as long as you continue to pay any applicable contribution). You will be notified following your termination of employment if the severance or force adjustment program or agreement under which you terminated employment provides for an extension of vision coverage. You may also contact the Frontier Benefits Service Center for assistance with questions.

### **If You Are Retiring From the Company**

Active Program coverage for you and your enrolled Dependents will continue through the end of the month in which you retire. If you are eligible for Eligible Former Employee (Retiree) vision coverage, your coverage will automatically be converted the first day of the following month. You may have different monthly required contributions when you retire.

The Frontier Benefits Service Center will send you information regarding your Eligible Former Employee vision coverage options and any required monthly contribution, if applicable. Contact the Frontier Benefits Service Center if you do not receive this statement and/or if you would like to make any changes to your coverage.

If you retire from the Company, you and your Eligible Dependents who are enrolled in the Program immediately before your retirement may be eligible to continue coverage under the Program as provided under COBRA. See the “Extension of Coverage — COBRA” section for more information.

### **If Your Active Employment Ends By Reason of Disability**

If you are an Eligible Employee receiving short-term disability benefits from a Company-sponsored short-term disability program (STD Program) and you were eligible to participate in this Program immediately before commencing STD Program benefits, your Program coverage continues as if you were actively at work.

After your STD Program benefits end, you and your Eligible Dependents who are enrolled for vision coverage under the Program immediately before the cessation of your STD Program benefits may be eligible to continue Program coverage under COBRA. See the “Extension of Coverage — COBRA” section for more information on COBRA.

### **If Your Active Employment Ends By Reason of Your Death**

If you die, the coverage under the Program for your surviving Eligible Dependents will end on the last day of the month during which your death occurs. Following your death, your surviving Eligible Dependents who are Qualified Beneficiaries may elect to continue vision coverage under COBRA. If elected, the COBRA continuation coverage will be effective as of the first day of the first month following the month during which you die. See the “Extension of Coverage — COBRA” section for more information. To report a death, call the Frontier Benefits Service Center.

### **If You Are Rehired**

Special rules apply in determining whether you qualify as a rehired Eligible Former Employee following your reemployment or when you may cease to qualify as a rehired Eligible Former Employee. These special rules are contained in the “Frontier Rehired Eligible Former Employee supplement.” See the “Rehired Eligible Former Employees” section for information.

### **If Your Dependent Becomes Ineligible**

Program coverage for your Eligible Dependent ends on the last day of the calendar year or month, as applicable, (in which your Eligible Dependent no longer meets the eligibility requirements. Your Eligible Dependent may continue coverage under COBRA. See the “Extension of Coverage — COBRA” section for more information on COBRA. See the “Eligible Dependents” section for information on when coverage for your Eligible Dependents ends.

### **If You Are on a Leave of Absence**

If you are on an approved leave of absence, you will receive a notice explaining the coverage that you and your Eligible Dependents are eligible to continue and whether you will be required to pay for this coverage. See the “Leave of Absence” section for additional information. If Company-provided coverage is not available during your leave, you may continue coverage under COBRA. See the “Extension of Coverage — COBRA” section.

### **If You Do Not Make Required Contributions**

Program coverage ends if you stop making any required contributions. Coverage will end on the last day of the month for which the required contributions were paid in full.

If you are an Eligible Former Employee, you will not be eligible for COBRA continuation coverage. Under these circumstances, you will not be eligible to re-enroll

for coverage under the Program until the next Annual Enrollment unless you experience a change in status event that permits you to enroll sooner.

### **If You Receive a Promotion**

If you are promoted to a management or a nonmanagement nonunion position with the Company, Program coverage ends for you and your Eligible Dependents on the last day of the month in which the promotion occurs. You and your covered Eligible Dependents may, however, be eligible for Company-sponsored vision coverage under the vision program that is applicable to your new employment classification.

### **If Coverage Is Cancelled**

Program coverage ends for you and your Eligible Dependents on the last day of the month during which Program coverage is canceled. If Program coverage is canceled, you may be eligible for COBRA. See the “Extension of Coverage — COBRA” section for more information on COBRA.

### **If the Program Is Terminated**

If the Company terminates the Program, coverage under the Program ends for you and your Eligible Dependents on the last day of the month in which the Program is terminated.

### **COBRA**

You and your covered Eligible Dependents may be eligible to elect COBRA coverage when Program coverage ends. See the “Extension of Coverage — COBRA” section beginning for information regarding your rights to elect COBRA continuation coverage.

# CONTRIBUTIONS

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## KEY POINTS

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

If you are an Active Employee, the amount you contribute toward the Cost of Coverage is affected by a number of factors, including:

Your employment classification (e.g., full-time or part-time).

The level of coverage in which you are enrolled.

You will receive information about contributions at Annual Enrollment each year. You also may obtain contribution information through the Frontier Benefits Service Center..

## Contributions for Eligible Employees

Refer to your enrollment materials for information concerning the contribution amount that applies to you.

## 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 are eligible under your Company FSA plan (unless you enroll through prospective enrollment or elect after-tax contributions). If you do not want these contributions deducted on a before-tax basis, you must elect after-tax contributions when you enroll. Even if you are eligible to change your Program 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 Status Change event as defined in your Company FSA plan. Although generally similar, not all Change-in-Status Events under the Program are considered qualified under your Company FSA plan. See the Frontier FSA Plan SPD for CWA 1298 Employees for more information on before-tax contributions and for a list of events that are considered Qualified Status Change events. If you are not an Active Employee, you must pay your Program contributions on an after-tax basis.

### ***The Difference Between Before-Tax and After-Tax Contributions***

It is important that you understand the difference between before-tax and after-tax contributions, and the rules that apply to before-tax contributions.

### **Before-Tax Contributions**

Your Company FSA Plan allows you to pay applicable Program contributions on a before-tax basis. When your contributions are deducted from your paycheck before federal, state and local (if applicable) taxes are taken out, they are known as before-tax contributions. Before-tax contributions reduce taxable income for federal income

tax purposes; therefore, you pay less in taxes. In most (but not all) states, before-tax contributions also reduce income subject to state (and local) taxes.

Before-tax contributions are subject to IRS regulations. These regulations require you to make elections for benefits paid through before tax-contributions during your initial or Annual Enrollment period. Before-tax contributions cannot be changed outside of these enrollment periods unless a Qualified Status Change occurs that allows the change.

If you experience a Qualified Status Change event as outlined in the FSA Plan, you may make changes to your benefits and associated changes to your before-tax deductions provided you report the event to the Frontier Benefits Service Center, and make the associated change in your benefits coverage within the time period specified for making the change under the Frontier FSA Plan.

For example, if you drop a dependent or cancel coverage outside an enrollment period without declaring a Qualified Status Change event within the required time frame, your before-tax contribution will not change even if the amount of your contribution would otherwise decrease. If you add a dependent or enroll in new coverage outside an enrollment period without timely declaring a Qualified Status Change event, and the contribution amount for your new dependent or coverage is greater than your before-tax contribution, the additional amount will be deducted from your pay on an after-tax basis. See the Change-in-Status Events table for a list of Qualified Status Change events.

**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.

### After-Tax Contributions

You are not required to pay applicable contributions on a before-tax basis. You may elect to have your contributions deducted from your paycheck on an after-tax basis. After-tax contributions do not reduce your taxable income. This means you pay income taxes on the amount of your contributions.

You must elect after-tax contributions by making an affirmative election.

### **Contribution Policy**

The amount that you must contribute monthly toward coverage is determined before Annual Enrollment each year and is subject to change annually at the sole discretion of the Company, subject to applicable collective bargaining agreements. The following table summarizes the amount you pay toward the Cost of Coverage under the Program in 2026.

Employee Classification		Contribution Rules
Regular Employee (at least 6 months Term of Employment)	Full-time	The Company pays the monthly Cost of Coverage
	Part-time (regardless of scheduled hours per week) with an original hire date before Jan 1, 1981	
	Part-time (25 or more scheduled hours per week) with an original hire date on or after Jan 1, 1981	
	Part-time (at least 17 scheduled hours but less than 25 scheduled hours per week) with an original hire date on or after Jan 1, 1981	You pay 50% of the monthly Cost of Coverage
	Part-time (less than 17 scheduled hours per week) with an original hire date on or after Jan 1, 1981	You pay 100% of the monthly Cost of Coverage
Eligible Former Employees	See Former Employee Eligibility and Enrollment table	

Your Participating Company pays for VDT coverage for all eligible Active Employees.

