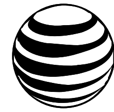
Summary Plan Description



IMPORTANT BENEFITS INFORMATION

AT&T East Bargained Employee Medical Program

Active Bargained Employees of Participating Companies

This is a summary plan description (SPD) for the AT&T East Bargained Employee Medical Program, a component program under the AT&T Umbrella Benefit Plan No. 3. This SPD replaces your existing Medical SPD and all of its summaries of material modifications.

Please keep this SPD for future reference.

NIN: 78-32765

IMPORTANT INFORMATION

In all cases, the official Plan documents govern and are the final authority on Plan terms. If there are any discrepancies between the information in this Summary Plan Description (SPD) and the Plan documents, the Plan documents will control. AT&T reserves the right to terminate or amend any and all of its employee benefits plans or programs. Participation in the plans and programs is neither a contract, nor a guarantee of future employment.

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 AT&T Umbrella Benefit Plan No. 3 (Plan) with respect to Benefits provided under this Program. See the "Eligibility and Participation" section for more information about Program eligibility and other Programs under the Plan.

Este documento contiene un resumen, en inglés. Si usted tiene dificultad en entender este documento, entre en contacto por favor con AT&T Benefits Center, **877-722-0020**.

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 AT&T 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 Administrador en la seccion de “Contact Information.”

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

- *The AT&T Umbrella Benefit Plan No. 3 (Plan) is a welfare benefit plan providing coverage for health and welfare benefits through component Programs.*
- *This is a Summary Plan Description (SPD) for the AT&T Umbrella Benefit Plan No. 3 (Plan) with respect to Benefits under the AT&T East Bargained Employee Medical Program*
- *This document is an SPD for the portion of the Program that applies to eligible Bargained Employees of Participating Companies.*

This is a Summary Plan Description (SPD) for the AT&T Umbrella Benefit Plan No. 3 (Plan). The Plan was established on Jan. 1, 2014, and incorporates certain welfare plans sponsored by AT&T Inc. Benefits under the Plan are provided through separate component programs. A program is a portion of the Plan that provides benefits to a particular group of participants or beneficiaries. Each program under the Plan applies to a specified set of benefits and group of Employees.

This SPD is a legal document that provides comprehensive information about the AT&T East Bargained Employee Medical Program (Program).

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

The Program offers a Preferred Provider Organization (PPO) Option and a Health Care Network (HCN) Option. You can find information about the options available to you in this SPD. 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 Jan. 1, 2015. 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 and your Participating Company or Former Participating Company and your Employee group listed in *Appendix A*.

Note: Separate documents describe the benefits provided under available Fully-Insured Managed Care Options. See the “Fully-Insured Managed Care Options” section. Contact the Eligibility and Enrollment Vendor for more information on Fully-Insured Managed Care Option availability. To obtain a copy of the document describing benefits available under a Fully-Insured Managed Care Option, contact the Fully-Insured Managed Care Option administrator. Contact information is available on your Program ID card. You can also obtain contact information from the Eligibility and Enrollment Vendor.

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. See *Appendix A* for the list of Participating Company names and employee groups and their associated acronyms. If you are not sure what information applies to you, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Section References

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

Terms Used in This SPD

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

Program Responsibilities

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

CONTENTS

Important Information 2
- What Is This Document? 2
- What Information Do I Need to Know to Use This SPD? 2
- What Action Do I Need to Take? 2
- How Do I Use This Document? 2
- Questions? 3

Using This Summary Plan Description 3
- Company Labels and Acronyms Used in This SPD 4
- Section References 4
- Terms Used in This SPD 4
- Program Responsibilities 4

Highlights 14

Eligibility and Participation 14
- Eligibility at a Glance 14
  - *Rehired Eligible Former Employees 15*
  - *Eligible Employees 15*
- How to Determine if Your Dependents Are Eligible for This Program 16
  - *Eligible Dependents 17*
- Dual Enrollment 17

What Coverage Options Are Available 18
- Program Options 18
  - *Fully-Insured Managed Care Option 18*

Enrollment and Changes to Your Coverage 19
- Enrollment Levels of Coverage 20
- Enrollment at a Glance 20
  - *Enrollment Rules for You 20*
- Annual Enrollment 21
- Prospective Enrollment 21
- Change-in-Status Enrollment 21
  - *Notice of A Change-In-Status Event 22*
  - *The Effective Date of Your Change-In-Status Enrollment 22*
  - *Your Change in Status May Affect Your Tax Treatment of Your Contributions 23*
- Enrollment Rules for Your Dependents 23
  - *Dependent Eligibility Verification 23*
  - *Certification of Disabled Dependents 24*
- Change-in-Status Events 25
  - *Permissible Change-in-Status Enrollment Events 25*
  - *Change in Coverage Level 25*
  - *Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum 26*