**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.

### Tax Consequences of Coverage for Legally Recognized Partners and Their Dependents

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

However, when an LRP or the LRP'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.

## 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 on a monthly basis. Payment is due on the first of the month for the following month of coverage. For example, payment for coverage for the month of July is due by July 1.

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 your 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 from the Frontier Benefits Service Center 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.

## YOUR PROGRAM BENEFITS

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### KEY POINTS

- *The Program provides Benefits for covered services or supplies provided by Network Providers and Non-Network Providers.*
- *Each time you need vision care, you decide whether to use a Network Provider or a Non-Network Provider.*
- *Program Benefits differ depending on whether you choose a Network Provider or a Non-Network Provider.*
- *Generally, your out-of-pocket expenses are lower when you use Network Providers.*

This section describes the Benefit provisions of the Program. The Program is designed to keep your vision care costs low while still allowing you the freedom to visit any Provider you choose. This is accomplished by giving you a choice of using Network Providers or Non-Network Providers for your vision care needs. The Network Providers are a group of Providers that comply with the quality standards of the Benefits Administrator and have agreed to limit their charges for most covered services or supplies. Each time you or your covered Eligible Dependents need care, you have the option of using a Network Provider or a Non-Network Provider.

If you use a Network Provider, and provide your insurance information before the services are provided, your out-of-pocket expenses will usually be lower than if you use a Non-Network Provider and you won't have to file any Claims.

If you use a Non-Network Provider, you pay the Non-Network Provider for the vision care services or supplies you receive and then you submit a Claim to be reimbursed for eligible vision care expenses.

### Accessing Network Providers

Each time you need vision care services, you decide whether to use a Network Provider or a Non-Network Provider. For example, you can visit a Network Provider for your Examination and purchase your Frames and Lenses from a different Network Provider or a Non-Network Provider. You do not have to use the same Provider each time you need vision care services or supplies.

When you need vision care services, you choose which Provider you want to use. You'll generally pay less out of pocket when you use a Network Provider. To find out which Providers in your area are Network Providers, contact the Benefits Administrator. See the Benefits Administrator for the Program table in the "Contact Information" section for contact information.

Before receiving services, provide your coverage information before the services are provided to verify the network status of the Providers for both the Examination and supplies (Lenses and Frames). For example, Providers that share the same facility

(such as an Ophthalmologist and an eyeglass/Contact Lenses supplier) might not both be Network Providers.

Note: If you use a Non-Network Provider, you will be responsible for any ineligible expenses under the Non-Network Provider provisions of the Program. It is important for you to verify that your Provider is a Network Provider and is accepting new patients by contacting the Provider or the Benefits Administrator before you seek vision care services.

### **What You Need to Know About Network Providers**

The Benefits Administrator is responsible for establishing and managing the network of Network Providers and for determining vision care Claim payments. Providers (such as Ophthalmologists) do not determine your Benefits under the Program and are not qualified to advise you about what the Program covers. Network Providers are independent practitioners. They are neither Company employees nor employees of the Benefits Administrator. It is your responsibility to select your Provider.

## BENEFITS AT A GLANCE

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### KEY POINTS

- *Program Benefits are summarized in the Benefits at a Glance table(s). 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 Vision Services.*

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

**A list, not an exhaustive list, of the most commonly used Covered Vision Services.** See the “What Is Covered” section for more detailed information on what is covered. Even if a Service is listed as a Covered Vision 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 list of limitations specific to the Covered Vision Services in the table.** This information is not exhaustive. See the “What Is Covered” section for more detailed information on limitations to the Covered Vision 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.

When you have an Examination, you are responsible for paying the required applicable Copayment. The Benefits Administrator pays the Network Provider directly for covered charges in excess of that Copayment.

If the Network Provider prescribes eyeglasses or Contact Lenses, you will be required to pay an additional Copayment directly to the Network Provider. The Benefits Administrator pays the Network Provider for eligible covered charges in excess of that Copayment. You are responsible for paying the Network Provider any applicable Copayments and any additional costs resulting from a cosmetic option or non-covered services and supplies you select.

If you have used a Non-Network Provider, you are responsible for paying the Provider in full and submitting a Claim for reimbursement to the Benefits Administrator based on the Non-Network Provider Benefits listed in the Vision at a Glance table.

**Benefits at a Glance**

	<b>Network</b>	<b>Non-Network</b>	<b>Limitations and Exceptions</b>
<b>Cost Sharing</b>			
Annual Limits	Amounts determined by the percentages below are applied to the Allowable Amount.	Dollar amounts below are what the Program pays up to.	Required: You must advise Provider of coverage at time of service to receive Network Benefits.  The VDT benefit is covered for Eligible Employees only.
<b>Exams</b>			
Routine vision exams	<p><b>First Pair</b></p> <p>Program pays 100%, after a \$15 Co-payment</p> <p><b>VDT Only</b></p> <p>Program pays 100%, after a \$10 Co-payment</p> <p>The Co-payment amount is based on eye exam performed and services requested.</p>	\$40	Once every 12 months, from last date of service.
<b>Standard Lenses</b>			
Single	<p><b>First Pair</b></p> <p>Program pays 100%, after a \$10 Co-payment</p> <p><b>VDT Only</b></p> <p>Program pays 100%, after a \$10 Co-payment</p>	\$25	Once every 12 months, from last date of service.
Bifocals		\$35	Once every 12 months, from last date of service.
Trifocals		\$45	Once every 12 months, from last date of service.
Lenticular		\$90	Once every 12 months, from last date of service.
Progressive		Not covered	\$0

	<b>Network</b>	<b>Non-Network</b>	<b>Limitations and Exceptions</b>
			the Network Provider.
Standard Lens Options	Not covered  Lens options include tints, progressive, polycarbonate (lightweight) lenses, scratch resistant, anti-reflective coating, photogrey/transitions, edge coating, edge polishing, etc.		Discounts may be available, check with the Network Provider.
<b>Frames</b>			
Frames	<b>First Pair</b>  \$10 Co-payment \$105 Allowance  <b>VDT Only</b>  \$10 Co-payment \$105 Allowance	\$35	Once every 24 months, from last date of service.  Discounts may be available, check with the Network Provider.
<b>Contact Lens Benefits</b>			
Elective Conventional Elective Disposable	\$10 Co-payment  \$115 Allowance  <b>VDT Only</b>  Not covered	\$80	Once every 12 months, from last date of service. Allowance includes supplies only.
Medically necessary lenses	Program pays 100% after \$10 Co-payment	\$155	Covered only with prior authorization from Benefits Administrator. If you require an additional exam due to a medical condition, Benefits may be available under

	<b>Network</b>	<b>Non-Network</b>	<b>Limitations and Exceptions</b>
			your medical program.
Contact Lens Examination Option - Fit and Follow-up	Not covered	Not covered	Discounts may be available, check with the Network Provider
<b>Other Services</b>			
LASIK Eye surgery	Not covered	Not covered	To obtain the name of a provider who participates in the discount LASIK offering contact the Frontier Benefits Service Center.

## VDT VISION CARE FOR ELIGIBLE EMPLOYEES

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If you use a Video Display Terminal (VDT) as part of your job, you are automatically covered under the VDT Vision Care portion of the Program as long as you enroll in the Program.

**IMPORTANT:** Only Active Employees are eligible for this coverage.

### Receiving VDT Benefits

To obtain VDT Vision Care Benefits you simply make an appointment with a vision Provider.

If you are receiving care from a Network Provider, the Program will pay him or her directly for covered charges. If you are receiving care from a Non-Network Provider, you will be reimbursed according to the Non-Network Provider level of Benefits in the Summary of VDT Vision Care Benefits table.

### Covered VDT Services and Appliances

The Program will cover the following VDT Benefits:

VDT Vision Examination — Analysis of the eyes and related structures to identify problems or abnormalities. Examinations are covered once every 12 months, from the last date of service.

Eyeglass Lenses — Eyeglass Lenses normally prescribed for use, such as single intermediate focal Lenses. Lenses are covered up to one pair per every 12-months, from the last date of service, if needed.

Eyeglass Frames — Special VDT eyeglass Frames are covered once every 24 months, from the last date of service. If you select a Frame that is more expensive than allowed, you will be responsible for paying the difference in cost.

**IMPORTANT:** Benefits payable under this part of the Program are in addition to those payable for the other vision services covered by the Program.

If you use a Network Provider, you pay a separate Copayment for each Examination and set of eyeglass Lenses and Frames provided.

If you combine your regular vision Examination and VDT eye Examination into one appointment, you will pay only one Copayment for both of the Examinations. However, you will be required to pay separate Copayments for covered regular vision care supplies and for covered VDT vision care supplies.

If you use a Non-Network Provider, you are required to pay for the full cost of the vision care services at the time of the service, but the Program will reimburse you

according to the Non-Network Provider level of Benefits described in the Summary of VDT Vision Care Benefits table above.

**What Is Covered**

The Program pays scheduled Benefits for:

One routine Examination with dilation, as necessary, or Contact Lenses Examination every 12 months from the last date of service.

One pair of prescription eyeglass Lenses or prescription Contact Lenses (conventional, disposable or medically necessary), subject to the Contact Lens allowance amount, every 12 months from the last date of service.

One Frame, if fitted and used with prescription Lenses, every 24 months from the last date of service.

The limits on the Benefits available within a 12- or 24-month period apply separately to you and each of your covered Eligible Dependents. The 12- or 24-month period, as applicable, begins on the last date of service. The limits apply regardless of whether you use a Network Provider or a Non-Network Provider. You can verify the last date of service for you and your dependents by logging into the Benefit Administrator’s website or by calling Customer Service.

The Program does not provide Benefits for both eyeglass Lenses/Frames and Contact Lenses during the same 12-month period. If the Program provides Benefits for Contact Lenses, you or your covered Eligible Dependent will not be eligible for the Frame Benefit during the 24-month period that begins on the date that you or your covered Eligible Dependent orders the prescription Contact Lenses.

See the “VDT Vision Care for Eligible Employees” section for information concerning the scheduled Benefits and limitations under the VDT Vision Care portion of the Program.

**Eligible Employees: Exclusions and Limitations**

Exclusions and Limitations	
General	Claims for Benefits submitted later than 12 months following the date of the service or the purchase of the supply occurred
	Examinations or supplies provided for any condition, disease, ailment or injury arising from, or in the course of, employment
	Examinations performed or Lenses and Frames ordered/purchased/submitted either (1) For an individual not covered under the Program (2) Before the individual became covered under the Program

<b>Exclusions and Limitations</b>	
	(3) After termination of the individual's coverage under the Program; or (4) Before the date of service the individual is eligible for that service or supply again.
	Services or supplies available from any government agency or covered by any government plan
	Services or supplies covered by any other health benefit program offered by the Company or by a safety lens program
	Services or supplies for which no obligation to pay exists or for which no charge would be made in the absence of Program Benefits
	Services or supplies not prescribed by a licensed Optometrist or Ophthalmologist or facility
	Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
Lens/Frames/Supplies	Charges for replacement of lost or broken Lenses (including Contact Lenses) or Frames before a 12- or 24-month period, as applicable, has passed since the date on which the supply was last ordered, from the last date of service
	Follow-up care, care kits, cleaners, solutions and subsequent office visits
	Drugs or any other medication
	Lens options (although Lens options are not covered by the Program, discounts may be available from Network Providers as part of their agreement with the Claims Administrator)
	Plano (nonprescription) Lenses, including sunglasses and Contact Lenses
	Additional charges for Oversized, Photosensitive or anti-reflective photochromatic or tinted, blended, progressive multifocal, cosmetic coated or laminated Lenses, whether or not medically necessary
	Two pairs of glasses in lieu of bifocals
Procedures/Treatments	Charges for services or supplies generally considered experimental, developmental or investigatory treatment
	Examinations or corrective eye wear required by the Company as a condition of employment

<b>Exclusions and Limitations</b>	
	Medical and/or surgical treatment of the eye, eyes or supporting structures
	Special or unusual treatment, including Orthoptic Training, Vision Training and associated supplemental testing, Subnormal Vision Aids, aniseikonic Lenses or Tonography
<p>The Program does not cover certain vision care services, supplies or expenses. These are called exclusions. The list of exclusions presented in this section applies to Network Providers and Non-Network Providers. If you have questions about whether a vision care service or supply is covered under the Program, contact the Benefits Administrator.</p>	

Some state or local laws may restrict the (1) scope of health care services that a provider may render and/or (2) the scope of health care items that a provider may prescribe or furnish. In such case, this Program will not cover such health care services or health care items. The plan (and each applicable 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.

## CLAIMS AND APPEALS PROCEDURES

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### KEY POINTS

- *Two types of Claims may be made and appealed under the Program: Claims for Eligibility and Claims for Benefits.*
- **Exhaustion of Administrative Remedies**

Before filing any claim (as defined below) in court or in another tribunal with respect to the 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, 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;
- An assertion that any entity or individual has breached any fiduciary duty;
- An assertion that 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.

### **Limitations on Actions**

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.

**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

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### 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. See the Frontier Benefits Service Center table in the "Contact Information" section. 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 Claims, along with any supporting documentation, with the Frontier Benefits Service Center.

You will be notified of the decision within 30 days of the date your Claim 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.

See the Frontier Benefits Service Center table in the “Contact Information” section for contact information.

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 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

## CLAIMS FOR BENEFITS

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### KEY POINTS

- *A Claim for Benefits is the initial request that is made to the Benefits Administrator 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.*

This section explains how to file a Claim for Benefits and how to file an Appeal if your Claim for Benefits is denied.

### 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.

An enrollment or eligibility request is not considered a Claim for Benefits. 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.

Generally, when you use Network Providers, you do not need to file Claims. Instead, in most cases, the Program will allow the Network Provider to file a Claim on your behalf, but the Program’s anti-assignment rules still apply. You will be notified if the Program will not accept a Claim filed by a Network Provider on your behalf. The Provider will collect any part of the cost of the services and supplies that will not be covered by the Program from you at the time of service or bill you for any amount not paid by the Program. You will receive an explanation of benefits (EOB) showing charges and Benefits paid.

If you choose to go to a Non-Network Provider when you need vision care, you must file a Claim for Benefits for covered services or supplies provided under the Program. The Provider will collect payment from you at the time of service or bill you. Claims for Benefits for expenses incurred by using a Non-Network Provider must be submitted to the Benefits Administrator using the Benefits Administrator’s claim form. The Benefits Administrator will reimburse you for covered services or supplies and will send you an EOB. You can request a claim form by contacting the Benefits Administrator. You can also download a claim form from the Benefits Administrator’s Web site. See the Benefits Administrator for the Program table in the “Contact Information” section for contact information.

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.

### ***Claim Filing Limits***

Your Claim for Benefits must be submitted within one year after the date of Service or the date you receive the prescription.

If the Program allows a Non-Network Provider or a Non-Network Retail Pharmacy to submit 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 your Claim for Benefits is not filed within this time period, Benefits will be denied or reduced at the Benefits Administrator's discretion.

You may be eligible for reimbursement through your Health Care FSA for expenses not covered by the Program. For more information, refer to the separate summary plan description for reimbursement accounts.

In no case will a Claim for Benefits be paid if filed more than 90 days after the end of the Plan Year during which the date of the service or the purchase of the supply occurred.

When you submit a Claim for Benefits, be sure to provide all the information requested on the Claim form and include the Provider's itemized bill. Keep a copy of the Claim form and itemized bill for your records.

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. Once a Claim for Benefits is approved, Benefits will be paid directly to you. Subject to the Program's anti-assignment rules, discussed below, the Benefits Administrator may also elect to pay your Provider. The Benefits Administrator will not reimburse third parties who have purchased or been assigned Benefits by Providers.

### **Time Period for Initial Determinations on Claims for Benefits**

Notification of an Adverse Benefit Determination on an initial Claim for Benefits will be made within 30 days of the Benefits Administrator's receipt of the Claim for Benefits. Notification may be in the form of an Explanation of Benefits (EOB).

In the event the Claimant fails to provide sufficient information for the Benefits Administrator to make a decision on the Claim for Benefits:

The extension notice to the Claimant will describe the specific information that is needed to enable the Benefits Administrator to make a decision on the Claim for Benefits;

The Claimant will have 45 days after the receipt of the extension notice to provide the Benefits Administrator with the specified information; and

The 45-day period of time for the Benefits Administrator to make a Benefit determination on the Claim for Benefits will be tolled from the date on which notification of the extension is sent to the Claimant until the date the requested information is received by the Benefits Administrator.