Leave of Absence 27

Extended Coverage for Employees on Active Military Duty ... 27
Extended Coverage While on an FMLA-Protected Absence or on FMLA ... 28
Repayment of Cost of Health Care Coverage Paid or Advanced by the Company ... *28*
Continuation of Coverage under COBRA ... *28*
For More Information ... *29*
Contributions ... 29
How Contributions Are Made ... 30
Before-Tax and After-Tax Contributions ... 30
Contribution Policy ... 31
Company Self-Funded Option ... *31*
Fully-Insured Managed Care Option ... *33*
Surviving Dependents ... 34
Tax Consequences of Coverage for Partners and Their Dependents ... 34
Employees on Leave of Absence ... 34
Individuals Covered Through COBRA ... 35
Benefits at a Glance ... 35
Eligible Employees enrolled in a Health Care Network Option: ... *36*
Eligible Employees enrolled in a Preferred Provider Organization Option: ... *41*
Your Program Coverage Overview ... 43
Conditions for Program Benefits ... 45
Cost Sharing ... 45
Annual Deductible ... *45*
Coinsurance ... *47*
Annual Out-of-Pocket Maximum for Participants Enrolled in the Health Care Network Option ... *48*
Annual Out-of-Pocket Maximum for Participants Enrolled in the Preferred Provider Organization Option ... *50*
Allowable Charge for Eligible Expenses for Participants Enrolled in a Preferred Provider Organization or a Health Care Network Option ... *51*
Benefit Maximums ... *52*
Medical Benefits ... 53
What You Need to Know About Providers ... *54*
How Network Areas Are Determined ... *55*
Network Benefits ... *55*
Non-Network Provider Benefits Paid as Network Benefits ... *56*
Non-Network Coverage ... 56
Outside Network Area (ONA) Coverage ... 57
Electing to Enroll in Network Coverage ... *57*
Comparison of Network, Non-Network and ONA Benefits ... 57
Comparison of Claims/Financial Responsibility ... *59*
Choosing Your Providers ... 60
How Your Choice of Providers Affects Your Benefits ... 60
Showing Your ID Card ... 61
Transition of Care ... 61

- *Non-MH/SA Transition of Care Procedures* *61*
- *MH/SA Transition of Care Procedures* *62*

Notification and Preauthorization Requirements 62

- *Notification and Preauthorization Process* *63*
- *Notification and Preauthorization Requirements Table* *64*
- *Notification and Preauthorization Requirements* *65*
- *Notification and Preauthorization Process if You Are Enrolled in Coverage Under a Preferred Provider Organization or Indemnity Option* *66*
- *Notification and Preauthorization Requirements Table* *67*
- *Prior Notification Requirements* *68*
- *Preauthorization Requirements for Participants Enrolled in a Preferred Provider Organization or an Indemnity Option* *69*
- *Predetermination of Benefits* *69*

Definition of Medically Necessary 70

Services Considered Not Medically Necessary 71

- *Examples of Services Considered Not Medically Necessary* *71*

Determination of Medically Necessary Covered Health Services 72

What Is Covered 72

Preventive Care Services 73

- *Preventive Care Transition of Care* *74*

Emergency Services 75

- *Emergency Room (Emergency Medical Condition)* *75*
- *Emergency Room (Nonemergency)* *75*
- *Urgent Care Facility* *76*
- *Ambulance Services* *76*

Inpatient Services 77

- *Room and Board* *77*
- *Lab and X-Ray* *77*
- *Other Inpatient Services* *77*
- *Hospital Expenses* *78*

Outpatient Services 80

- *Office Visits* *80*
- *Outpatient Care* *80*

Mental Health and Substance Abuse (MH/SA) Services 81

- *MH/SA Professional Services* *81*
- *MH/SA Inpatient Hospital Care* *82*
- *MH/SA Emergency Services* *82*

Family Planning/Maternity Services 83

Family Planning/Maternity Services 83

- *Family Planning* *83*
- *Maternity Services* *83*

Rehabilitation Services 84

Rehabilitation Services 84

Additional Services 85

- *Alternate Care* *85*
- *Anesthesia Services* *86*

Chiropractic Treatments ... *86*
Durable Medical Equipment ... *86*
Gender Dysphoria (Reassignment) Treatment ... *86*
Hearing Benefit ... *87*
Home Health Care ... *89*
Hospice Care ... *89*
Medical Equipment (Rentals or Purchase) ... *89*
Organ or Tissue Transplants ... *89*
Organ Transplants ... *90*
Prosthetics ... *91*
Skilled Nursing Facility ... *91*
Exclusions and Limitations ... 92
General Health Care Exclusions ... 92
Specific Health Care Exclusions ... 93
Alternative Treatments ... *93*
Dental ... *93*
Devices and Appliances ... *93*
Foot Care ... *93*
Mental Health/Substance Abuse (MH/SA) ... *93*
Personal Care, Comfort or Convenience ... *95*
Physical Appearance ... *95*
Procedures and Treatments ... *95*
Provider Services ... *96*
Reproduction ... *96*
Transplants ... *96*
Types of Care ... *96*
Vision ... *96*
All Other Exclusions ... 96
General Health Care Exclusions for Participants Enrolled in the Preferred Provider Organization Option ... 97
Specific Health Care Exclusions ... 97
Dental ... *97*
Devices, Appliances and Prosthetics Drugs ... *98*
Drugs ... *98*
Foot Care ... *98*
Mental Health/Substance Abuse (MH/SA) ... *98*
Nutrition ... *100*
Personal Care, Comfort or Convenience ... *100*
Physical Appearance ... *100*
Procedures and Treatments ... *100*
Reproduction ... *100*
Transplants ... *101*
Vision ... *101*
All Other Exclusions ... 101
Prescription Drug Coverage ... 102
Benefits at a Glance ... 103

Cost Sharing 106
Co-payments *106*
Annual Out-of-Pocket Maximum *106*
Prescription Drug Coverage 107
Covered and Excluded Medications *107*
Classification of Prescription Drugs *107*
Generic/Brand-Name Exception *109*
Medication Management Services *109*
Prescription Drug Benefits Administrator *110*
Filling Your Prescriptions 110
Retail Prescription Drug Services *110*
Mail Order Prescription Drug Services *111*
Replacement/Early Refill Policy *112*
Specialty Prescription Drug Services *112*
Pharmacy Choice Can Affect Your Prescription Drug Benefits *114*
Prescription Drug Benefit Coverage and Medicare Part D 114
What Is Covered 115
Personal-Choice Drugs *116*
Preventive Care Drugs *116*
What Is Not Covered 117

Claims and Appeals Procedures 120

Claims for Eligibility 121
When to File a Claim for Eligibility 121
How to File a Claim for Eligibility 121
What Happens If Your Claim for Eligibility Is Denied 122
How to Appeal a Denied Claim for Eligibility 123
Internal Appeals Process 123
External Review Process for Certain Eligibility Claims 124

Claims for Benefits 124
How to File a Claim for Benefits 124
Claim Filing Limits *125*
Information to Include in Your Claim for Benefits *126*
Payment of Benefits *126*
Benefit Determinations *127*
What Happens If Your Claim for Benefits Is Denied *129*
How to File an Appeal for Benefits *130*
Internal Appeals *131*
Urgent Care Appeals That Require Immediate Action *132*
External Review *133*

Coordination of Benefits 133
Determining Which Plan or Program Pays First 134
COB for Eligible Dependent Child(ren) 135
How COB Works 135

If You, Your Spouse or Your Dependent is Eligible For Medicare 136
Medicare Parts A and B 137

Impact of Medicare Parts A and B on Program Benefits ... *137*
Other Consequences of Not Enrolling in Medicare Part A and Part B ... *140*
Medicare Enrollment Periods and Late Enrollment Penalties ... *140*
Medicare Special Enrollment Period ... *140*
If You Work Past the Age of 65 ... *141*
If You Become Disabled Before the Age of 65 ... *141*
If Your Dependent Becomes Eligible for Medicare While You Are Actively at Work ... *141*
If You Are Enrolled in a Fully-Insured Managed Care Option ... *142*
If You Have End-Stage Renal Disease (ESRD) ... *142*
If You Have Other Group Health Insurance ... *142*
Medicare Crossover Program ... *143*
More Information on Medicare ... 143
Benefits Administrator ... *143*
Assistance with Medicare Questions ... *143*
Medicare Part D ... 144
Coverage Under Medicare Part D ... 144
Enrollment in Medicare Part D ... 144
If You Enroll in Medicare Part D ... *144*
You Are Not Required to Enroll in Medicare Part D ... *145*
Reimbursement of Medicare Part D Premiums ... 145
Medicare Part D Low Income Assistance ... 145
Creditable Coverage and Late Enrollment Penalties ... 146
Creditable Coverage ... *146*
Late Enrollment Penalties ... *146*
Qualified Status Changes Associated with Medicare ... 146
Additional Medicare Contact Information ... 146
For More Information About Medicare Part D and This Program ... *146*
For More Information About Your Options Under Medicare Part D Prescription Drug Coverage ... *147*
When Coverage Ends ... 147
For Employees ... 147
For Covered Spouse/Partner and Child(ren) ... 148
Rescission of Coverage ... 148
If You Are Laid Off From Active Employment ... 148
If You Are Leaving the Company ... 149
Eligibility Rules ... *149*
Contribution Rules - Company Self-Funded Option ... *150*
If Your Active Employment Ends by Reason of Disability ... 151
If Your Active Employment Ends by Reason of Your Death ... 151
Extension of Coverage - COBRA ... 151
COBRA Continuation Coverage ... 152
What Is COBRA Continuation Coverage? ... 152
COBRA-Qualifying Events: When Is COBRA Continuation Coverage Available? ... 153
Eligible Employee ... *153*