### ***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, or not Medically Necessary or appropriate. You have the right to appeal any Adverse Benefit Determination of the Claim 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, which may be in the form of an Explanation of Benefits (EOB). The notification will include all of the following:

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.

## How to Appeal an Adverse Benefit Determination on a Claim for Benefits

You have the right to appeal any Adverse Benefit Determination under the procedures described below. 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. This is referred to as a First Level Appeal.

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 Claim, you must contact the Benefits Administrator in writing to appeal.

**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 the Frontier Benefits Service Center.

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.

If the Program fails to meet the time requirements for your Claim for Benefits, your Claim for Benefits is deemed denied and you may begin an Appeal. If the Program fails to meet the time requirements for your Appeal of an Adverse Benefit Determination, your Appeal is deemed denied and you may pursue your Claim for Benefits in a civil action under ERISA.

You have the right to, upon request and free of charge, reasonable access to 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.

### ***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 the following information:

Your name

Patient's name and patient's identification number from his or her vision 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 vision services.

If the Adverse Benefit Determination was based on ineligibility to enroll or participate, the first-level appeal will be reviewed by the Frontier Benefits Service Center and the second-level appeal will be reviewed by the Plan Administrator. See the “How to Appeal a Denied Claim for Eligibility” above.

The Benefits Administrator or Frontier Benefits Service Center, as applicable, will make a decision on the first-level appeal of an Adverse Benefit Determination within 30 days after receipt of the appeal.

If an Adverse Benefit Determination is made by the Benefits Administrator or Frontier Benefits Service Center, as applicable, on the first-level appeal and the claimant is not satisfied with that decision, the claimant has the right to request a second-level appeal from the Benefits Administrator, as applicable. The Claimant’s request for a second-level appeal:

Must be made in writing within 180 days after the Claimant receives notification of the Adverse Benefit Determination on the first-level appeal; and

Must state, as clearly and specifically as possible, all issues that relate to the Claim for Benefits which is the subject of the appeal and all reasons why the Claimant believes the Adverse Benefit Determination on the first-level appeal is incorrect.

The second-level appeal of an Adverse Benefit Determination (excluding an Adverse Benefit Determination based on ineligibility to enroll or participate) should be submitted to the Benefits Administrator at the address stated previously in this section. A second-level appeal of an Adverse Benefit Determination based on ineligibility to enroll or participate should be submitted to the Plan Administrator through the Frontier Benefits Service Center.

The Benefits Administrator, as applicable, will make a decision on the second-level appeal of an Adverse Benefit Determination within 30 days after receipt of the request for review of the first-level appeal decision.

The Benefits Administrator will review the first-level and second-level appeals of an Adverse Benefit Determination, unless the Adverse Benefit Determination was based on your or your dependent’s ineligibility to enroll or participate in the Program.

## **Decisions on Appeals Involving Claims for Benefits**

The decision after each level of the appeal of an Adverse Benefit Determination on a Claim for Benefits will be communicated in writing to the Claimant. In the event that an Adverse Benefit Determination is made on the appeal, the Benefits Administrator or the Frontier Benefits Service Center, as applicable, will provide written notification to the Claimant which will include all of the following:

Specific reasons for the denial.

Specific reference to the Program provisions upon which the Adverse Benefit Determination 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.

A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

A qualified individual who was not involved in the decision to deny your initial claim or to review your first appeal will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field and who was not involved in the initial determination. The Benefits Administrator may consult with, or seek the participation of, vision experts as part of the appeal resolution process.

When you file your claim or appeal, you consent to this referral and the sharing of pertinent vision claim information.

## **Scope of Review — Claims for Benefits**

Except for appeals based on ineligibility to enroll or participate in the Program, an Appeal of an Adverse Benefit Determination:

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.

Follow reasonable procedures to verify that its Benefit determination is made in accordance with the applicable Program documents.

Follow reasonable procedures to ensure that the applicable Program provisions are applied to the Claimant in a manner consistent with how such provisions have been applied to other similarly situated Claimants.

The Benefits Administrator shall serve as the final reviewer under the Program for all Claims for Benefit except those that have been denied based on ineligibility to enroll or participate in the Program. The Plan Administrator shall serve as the final review committee under the Program for all Claims for Benefits that have been denied based on eligibility to enroll or participate in the Program. In their respective capacities, the Benefits Administrator and the Plan Administrator shall have sole and complete discretionary authority to determine conclusively for all parties and, in accordance with the terms of the documents or instruments governing the Program:

Any and all questions arising from the administration of the Program and interpretation of all Program provisions.

All relevant facts.

The construction of all terms of the Program.

The Benefits Administrator shall also have sole and complete discretionary authority to determine (i) all questions relating to eligibility for Benefits and (ii) the amount and type of Benefits to be provided to any Eligible Employee or covered Eligible Dependent. The Plan Administrator shall also have sole and complete discretionary authority to determine all questions relating to eligibility for enrollment and participation of Employees and their dependents. Respective decisions on appeals of Adverse Benefit Determinations by the Benefits Administrator and the Plan Administrator shall be conclusive and binding on all parties and not subject to further review.

In any case, as an Employee/Eligible Former Employee or Eligible Dependent covered under the Program, you may have further rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA). See the “ERISA Rights of Participants” section.

A Claimant must pursue all the Claim and appeal rights described above before seeking any other legal recourse regarding Claims for Benefits.

**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

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### 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.*

### Receiving Benefits From Other Coverage

You may be eligible to receive Benefits for vision care services and supplies from the Program and another source. This can happen if you or any of your covered Eligible Dependents have coverage under both the Program and another plan that provides benefits for vision care services and supplies. It can also happen if the Program pays Benefits and you later receive a legal settlement that includes all or part of the cost of your vision care. This section explains how Benefits are determined in these circumstances.

### When Coordination of Benefits Applies

The Program contains a provision called “coordination of benefits” (COB). This feature coordinates benefits from all group plans covering you and your covered Eligible Dependents to prevent duplication of vision care benefit payments. Under COB, the total benefits paid by all plans combined will not exceed 100 percent of the Allowable Amount of your vision care expenses. See the “How COB Works” section for additional information.

The COB feature applies when you are eligible for vision care benefits (in addition to those provided under your Program) from another source, such as:

A group-sponsored insurance or prepayment plan.

A government-sponsored plan.

COB rules apply to all of your covered Eligible Dependents. However, COB doesn't apply to any personal insurance policy (except no-fault or other state-mandated automobile insurance).

### Determining Which Plan or Program Pays First

Under the COB provision, the Claims Administrator follows standardized rules to determine which plan is “primary” and which plan is “secondary.” Under this provision, the primary plan pays benefits first. After the primary plan has processed your claim, you can then submit your claim to the secondary plan, along with the Explanation of Benefits you received from the primary plan and the Provider's itemized bill. This is how primary and secondary plans are determined:

When the other plan doesn't have a COB provision, that plan is considered primary and the Program is secondary.

When both plans have COB provisions, one plan must be designated as the primary plan. The determination is generally made in accordance with the following guidelines:

A plan that covers the Claimant as an active employee is primary over a plan that covers the Claimant as a former employee.

A plan covering the Claimant as an active or eligible former employee is primary over a plan that covers the Claimant as a dependent.

### Special Rules

Even if the Program is your normal primary or secondary health plan, in all events any worker's compensation coverage, the health or other compensation component of a personal umbrella insurance policy or contract, the health 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)**

For Eligible Dependent Children, determining primary and secondary coverage follows this sequence:

The plan covering the parent whose birthday comes first in the year (month and day) is the primary plan for the Children; the plan covering the other parent is secondary for the Children. This is called the birthday rule. The program uses this rule. If both parents have the same birthday, the primary plan is the plan that has covered the parent for the longer period of time.

In plans that don't include the birthday rule, the father's group insurance is the primary plan for the Children; the mother's group insurance is secondary for the Children. This is called the male-female rule.

If one parent is covered by the male-female rule and the other by the birthday rule, the male-female rule applies to the extent permitted by applicable law.

## **COB If the Parents Are Divorced or Legally Separated**

If the parents of Eligible Dependent children are divorced or legally separated, the claims Administrator will determine if there is a court decree of Qualified Medical child support Order (QMCSO) establishing financial responsibility for vision care:

If there is such a decree of QMCSO, the plan covering the parent who has that responsibility will be the primary plan.

If there is no decree of QMCSO, the plan that covers the parent with custody will be the primary plan; the other parent's plan will be secondary.