Spouse or Partner 153
Child(ren) 154
FMLA (Active Employee Only) 154
Important Notice Obligations 155
Your Employer's Notice Obligations 155
Your Notice Obligations 155
COBRA Notice and Election Procedures 156
Electing COBRA Continuation Coverage 156
Paying for COBRA Continuation Coverage 158
How Long Does COBRA Continuation Coverage Last? 158
18 Months (Extended Under Certain Circumstances) 159
Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period 160
Information About Other Individuals Who May Become Eligible for COBRA Continuation Coverage 161
Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period 161
Annual Enrollment Rights and HIPAA Special Enrollment Rights 161
Alternate Recipients Under Qualified Medical Child Support Orders 161
When You Must Notify Us About Changes Affecting Your Coverage 161
For More Information 162
Contact Information 162
Surviving Dependent Coverage 162
What Happens When You Leave The Company 163
Active Program Coverage 163
Post-Employment Coverage 163
Dependent Coverage 164
Annual Deductible Credit 164
Enrollment in Medicare 165
COBRA Coverage in Lieu of Post-Employment Benefits 165
Extension of Benefits 165
Plan Administration 165
Plan Administrator 166
Administration 166
Nondiscrimination in Benefits 167
Amendment or Termination of the Plan or Program 167
Limitation of Rights 167
Legal Action Against the Plan 167
You Must Notify Us of Address Changes, Dependent Status Changes and Disability Status Changes 168
Plan Information 169
Type of Administration and Payment of Benefits 171
What Happens When Benefits Administrators Change 172
Right of Recovery and Subrogation 172
Summary of the Program's Right of Recovery 173
Right of Recovery of Overpayments 174

ERISA Rights of Participants and Beneficiaries 174
Your ERISA Rights 174
Prudent Actions by Plan Fiduciaries 175
Enforce Your Rights 175
Assistance With Your Questions 176
Other Program Information 176
Patient Protection and Affordable Care Act 177
Qualified Medical Child Support Orders 178
Your Conversion Rights 178
Important Notices About Your Benefits 179
Genetic Information Nondiscrimination Act (GINA) 179
Women’s Health and Cancer Rights Act of 1998 (WHCRA) 179
The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 180
Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families 180
Notice of HIPAA Privacy Rights 181
Protecting the Privacy of Your Protected Health Information – Notice of HIPAA Privacy Rights 181
Newborns’ and Mothers’ Health Protection Act 181
Contact Information 182
Information Changes and Other Common Resources 187
Definitions 189
Appendix A: Participating Companies and Former Participating Companies 206
Participating Companies 206
Appendix B: Change-in-Status Events 207
Change-in-Status Events 207
Change in Legal Marital or Partnership Status 207
Change in Number of Dependents or Dependent Eligibility 207
Change in Employee’s Employment Status 208
Change in Spouse’s or Dependent’s Employment Status 209
Change in Residence 210
Change in Benefit Coverage Under Another Employer’s Plan 210
Loss of Coverage Under a Government or Educational Institution 210
Gain or Loss of Medicaid Coverage and CHIP Premium Assistance 211
Change in Cost 211
Change in Coverage Under Another Employer’s Plan 212
Addition or Significant Improvement of Benefit Plan Option 213
Significant Curtailment of Coverage (With or Without Loss of Coverage) 213
Medicare or Medicaid 214
Leave of Absence (LOA) 214
Judgments, Orders and Decrees 215
Change in COBRA Continuation Coverage 216
Status Change Codes: 216

Appendix C: Special Medical Benefits Administrator Offering....217
Organ and Tissue Transplant Services....217
Coverage for Donor and Recipient Services....218
Transportation and Lodging....218

HIGHLIGHTS

This SPD describes the Program effective Jan. 1, 2015, unless otherwise noted. Some of the more significant changes to the SPD document since the last restatement of this SPD in 2013 are listed below.

- Revision of the list of Participating Companies and Bargaining Units to add or remove companies and bargaining units, as applicable.
- The consolidation of the PPO and HCN options into one SPD.
- Incorporation of changes made in summaries of material modifications (SMMs) distributed since the previously published SPD, if applicable.
  - Health and Welfare Program Changes, Dec. 2013, NIN 78-30657.
  - AT&T East Medical Program, Dec. 2013, NIN 78-30170.
  - AT&T East Medical Program, Dec. 2013, NIN 78-30160.

ELIGIBILITY AND PARTICIPATION

KEY POINTS

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

Eligibility at a Glance

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

In order to determine your eligibility for the Program, you need to know your employment classification and if you are in a bargaining unit or population group of a Participating Company listed in *Appendix A*. Locate the information applicable to you in the “Eligibility Rules” section of the table(s) to determine if you meet the eligibility requirements noted in the table(s) below.

Special eligibility rules apply to employees who transfer or change positions under circumstances specified in the *Benefits Rules for Movement* or similar provisions in your collective bargaining agreement. If you move between bargained groups, contact the Eligibility and Enrollment Vendor.

If you do not meet the eligibility requirements for the Program described in this Summary Plan Description (SPD), contact the Eligibility and Enrollment Vendor 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.