If there is no decree or QMCSO and the parent with the custody remarries, that parent's plan remains primary; the stepparent's plan is secondary. The noncustodial parent's plan is third.

If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan.

Refer to the 'Qualified Medical Child Support Orders' section for more information.

## **How COB Works**

When you are covered by more than one group plan that provides vision care benefits, you should always submit claims to the primary plan first. Then, when you submit your claims to the secondary plan, include the explanation of benefits statement you received from the primary plan along with the itemized bills.

When the Program is the primary plan, it will pay Benefits as specified in the Program. If the Program is the secondary plan, then the Program will coordinate Benefits with the primary plan to ensure that the benefits payable under both plans do not exceed 100% of the Participants Allowance so the total amount reimbursed by both plans will equal the amount payable by the more generous of the two plans. If service frequency maximums apply, the services covered under the primary plan will be counted toward the frequency maximum under the Program.

## **Example: How COB Works**

Here's an example of how COB works when the Program is the secondary coverage plan.

<b>Example of How COB Works</b>	
<b>Primary Coverage Plan</b>	Your Spouse's plan because your Spouse is the patient
<b>Secondary Coverage Plan</b>	The Program
<b>Vision Service</b>	Your Spouse purchases new Contact Lenses from a Network Provider

<b>Example of How COB Works</b>	
<b>Network Provider's Charge for the Service</b>	\$100
<b>Primary Coverage Plan Benefit</b>	\$80 (80% x \$100 = \$80)
<b>Program Benefit If It Is the Primary Coverage Plan</b>	\$80
<b>Vision Benefit After Coordination of Benefits</b>	\$20 (Allowance for vision care expense of \$100 minus the primary coverage plan payment of \$80 = \$20)

## **EXTENSION OF COVERAGE - COBRA**

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### **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 the Frontier Benefits Service Center. See the Frontier Benefits Service Center table in the “Contact Information” section for contact information.

## **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.

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 of a Participating Company and are 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 an 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 continuation 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 COBRA Administrator in a timely manner that a Qualifying Event has occurred.

### ***Your Employer's Notice Obligations***

When the Qualifying Event is one of the following, your employer 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 COBRA Administrator 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 paid.

If the COBRA Administrator is provided with timely notice of a Qualifying Event that has caused a loss of coverage for a Spouse/Partner or Child, then the COBRA Administrator will send a COBRA Enrollment Notice to the last known address of the individual who has lost coverage. The COBRA Administrator 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

Eligible Former Employee's death

Eligible Former Employee becomes entitled to Medicare (Part A, Part B or both)

## **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 (after any pre-existing condition exclusion in that other plan ends) or becomes enrolled in Medicare. If this occurs, the other Qualified Beneficiaries may still elect COBRA continuation coverage.

## **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 the Frontier Benefits Service Center 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 from the Frontier Benefits Service Center. 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. Subsequent premiums are due 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.

<b>COBRA Events</b>	
<b>Event</b>	<b>Length of Coverage</b>
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*

COBRA Events	
Event	Length of Coverage
<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 or insurance 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 the Frontier Benefits Service Center 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 continuation 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 the COBRA Administrator 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 the Frontier Benefits Service Center 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).

#### ***Conversion Policy Not Available***

No conversion of Program coverage to an individual policy is available to a Qualified Beneficiary at the end of the 18-, 29- or 36-month period of COBRA continuation coverage, or at any earlier time when COBRA continuation coverage for the Qualified Beneficiary ends.

### **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) that has no exclusion or limitation with respect to any pre-existing condition that you have. If the other plan/program has applicable exclusions or limitations that would make your COBRA continuation coverage continue to be of value to you, then your COBRA continuation coverage will terminate after the exclusion or limitation no longer applies. 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 Prospective Enrollment 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***

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. 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 during 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).

## **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 [dol.gov/ebsa](http://dol.gov/ebsa) (EBSA’s website).

## **Contact Information**

For contact information for the COBRA Administrator, see the Frontier Benefits Service Center table in the “Contact Information” section. For contact information for the Plan Administrator, see the Other Plan Information table in the “Plan Information” section.

## PLAN ADMINISTRATION

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### 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 and for bringing a court action.*
- *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 Claims 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.

## **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 your Participating Company or any other Frontier-affiliated Company.

## **Legal Action Against the Plan**

If you wish to bring any legal action concerning your right to participate in the Plan or your right to receive any Benefits under the Plan, you must first go through the Claims and Appeals process described in this SPD. You may not bring any legal action against the Plan for any denied Claim until you have completed the Claims and Appeals process, except as provided in the "Claims and Appeals" section of this SPD. Legal action involving a denied Claim for Benefits under the Plan must be filed directly against the Plan. The Plan Administrator is the Plan's agent for receipt of legal process in legal actions for Benefits under the Plan, as provided in the Plan Information table below.

Any claims or action that is filed in a court or other tribunal against or with respect to the Plan or the Plan Administrator must be brought within the following timeframes:

- For any claim or action relating to vision benefits, the claim or action must be brought within three years of the date the supply was furnished or the service was rendered.
- For all other claims (including eligibility claims), the claim or action must be brought within two years of the date when you know or should know of the actions or events that gave rise to your claim.

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. Your address 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.

For employees on a disability, a leave of absence or former Employees, if your mailing address or contact information changes, you must promptly report your address change to the Frontier Benefits Service Center.

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 if 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 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.

**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.

<b>Other Plan Information</b>	
Plan Name	Frontier Communications Health Care Plan No. 505
Program Name	Frontier CWA 1298 Vision Program
Plan Number	505
Plan Sponsor/Employer Identification Number (EIN)	Frontier Communications 2 Washington Street Norwalk, CT 06854 <a href="mailto:Frontier.Benefits.Team@ftr.com">Frontier.Benefits.Team@ftr.com</a> EIN 86-2359749
Plan Administrator	Frontier Communications Attn: Plan Administrator 2 Washington Street Norwalk, CT 06854 <a href="mailto:Frontier.Benefits.Team@ftr.com">Frontier.Benefits.Team@ftr.com</a>
Name and Address of Employer	Frontier Communications 2 Washington Street Norwalk, CT 06854 <a href="mailto:Frontier.Benefits.Team@ftr.com">Frontier.Benefits.Team@ftr.com</a>
Type of Administration	The Plan Administrator has contracted with third parties for certain functions associated with the Program.  Claims and Appeals for Benefits under the Program are administered on a contract basis with the Benefits Administrator, see the "Contact Information" section for more information. The Benefits Administrator has full discretionary authority to interpret Plan provisions as they apply to entitlement for benefits.

<b>Other Plan Information</b>	
	<p>The Plan Administrator administers enrollment, eligibility, monthly contribution and COBRA under the Program provisions, including the determination of initial Claims for eligibility, through the Frontier Benefits Service Center.</p> <p>The Plan Administrator determines final Appeals from the denial of eligibility. The Plan Administrator has full discretionary authority to interpret Plan provisions as they apply to eligibility for benefits.</p>
Agent for Service of Legal Process	<p>Frontier Communications            Attn: General Counsel            2 Washington Street            Norwalk, CT 06854</p>
Type of Plan	The Plan is an employee welfare benefit plan providing vision benefits
Plan Year	Jan. 1 through Dec. 31
Plan Funding and Contributions	Certain Participating Company Employees and Employees share in the cost of the Program. The Program is a self-insured Program; benefits are not paid by insurance.
Plan Records	Jan. 1 and ending Dec. 31.
Collectively Bargained Plan	<p>With respect to certain Eligible Employees, the Program 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.</p>

### ***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 with this Program, as described below. Benefits are paid from Frontier's general assets. The Benefits Administrators below do not insure Benefits provided under the Program.

#### **Benefits Administrator**

The Plan Administrator administers Claims and appeals for vision Benefits under this Program on a contract basis with EyeMed Vision Care. The Plan Administrator has discretionary authority to interpret the provisions of the Program and to determine entitlement to vision Benefits. Benefits are payable only if the Benefits Administrator determines they are payable.

#### **Frontier Benefits Service Center**

The Plan Administrator administers enrollment, eligibility, monthly contributions and COBRA under the Program provisions, including the determination of initial Claims of 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.