Rehired Eligible Former Employees

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

- You are an Employee of a Participating Company in the Program 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 Eligible Former Employee benefits under a plan program sponsored by AT&T Inc. or a member of the AT&T Inc. Controlled Group of Companies.

If you are a Rehired Retiree, the provisions of the AT&T 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 Eligibility and Enrollment Vendor to obtain the AT&T Rehired Eligible Former Employee Supplement. It will be mailed to you at no cost. See the Eligibility and Enrollment Vendor table in the “Contact Information” section for contact information. In no event will you be eligible for benefits from a Program under AT&T Umbrella Benefits Plan No. 1 while you are an Active Employee, except in certain limited circumstances.

Eligible Employees

Eligibility Rules	
Eligible Employees	
You are an Eligible Employee if…	You are (1) Actively at Work and employed by a Participating Company (2) A member of one of the covered bargaining units listed below; and (3) Classified by your Participating Company as one of the types of Employees listed below as eligible under the Program for your bargaining unit.
Population Groups: Employee Classifications	You are a Regular, Term or Temporary Employee covered under the following collective bargaining agreement • AT&T East Core Contract - CWA District 1
Dual Enrollment - Special Rule	
Dual Enrollment	While you may be eligible under more than one status (for example, as an Employee, Eligible Former Employee and a dependent in the Program), you are not allowed to be enrolled in this Program or any other medical program or plan sponsored by a member of the AT&T Controlled Group (with the exception of the AT&T CarePlus - A Supplemental Benefit Program) at the same time. In addition, you and your Spouse/Partner cannot cover your dependents at the same time. See the "Dual Enrollment" section for more information.

How to Determine if Your Dependents Are Eligible for This Program

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

Unless your dependent's eligibility for coverage is due to surviving dependent status, military orders under Military Service Leave for those called to involuntary active duty by Presidential Executive, or COBRA continuation coverage, your dependent(s) cannot be enrolled in the Program, unless you are also enrolled. In general, if more than one coverage option is available under the Program, you and your Eligible Dependents must be enrolled in the same coverage option, unless one or more of you and your Eligible Dependents are Medicare Eligible and others are not. However, in some instances, your Eligible Dependent(s) may be permitted to enroll in a different coverage option due to certain Network geographic restrictions. See the "Enrollment and Changes to your Coverage" section for more information. You may not cover a Spouse and a Partner as Eligible Dependents under the Program at the same time. In addition, there may be restrictions on whether you can cover another Employee or Eligible Former Employee as a dependent under this Program. See the "Dual Enrollment" section for more information.

The Company reserves the right to verify eligibility of any enrolled dependents. See the "Dependent Eligibility Verification" section for more information. Once a dependent is enrolled, it is your responsibility to contact the Eligibility and Enrollment Vendor 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

<table>
<tr><th colspan="2">Eligibility Rules</th></tr>
<tr><td>Eligible Dependents</td><td></td></tr>
<tr><td>Your dependents who meet the eligibility rule are eligible for Program coverage.</td><td>(1) Your Spouse/Legally Recognized Partner (LRP).

(2) Your Child(ren) until the end of the month in which the Child reaches the age of 26 regardless of marital status.

The term Child(ren) means any of the following until the end of the month in which they reach age 26:
• Your biological Child(ren).
• Child(ren) placed with you for purposes of adoption.
• Child(ren) you have legally adopted or, your stepchild(ren).
• The Child(ren) of your LRP.
• Child(ren) for whom either you or your Spouse/LRP is a Legal Guardian. The term does not include wards of the state or foster Child(ren) who are not placed for adoption.

(3) Your unmarried Disabled Child(ren) who is mentally or physically disabled before the end of the month in which the Child reaches the age of 26. You must provide satisfactory evidence of disability in order for your Disabled Child(ren) to be eligible for coverage under the Program. In addition, an independent medical examination of your dependent may be required. See the "Certification of Disabled Dependents" section for information on how to certify disability.</td></tr>
<tr><td colspan="2">IMPORTANT: Not all Fully-Insured Managed Care Options cover an LRP and Child(ren) of an LRP.</td></tr>
</table>

Dual Enrollment

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

The Program does not permit you or a dependent to be enrolled in the Program as an Employee, Eligible Former Employee or Eligible Dependent at the same time. In addition, you and your dependents cannot be enrolled in this Program at the same time as you are enrolled in any other medical program or plan sponsored by a member of the AT&T Controlled Group (with the exception of the AT&T CarePlus – A Supplemental Benefit Program).

WHAT COVERAGE OPTIONS ARE AVAILABLE

KEY POINTS

- *The Program provides coverage under one or more options that may include Company Self-Funded Option(s) and Fully-Insured Managed Care Options.*
- *The Program options available to you are generally determined based on the ZIP code for your home address in Company records.*

Program Options

The Program provides coverage under one or more options. The Company Self-Funded Option(s) available to you and your enrolled dependents are determined based on the requirements specified below. You also may be eligible for Fully-Insured Managed Care Option coverage as described in the "Fully-Insured Managed Care Option" section.

The coverage options listed below are available under the Program.

The Company Self-Funded and Fully-Insured Managed Care Options availability will be determined based on the ZIP code for your home address in Company records. You will be able to elect one of the Company Self-Funded or Fully-Insured Managed Care Options if you meet the requirements described below:

- Company Self-Funded Health Care Network (HCN) Option: The HCN includes the Network and ONA Options. Network and ONA Option availability will be determined based on your ZIP code in Company records. If your ZIP code is in the Network Area, you will be able to elect the HCN Network option. If your ZIP code is outside the Network Area, you will be able to elect either the HCN Network or ONA options.
- Company Self-Funded Preferred Provider Organization (PPO) Option availability is not determined by your ZIP code.
- Fully-Insured Managed Care Option (if made available in your ZIP code area).

You can request SPD(s) by contacting the Eligibility and Enrollment Vendor. See the "Contact Information" section for contact information.

If you are enrolled in a Fully-Insured Managed Care Option, you may obtain a copy of your Evidence of Coverage by contacting the insurer. The Evidence of Coverage for any Fully-Insured Managed Care Option is incorporated by reference in this SPD.

Fully-Insured Managed Care Option

At the Company's discretion one or more Fully-Insured Managed Care Options may be available under the Program to provide an alternative to the Company Self-Insured Program coverage. Each Fully-Insured Managed Care Option is available as an option, only in the geographic area designated by the Company. The fact that an option was available in a prior year or is available generally to the public in an area does not mean that the option will be available under the Program. Whether you reside in a geographic area in which a Fully-Insured Managed Care Option is available to you is based on the ZIP code for your home address as reflected in the Company records. Information concerning the Fully-Insured Managed Care Options available to you, if any, will be provided when you have an opportunity to enroll or change your coverage elections.

If you have enrolled in the Fully-Insured Managed Care Option, you will continue to refer to the Program for the rules on eligibility, enrollment and contributions. In most cases, these rules will govern over the eligibility provisions otherwise applicable under the insurer's policy. However, in limited circumstances, coverage for certain dependents, principally a Partner or a Disabled Child(ren) over the age of 26, may not be available under a specific Fully-insured Managed Care Option if coverage would not be permitted under the option's Certificate of Insurance. Also, rules established by the Centers for Medicare Services (CMS) may affect your eligibility for and the timing of your enrollment in a Medicare HMO. See the "Eligibility and Participation" section for more information.

Coverage in a Fully-Insured Managed Care Option under the Program for you and any of your dependents is available only while the individual is enrolled for coverage under the Program. Other insurance coverage may be available directly from the insurer after Program coverage terminates.

Any contributions you are required to pay for coverage under a Fully-Insured Managed Care Option also are determined under the Program. See the "Contribution Policy" section for more information.

Those enrolled in a Fully-Insured Managed Care Option must refer to the separate insurance booklets applicable to the Fully-Insured Managed Care Option for all terms and conditions, other than eligibility, enrollment and contributions, such as what health services are provided and Claims and Appeals procedures for Claims and Appeals that are not related to eligibility and enrollment. Except for the rules on eligibility, enrollment and contributions, the terms of the Fully-Insured Managed Care Option will govern in the event of any conflict between the terms of the Fully-Insured Managed Care Option and the terms of the Program. If you have any questions about the terms of the Fully-Insured Managed Care Option, contact your Fully-Insured Managed Care Option coverage provider for more information. The telephone number is included on your ID card. If you have questions about your eligibility, enrollment or contributions for a Fully-Insured Managed Care Option under the Program, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

- *You must enroll to receive Program coverage.*
- *For your dependents to receive Program coverage, you and your dependents must be enrolled.*
- *You must act within the required time frames for enrolling and making changes to your Program coverage. If you miss the window of opportunity to enroll or make changes to your elections, you may have a gap in coverage or may not be able to make changes you desire to your coverage.*
- *You have certain responsibilities. You must notify the Eligibility and Enrollment Vendor if:*

  - Your address changes.

- You have a change in enrollment.
- You receive a Qualified Medical Child Support Order (QMCSO).
- You or a covered dependent enrolls in Medicare.
- An enrolled dependent loses eligibility for any reason, such as divorce and attaining a certain age.

Enrollment Levels of Coverage

The Program offers the following levels of coverage:

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

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

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

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

Enrollment at a Glance

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

Enrollment 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 and Term Employees or if you are a Temporary Employee, for coverage to be effective the first day of the month you complete six months of service provided you enroll within the 31-day initial enrollment period. If you miss the 31-day deadline, you will not be able to enroll until Annual Enrollment or if you are permitted to enroll due to a "Change-in-Status".
Annual Enrollment	During Annual Enrollment - for coverage to be effective on the first day of the following Plan Year.