*Note: Contact information for the above Benefits Administrators and the Frontier Benefits Service Center is located in the "Contact Information" section.*

### **No Assignment of Rights and Benefits**

Your rights and benefits under the program 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 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 (internal and external), 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 benefits administrator to a 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 provider;
- Shall apply at all times, including before and after services are rendered or the products are provided (as applicable);

- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the plan, the plan administrator or a benefits 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 Provider Agreements**

To the extent allowed by the benefits administrator, you may authorize your benefits administrator to make payments directly to a provider for covered services. Further, even without such authorization, a benefits administrator may make direct payments to a provider for covered services according to the benefits administrator's rules and procedures at the applicable time. Authorization of payments to a provider or direct payments to a provider are not assignments of benefits. Even though you may authorize a provider to receive a payment or reimbursement of covered services and even though a benefits administrator may pay a 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 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 provider requests that you sign various agreements and other documentation as a condition of receiving services from the provider. Any agreement, assignment or other document executed by you and a provider (or executed by parties that include you and a 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 benefits administrator. Further, a payment or reimbursement of covered services by a benefits administrator to a 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 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 the plan, the plan administrator or a benefits 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, you must follow the rules and procedures of the applicable benefits administrator for such claim or appeal. To the extent a benefits 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,
- Satisfy any other legal requirement applicable to appointments under state or federal law, AND
- Be approved by the Plan Administrator in writing.

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 benefits administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

## **Reimbursing the Plan**

If you suffer a loss or injury caused by the actions or omissions of a third party, that third party may be responsible for paying your health expenses. 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 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., supplemental policies). 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. Your insurance company may also be a third party. You will be required to provide the plan or its agents information concerning any claim or lawsuit you may have against a third party for injury caused by that party. You must also provide the plan or its agents any documents or information relevant to the protection of the plan’s rights of reimbursement.

You agree to cooperate fully with the plan’s efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You agree to provide the plan or its representatives notice of any third party proceeds or other recovery you obtain prior to receipt of such funds or within 5 days if no notice was given prior to receipt. Further, you agree to provide notice prior to any disbursement of third party proceeds or any other recovery of funds. You shall provide all information requested by the plan, the benefits administrator or its representative including, without limitation, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. You shall do nothing to prejudice the plan’s subrogation or recovery interest or prejudice the plan’s ability to enforce the terms of any plan provision. This includes, without limitation, refraining from making any settlement or recovery that attempts to reduce or exclude the cost of any or all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the plan’s reimbursement interest.

If you do not cooperate as required or requested, the benefits administrator may terminate your injury-related benefits from and after a certain date even if your injury-related benefits were approved before that date. 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) by the amount of the third party proceeds and may initiate actions to collect prior plan benefits that were paid. 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.

The plan may initiate legal action against you (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 health expenses. The plan is entitled to recover from any and all settlement or judgements, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's reimbursement claim shall not be reduced due to your own negligence. Further, 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 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, 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 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 and any other person or entity holding the proceeds, including a legal representative or trust.

- 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 hereby submit to each jurisdiction regardless of your current or future residence.
- An assignment to the plan of any benefits or claims or rights of recovery you have under any insurance policy or other coverage to the full extent of the plan's reimbursement claims.

Third party proceeds held directly or indirectly by you are intangible assets of the plan and are held by you 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. No disbursement of third party proceeds or other recovery funds from any insurance coverage or other source shall be made until the plan's right of reimbursement interest is fully satisfied.

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**

If a benefit payment is made under the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment from any person, insurance company or other entity or organization to whom the overpayment was made; and/or
- Reduce and/or offset current and/or future plan benefits (including those of another person in the family) at any time to recover the overpayment.

The reduction and/or offset noted above shall be accomplished by the plan as a right of administrative set off without the need to initiate any legal action. Such reduction and/or offset may occur from and after a designated date, even if plan benefits were not reduced and/or offset prior to a designated date.

An "overpayment" includes – (1) any payment of plan benefits received by or on behalf of yourself or a dependent, which you or a dependent is not entitled to under the terms of the plan, (2) any payment of plan benefits received by or on behalf of yourself or a dependent, which are in excess of the amount necessary to satisfy the requirements of this plan, and (3) 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 dependent and you or the dependent has failed to remit all or a portion of the previous payment(s) to the provider. Overpayments also include any legal costs, attorneys' fees and court costs incurred as a result of or relating to the overpayment.

This right does not affect any other right of recovery the plan may have with respect to overpayments.

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**

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### **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 including vision coverage under this Program 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

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### KEY POINTS

- *This section describes various laws that may impact your right to Program Benefits.*
- *Some laws provide specific Program eligibility rights.*
- *Certain laws protect the privacy and security of your protected health 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.

## **IMPORTANT NOTICES ABOUT YOUR BENEFITS**

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### **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.

## CONTACT INFORMATION

<b>Contact Information</b>	
<b>Benefits Administrator</b>	
Name	EyeMed
Type	Vision
Services Provided	Vision Benefits Administration
<b>Benefits Administrator Contact Numbers</b>	
Domestic Telephone Number	<b>866-723-0514</b>
<b>Benefits Administrator Hours of Operation</b>	
Hours of Operation	<b>Service Center:</b> Mon-Fri - 8AM - 11PM, Saturday 11:00AM - 4PM, Sunday 12:00PM - 4AM
<b>Benefits Administrator Website</b>	
Website	<a href="http://www.eyemed.com">www.eyemed.com</a>
Website Access Information	When you access the website for the first time, you will be asked to register. After you have completed the registration, you will have immediate access to the site. Through <b>eyemed.com</b> , you can Locate a Provider, check eligibility, find Benefits information and download a Non-Network Benefits Claim form.
<b>General Mailing Address</b>	
Mailing Address Information	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040
<b>Claims</b>	
Claims Regular	FAA/EyeMed Vision Care, LLC Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 Attn: Claims Department

<b>Contact Information</b>	
<b>Appeals</b>	
Appeals Regular	FAA/EyeMed Vision Care, LLC Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Fax: (513) 492-3259
<b>Special Instructions</b>	
Instructions	<p>If you use Non-Network Providers, you will have to file a Claim for Benefits. Refer to the "Claims for Benefits" section for information concerning the Program's procedures for submitting and processing Claims and appeals.</p> <ul style="list-style-type: none"> <li>• Claim forms are available through eyemed.com (the EyeMed website - registration is required); or</li> <li>• The EyeMed Customer Service Center at the telephone number provided in this table.</li> </ul> <p>To use a Claim form, you must</p> <ul style="list-style-type: none"> <li>• Complete the Claim transmittal form; and</li> <li>• Mail the form and the vision care bills to the address on the form.</li> </ul> <p><b>IMPORTANT:</b> Claims for Benefits must be submitted no later than 12 months after the date of the service or the purchase of the supply. Claims for Benefits submitted after the filing deadline will not be considered for reimbursement.</p> <p>Remember to keep a copy of your Claim for Benefits for your records.</p>

<b>Vendor</b>	
Name	<b>Frontier Benefits Service Center</b>
Type	Plan Administration / Eligibility
Services Provided	Eligibility, enrollment, contributions, billing and COBRA processing
<b>Vendor Contact Numbers</b>	
Domestic Telephone Number	<b>(855) 387-2887</b>
<b>Vendor Hours of Operation</b>	
Hours of Operation	<b>Service Center:</b> Monday through Friday 9 a.m. to 6 p.m. Eastern time.
<b>Website</b>	<a href="http://www.frontierbenefitscenter.com">http://www.frontierbenefitscenter.com</a>
<b>Vendor Mailing Address</b>	Empyrean c/o Frontier Benefits Service Center PO Box 2607 Bellaire, TX 77402

## DEFINITIONS

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**Active Employee.** An Employee who is on a Participating Company's active payroll, regardless of whether such Employee is currently receiving pay.

**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.

**Allowances.** The portion of a Provider's charge that is eligible for reimbursement either in full or in part.

**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.

**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.

**Benefits.** Payments for covered services or supplies 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 at a Glance.** A list of covered services and supplies and the maximum dollar amount the Program will pay in Benefits for each.

**Bifocal Lenses.** Lenses containing two foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

**Blended Lenses.** Bifocal lenses having two distinct powers; one on the top for distance and one of the bottom for near. The blended bifocal is where the line is blended, appearing invisible.

**Change-in-Status Event.** Certain life events such as marriage, birth of a Child, loss of benefits under another employer's vision 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.

**Claimant.** A Participant of the Participant's authorized representative who has submitted a Claim for Benefits under the Program.