Enrollment	
Prospective Enrollment	At any time, changes to current coverage or newly elected coverage resulting from Prospective Enrollment are effective on the first day of the month following the request for enrollment. Prospective Enrollment does not permit you to change Program options. See the "Prospective Enrollment" section for further information about eligibility and how to prospectively enroll.
Change-in-Status Enrollment	See the "Change-in-Status Enrollment" section.

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 Sept. 1 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 online via the Eligibility and Enrollment Vendor website or by calling the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

Prospective Enrollment

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

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

Change-in-Status Enrollment

Circumstances often change. You may get married, welcome a Child to the family, lose benefits under another employer’s medical plan or you or a family member takes a leave of absence. These important events are called “Change-in-Status Events” and the Program allows you to

change your enrollment when you experience specific Change-in-Status Events. See the "Change-in-Status Event" section for more information on events that are considered a Change-in-Status.

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

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 Eligibility and Enrollment Vendor within *31 days* after the event.

There are some exceptions to this rule:

- If you gain or lose eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, you must inform the Eligibility and Enrollment Vendor within 60 days of the gain or loss of coverage.
- If you or a covered dependent dies, the Fidelity Service Center should be notified *as soon as possible* at **800-416-2363** to initiate the appropriate changes to Program enrollment.

The Effective Date of Your Change-In-Status Enrollment

It is very important that you notify the Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

As noted above, your change in enrollment request is subject to review by the Eligibility and Enrollment Vendor. 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 Eligibility and Enrollment Vendor within the time required, your new enrollment will become effective either on:

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

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 Eligibility and Enrollment Vendor.

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

Enrollment Rules for Your Dependents

Program coverage is not automatic for you or your Eligible Dependents. You must enroll through the Eligibility and Enrollment Vendor to have coverage. To enroll a dependent, you must be enrolled in coverage. See the *Eligibility and Enrollment Vendor* table for contact information.

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

Your dependent enrollment elections can be made:

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

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

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

See the *Eligibility and Enrollment Vendor* table for contact information. For information about contributions required to maintain your Program coverage, see the "Contributions" section.

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

Dependent Eligibility Verification

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

In order to enroll your dependent, you must call the Eligibility and Enrollment Vendor.

The Eligibility and Enrollment Vendor will mail a dependent eligibility verification package to your address. If you do not receive the package in 7-10 days, it is your responsibility to call the Eligibility and Enrollment Vendor again. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

The dependent eligibility verification package will contain instructions for submitting documents that verify your dependents' eligibility for coverage, including a list of documents that would meet this requirement. For example, if you are enrolling a Child, you will be required to provide a copy of a birth certificate and/or other specified document that establishes the Child's relationship to you.

> **IMPORTANT:** You must provide documentation proving the eligibility of your dependent prior to the date specified by the Eligibility and Enrollment Vendor and before your dependent's coverage can become effective under the Program.

If you provide the required documentation within the required timeframe and the Eligibility and Enrollment Vendor has reviewed your documents and approved the eligibility of your dependent, coverage under the Program will become effective as of the first of the month following the date you requested enrollment (if Prospective Enrollment is permitted under the Program), or earlier if pursuant to Annual Enrollment or a qualified status change as described under the Program.

If the Eligibility and Enrollment Vendor denies your application to add your dependent for coverage under the Program, you may file a Claim on this decision to the Eligibility and Enrollment Vendor. If the Eligibility and Enrollment Vendor denies your initial Claim, you may appeal that decision to the Eligibility and Enrollment Appeals Committee (EEAC). See the section on "How to File a Claim for Eligibility to Enroll or Participate in the Program."

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

Note: Enrollment of an ineligible dependent in the Program constitutes benefits fraud and violates the AT&T Code of Business Conduct. The Company will refer suspected fraudulent enrollments to AT&T Asset Protection for investigation, which may result in legal action and financial consequences.

Certification of Disabled Dependents

It is necessary to certify that your Child(ren) is disabled in order to obtain extended eligibility under the Program. Your disabled dependent will not receive Benefits under the Program if you fail to certify his or her disabled status. Review this section carefully to understand the steps necessary for certification (and recertification).

To certify an unmarried Child (including the Child of a Partner) who is disabled, you must contact the Eligibility and Enrollment Vendor to obtain the required forms for certification and follow the instructions on the forms. You and the Child's Physician must complete the application form and submit it for approval as directed in the form. The Eligibility and Enrollment Vendor will advise you whether the Child qualifies for coverage under the terms of the Program. The Eligibility and Enrollment Vendor will enroll your Child for coverage, if your Child is eligible under the terms of the Program. In addition, the Eligibility and Enrollment Vendor will periodically solicit you for disabled dependent verification.

Medical coverage for a Disabled Child(ren) begins when the Child(ren) is certified. Coverage is not retroactive for medical expenses incurred before certification.

> **IMPORTANT:** It is best to contact the Eligibility and Enrollment Vendor three to six months before the Child reaches age 26. Failure to timely certify your dependent prior to age 26 will result in a break in Program coverage.