**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.

**Common Law Marriage.** A marriage occurring in a state recognizing common-law marriages and satisfying the specific minimum state requirements to be considered married under common law.

**Company.** Frontier and affiliates that are Participating Companies, former Participating Companies, 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.

**Contact Lenses.** The prescription lenses that fit directly on the eyeball under the eyelids.

**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 for more information.

**Co-pay (Co-payment).** The fixed amount you are required to pay generally at the time care is received for the eye exam and/or supplies.

**Cost of Coverage.** The total cost of the Program on which your specific contributions are based, if applicable.

**Course of Treatment.** The continuous treatment of a person for a condition. Coverage Plan. See the “Coordination of Benefits” section.

**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.

**Disabled Child(ren).** Your Child who is over the limiting age and meets the requirements to be eligible for Program coverage due to disability. See the “Eligible Dependents” section for more information.

**Disability Pensioner or Disability Service Pensioner.** A former employee who terminated employment from the Frontier Controlled Group and was granted a disability pension or disability service pension under a Company management pension plan.

**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; and

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.

**Domestic Partner’s Child(ren).** The Child(ren) of your Domestic Partner. See the “Eligible Dependent” section for information and enrollment requirements.

**Dual Enrollment.** See the “Dual Enrollment” section for more information. East Region. The states of Connecticut, Massachusetts and Rhode Island.

**Eligible Dependent.** An individual who is eligible to participate in the Program as described in the “Eligible Dependents” section.

**Eligible Employee.** An Employee of a Frontier Participating Company who satisfies the conditions for eligibility to participate in the Program set forth in the “Eligibility and Participation” section.

**Eligible Former Employee.** An Employee who has terminated employment with a Participating Company or former Participating Company and who meets the eligibility requirements for Program coverage described in the “Eligible Former Employees” (or Retiree) SPD.

**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 Participating Company, in exchange for services rendered to that Frontier 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 Frontier 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 Frontier 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 Frontier Participating Company, even if such individual is later determined (by judicial action or otherwise) to have been a common-law employee of a Frontier 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 Frontier 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.

**Examination.** Examination means, but is not limited to, these component services when performed by an Ophthalmologist or Optometrist, including: (1) case history; (2) external examination of the eye and adnexa; (3) determination of refractive status; (4) ophthalmoscopy; (5) application of pharmaceutical agents for diagnostic purposes when indicated and allowed by state law; (6) tonometry test when indicated; (7)

binocular measure; (8) summary findings and recommendations; and (9) prescribing corrective Lenses, if needed.

**Explanation of Benefits (EOB).** A statement you receive after a Benefits Administrator has processed your Claim for Benefits. 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.

**Family Coverage.** Coverage for a Covered Person and more than one dependent as described in the “Levels of Coverage” section.

**FMLA.** The Family Medical Leave Act, as amended from time to time.

**Frames.** Standard eyeglass frames adequate to hold two prescription Lenses.

**Frontier Controlled Group.** Frontier Controlled Group includes any of the following:

- 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.

**Full-Time Student.** A student is considered full-time if he or she is unmarried and taking 12 or more credit hours per semester (or the equivalent) at an accredited institution. If your Child is no longer a full-time student, you must notify the Frontier Benefits Service Center. See the Frontier Benefits Service Center table for additional information on this process.

**HIPAA.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended from time to time including any applicable regulations and rulings.

**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 Sickness, including all related conditions and recurrent symptoms.

**Legal Guardian or Legal Guardianship.** A legally declared guardian under applicable state law between you and/or your Spouse/Partner and a Child, if a court of competent jurisdiction has issued a guardianship order assigning to you and/or your Spouse/Partner sole and exclusive care, custody and control of the Child, as well as exclusive financial and legal responsibility for the Child.

**Legally Recognized Partner (LRP).** Any individual:

Who is a Registered Domestic Partner (RDP), 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 civil union or other legally recognized arrangement that provides similar legal benefits, protections and responsibilities under state law to those afforded to a Spouse.

**Lens or Lenses.** An ophthalmic corrective lens, either glass or plastic, ground or molded, as prescribed by an Ophthalmologist or Optometrist, to be fitted into a Frame.

**Low Vision Devices.** Lenses or optical devices such as hand-held magnifiers and other high-magnification devices for a person with little correctable sight.

**Medicaid.** The program providing health care benefits under Title XIX of the Social Security Act of 1965, as amended.

**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.

**Modified Rule of 75.** A post-employment eligibility provision under the Program. See the “Eligible Former Employees” section for information.

**Network Provider.** Any doctor of optometry or ophthalmology licensed to render vision care services and practicing within the scope of that license who acts as an independent contractor for the Benefits Administrator, and has agreed to limit his or her charges to Participants for most covered services and supplies.

**Non-Network Provider.** Any doctor of optometry or ophthalmology licensed to render vision care services and practicing within the scope of that license but who is neither a member nor a participant in the Benefits Administrator’s Vision Network.

**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.

**Ophthalmologist.** A licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his or her license, performs vision Examinations and prescribes Lenses to improve visual acuity.

**Optician.** A person qualified in the state in which the service is rendered to supply eyeglasses according to prescriptions written by an Ophthalmologist or Optometrist, to grind or mold Lenses or have them ground or molded according to prescription, to fit them into a Frame and to adjust the Frame to fit the face.

**Optometrist.** Any doctor of optometry who is legally qualified to practice optometry in the state in which vision care services are rendered, perform Examinations and prescribe Lenses to improve visual acuity.

**Orthoptic Training.** A series of scientifically planned exercises for developing or restoring coordinate ocular movements.

**Oversized Lenses.** Generally means glass Lens Blanks with a diameter exceeding 66 millimeters or a plastic Lens Blanks with a diameter exceeding 68 millimeters.

**Participating Company.** Any Frontier Controlled Group member which has elected to participate in the Program subject to approval by Frontier.

**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.

**Payroll.** The system used by an entity to pay those individuals it considers Employees and to withhold employment taxes from the compensation it pays those Employees. "Payroll" does not include any system that an entity uses to pay individuals whom it does not consider its Employees and for whom it does not actually withhold employment taxes (including individuals whom it regards as independent contractors).

**Photosensitive Lenses.** Lenses that tint in the presence of light. In bright illumination, the Lenses darken; in dim illumination, the Lenses lighten. The Lenses may be worn continuously and do not require a change from one environment illumination to another. Photochromic Lenses are a type of Photosensitive Lenses.

**Plan.** The Frontier Communications Health Care Plan. References to the Program include the Plan, and references to the Plan include the Program.

**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 "If You Are Retiring From the Company" subsection of "When Coverage Ends" for information.

**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 doctor of optometry or ophthalmology licensed to render vision 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.

**Represented Employee.** An Employee:

Whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union; or

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.

**Service Pensioner.** A former Employee who satisfies the conditions for a ‘Service Pensioner’ described in the ‘Eligibility and Participation’ section.

**Spouse.** The person to whom you are legally married under applicable state or foreign law, including through Common Law Marriage. (Civil unions are not considered marriages for this purpose.)

**Standard Progressive Lenses.** Bifocal Lenses or Trifocal Lenses that are line-free. The power gradually changes from distance vision to intermediate vision to near vision moving invisibly from the top to the bottom of the Lens.

**Subnormal Vision Aids.** Aids relating to a set of procedures involving patients who are partially sighted, partially blind or legally blind. Subnormal Vision Aids are special Lens forms, such as ocular microscopes, ocular telescopes, hand-held magnifiers and other ophthalmic devices that include very high ocular prescriptions. Patients with low-vision aids are given special instructions in order to accommodate their special visual needs. Subnormal Vision Aids are sometimes called low-vision aids.

**Summary Plan Description (SPD).** Each of the Program descriptions that are required by Section 102 of ERISA that provide a summary of the vision 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.

**Trifocal Lenses.** Lenses containing three foci, usually arranged with the focus for distance above, for intermediate distance in the middle and for near vision below.

**Vision Training.** A set of procedures involving visual reeducation, visual posturing and visual exercises used to alleviate problems related to the efficient coordination of both eyes. These problems may include convergence, insufficiency, amblyopia and visual skills.

## 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.

#### ***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.

For specific information about dependent eligibility, see the “Eligible Dependent” information detailed in the “Eligibility and Participation” section.

<b>Change in Legal Marital or Partnership</b>	<b>Changes</b>	<b>Notes</b>
Status	Permitted	
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 vision plan.
Death of Spouse/Partner’	AD, C, DD, DS, E	E, AD: Only if you lose coverage under your Spouse/Partner’s vision plan. DD: Only if other dependent loses coverage under your Spouse/Partner’s vision 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 vision plan. DD: Only if dependent loses coverage under your Spouse/Partner’s vision 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.

<b>Change in Number of Child</b>	<b>Changes</b>	<b>Notes</b>
Dependent(s)	Permitted	
Birth, Adoption or Placement for Adoption	AD, AS, C, E, W, DD, DS	W: Only if vision coverage is effective under your Spouse/Partner's vision plan.
Death of Child Dependent'	DD	You may only drop the deceased dependent.

#### ***\*If a Dependent Dies***

If your dependent dies, you must notify the Frontier Benefits Service Center. 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.

<b>Change in Dependent Status</b>	<b>Changes Permitted</b>	<b>Notes</b>
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.

<b>Change in Employee Employment Status</b>	<b>Changes Permitted</b>	<b>Notes</b>
Gain of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	AD, AS, E	Only if eligibility for vision 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.

<b>Change in Employee Employment Status</b>	<b>Changes Permitted</b>	<b>Notes</b>
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 vision 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 vision 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.

<b>Change in Spouse/Partner or Dependent’s Employment Status</b>	<b>Changes Permitted</b>	<b>Notes</b>
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 vision 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 vision plan.
Change in Work Schedule that Triggers a Loss of Eligibility Under their Employer’s Vision Plan	AD, AS, C, E	AD, AS, E: Only with respect to the individual who lost coverage under another employer’s plan.

<b>Change in Spouse/Partner or Dependent's Employment Status</b>	<b>Changes Permitted</b>	<b>Notes</b>
Change in Work Schedule that Triggers a Gain of Eligibility under their Employer's Vision 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 vision benefit option under the Program.

<b>Change in Residence</b>	<b>Changes Permitted</b>	<b>Notes</b>
Relocation Triggers Gain in Eligibility	AD, AS, E	
Relocation Triggers Gain in Vision 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 Vision 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 vision coverage for you, your Spouse/Partner or dependent if any of you gain or lose coverage under another employer's vision plan.

Change in Benefit Coverage	Changes Permitted	Notes
Gain of Vision Coverage under Another Employer's Plan	DD, DS, C, W	
Loss of Vision Coverage under Another Employer's Vision Plan	AD, AS, C, E	AD, AS: Only with respect to the Spouse/Partner or dependent who lost coverage under another employer's vision 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 vision plan.
You Gain Eligibility Under Another Employer's Vision Benefit Plan(s)	DD, DS, W	If Employee, Spouse/Partner and/or dependent coverage under other employer's vision plan is effective.
You Lose Eligibility Under Another Employer's Vision 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	

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance	Changes Permitted	Notes
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 vision 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 vision plan.

Enrollment changes may include revoking existing coverage and enrollment in a similar alternative coverage or waiving coverage altogether.

If the cost of a vision option significantly decreases, eligible individuals who have not enrolled in the Program may enroll. Those already enrolled in the Program may change their current vision option to the option with the lower cost.

The Frontier Benefits Service Center generally will notify you of increases or decreases in the cost of vision coverage.

If there is an insignificant increase or decrease in the cost of your current vision option, the Frontier Benefits Service Center may automatically adjust your enrollment contributions to reflect the minor change in cost and you will not be permitted to change your vision coverage.

Change in Cost	Changes Permitted	Notes
Significant Increase in Cost of Your Vision Benefit Option	AS, AD, C*, DD, DS, E, W  <i>*Only if Company contributions cease</i>	May change enrollment to match cost increase  OR  W and AD, AS, E: Another vision benefit option providing similar coverage  OR

<b>Change in Cost</b>	<b>Changes Permitted</b>	<b>Notes</b>
		W, DD, DS: If no other vision benefit option provides similar coverage
Significant Decrease in Cost of Your Vision 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 vision benefit option and add the vision benefit option with decreased cost
Increase in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, C*, E	<i>*Only if Company contributions cease</i>
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 Vision 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.

<b>Change in Enrollment Under Another Employer's Plan</b>	<b>Changes Permitted</b>	<b>Notes</b>
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.

Change in Enrollment Under Another Employer's Plan	Changes Permitted	Notes
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.  <i>*Only if Company contributions cease</i>

***Addition or Significant Improvement of Benefit Plan Option***

You may change your enrollment if the Program adds a new vision benefit option or significantly improves an existing vision benefit option; the Plan Administrator may permit you to enroll in the new or improved vision benefit option.

If a vision 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 vision 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 Vision Benefit Option	AD, AS, DD, DS, E, W	DD, DS, W then AD, AS, E: May drop current vision benefit option and elect the new or significantly improved vision benefit option.  AD, AS: If previously enrolled in a vision benefit option, you may elect the new or significantly improved vision benefit option.
Addition or Significant Improvement of Vision 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 vision benefit option even if there is no loss of coverage. An enrollment may be changed to a different vision 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 Vision 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.

<b>Change Due to Medicare or Medicaid</b>	<b>Changes Permitted</b>	<b>Notes</b>
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.

<b>Change Due to LOA</b>	<b>Changes Permitted</b>	<b>Notes</b>
You begin an LOA	DD, DS, W	Whether paid or unpaid whether FMLA or nonFMLA.
You return from an LOA	AD, AS, E	Whether paid or unpaid whether FMLA or nonFMLA.
Spouse/Partner or Dependent Begin an Unpaid LOA (including a FMLA leave) Resulting in a Loss of Eligibility under Another Employer's Vision 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 Vision 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.

<b>Change Due to LOA</b>	<b>Changes Permitted</b>	<b>Notes</b>
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 vision 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 vision coverage of a dependent between ex-Spouses.

<b>Change in Coverage Under a Judgment, Order or Decree</b>	<b>Changes Permitted</b>	<b>Notes</b>
QMCSO or Court Order Requiring You to Cover a Dependent	AD, C	QMCSO or Court Order Requiring You to Cover a Dependent
QMCSO or Court Order Requiring Another Individual to Cover Your Dependent	DD	QMCSO or Court Order Requiring Another Individual to Cover Your Dependent
Expiration or Termination of a QMCSO or Court Order	W, DD, C	Expiration or Termination of a QMCSO or Court Order

***Change in COBRA Continuation Coverage***

<b>Change in COBRA Continuation Coverage</b>	<b>Changes Permitted</b>	<b>Notes</b>
Mid-Year Expiration of Maximum Coverage	AD, AS, C *Only if there is a loss in	You must exhaust the maximum COBRA coverage period

Change in COBRA Continuation Coverage	Changes Permitted	Notes
Period of COBRA Continuation Coverage  Under Another Employer's Group Health Plan.	coverage consistent with the event.	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.

**Status Change Codes:**

E	Enroll yourself and/or your Eligible Dependent under the Program
AS	Add your Spouse/Partner to vision coverage under the Program
DS	Drop vision coverage for your Spouse/Partner under the Program
AD	Add your Eligible Dependent(s) to vision coverage under the Program
DD	Drop vision coverage for your dependent under the Program
W	Waive or terminate your vision coverage enrollment under the Program
C	Change vision coverage options under the Program

requirements, except as otherwise noted in this SPD or as otherwise required pursuant to the applicable collective bargaining agreement.

***Bargained Employees of Frontier***

You are an Eligible Former Employee if:

You terminated employment from a Participating Company after exhausting disability benefits under a Company-sponsored disability benefit program; and

At the time you exhausted such disability benefits, your Term of Employment was 15 or more years with one or more Participating Companies

**IMPORTANT:** Unless you meet the criteria stated above, and unless required by the collective bargaining agreement, if you terminate your employment, you are not eligible for Benefits as an Eligible Former Employee.

## **APPENDIX B: LASER VISION CORRECTION CARE**

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Access to laser vision correction care (i.e., Laser Assisted In-Situ Keratomileusis [LASIK]) through a network of Providers is available at a reduced cost to you and your covered Eligible Dependents. You can receive treatments at a lower cost than you would otherwise pay without the negotiated discounts. Contact the Frontier Benefits Service Center to obtain information regarding Providers who participate in the discount LASIK offering.

**IMPORTANT:** The discounts for laser vision correction care are arranged by the Network Administrator and are not part of the Program. The Program does not pay any Benefits toward the cost of laser vision correction care; you pay the full cost of such services.