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

Change-in-Status Events

Permissible Change-in-Status Enrollment Events

Change-in-Status Events permit you to change your Program enrollment. For a detailed description of each of these events, see *Appendix B*. The permitted enrollment changes reflected in *Appendix B* 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 B* for an explanation of the codes used in the tables.

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

- **The enrollment change must be consistent with the event**. The Change-in-Status Event must:
  - Affect eligibility and coverage under the Program; and
  - Must be on account of and consistent with the event.
- **Request your enrollment before the deadline.** Your request for a change in your enrollment must occur within 31 days after the Change-in-Status Event.
- **Document your event.** While not always required, the Program has the right to request documentation that supports your Change-in-Status Event. For example:
  - Adding a newborn dependent Child will require a copy of the Child's birth certificate
  - Adding a new Spouse will require a copy of a marriage certificate
  - Waiving coverage under the Program in favor of coverage under another employer's medical plan may require proof of enrollment in the other medical plan.

Change in Coverage Level

<u>If You Add or Drop a Dependent Resulting in a Change to Your Coverage Level</u>

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

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

Action	Medical Levels of Coverage Changes	Annual Deductible and Annual Out-of-Pocket Maximum
Add a dependent midyear	Change from Individual to: • Individual + 1*, or • Individual + 2* or more	Increase consistent with new coverage tier
Drop a dependent midyear	Change from: • Individual + 1* to Individual, or • Individual + 2 or more to Individual + 1, or* • Individual + 2* or more to Individual	Previous expenses for dropped dependent are not transferable
May also be referred to as Family Level of Coverage.		

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

Your Annual Deductible and Annual Out-of-Pocket Maximum are affected by the following midyear changes to your coverage option or coverage tier.

Change in Coverage Option

Prior Coverage Option		New Coverage Option	Effect on Annual Deductible and Annual Out-of-Pocket Maximum
Fully-Insured Managed Care Option	→	Company-Self-Funded Option	Expenses are not transferable
Company-Self-Funded Option	→	Fully-Insured Managed Care Option	Expenses are not transferable
Company Self-Funded HCN Option	→	Company Self-Funded PPO Option	Expenses are transferable
Company Self-Funded PPO Option	→	Company Self-Funded HCN Option	Expenses are transferable
Company Self-Funded HCN ONA Option	→	Company Self-Funded HCN Network Option	Expenses are transferable
Company Self-Funded HCN Network Option	→	Company Self-Funded HCN ONA Option	Expenses are transferable

> **IMPORTANT:** The counting of Eligible Expenses for purposes of your Annual Deductible or Annual Out-of-Pocket Maximum is not automatic. Eligible Expenses will only be credited toward your new Annual Deductible and Annual Out-of-Pocket Maximum if you contact the Benefits Administrator and request the prior expenses be counted.

LEAVE OF ABSENCE

KEY POINTS

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

Your eligibility for continued coverage under this Program and whether you are required to pay for this coverage during your leave of absence, depends on the type of absence and, in some cases, on the duration of your leave. If you are on an approved leave of absence, you will receive a notice explaining what coverage you are eligible to continue to receive and whether you will be required to pay for this coverage. If you continue coverage, you must make all contributions during the required time frame to avoid interruption of your benefits. If you do not continue coverage under the Program while you are on your leave of absence, you must re-enroll upon your return to work by contacting the Enrollment and Eligibility Vendor and speaking to a representative. All coverage that continued while you were on leave will be continued when you return to work unless your eligibility has changed, for example, a change in your position results in eligibility for a different benefit program.

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

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

Extended Coverage for Employees on Active Military Duty

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

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

If you are qualified to continue coverage pursuant to USERRA, you may elect to continue your coverage under this Program by notifying the Eligibility and Enrollment Vendor in advance and

providing payment of any required contribution for this coverage. This may include the amount the Company normally pays on your behalf. If your Military Service is for a period of time shorter than 31 days, you will not be required to pay more than your regular contribution amount for your coverage under this Program.

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

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

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

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 Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section 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 for up to 12 weeks of leave 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 billed and required to pay your required contributions.

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

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

Continuation of Coverage under COBRA

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

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

For More Information
FMLA leave information is available on the OneStop website at **onestop.web.att.com**. At the OneStop home page, select the *Your Time & Attendance* tab, then the *Family Medical Leave Act* section. The website contains information on FMLA Qualifying Events, eligibility requirements, details on the application process and other helpful resources. If you are not at work, you will be able to find additional information about FMLA leaves at **access.att.com**.

You also may send correspondence to:

AT&T FMLA Operations
105 Auditorium Circle, 12th Floor
San Antonio, TX 78205

Telephone Number
Toll-free: **888-722-1787**

Hours of Operation
Customer Care Specialists are available Monday through Friday, 8 a.m. to 6 p.m. Central time.

CONTRIBUTIONS

KEY POINTS

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

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

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

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

You will receive information about contributions at Annual Enrollment each year, any time the Eligibility and Enrollment Vendor determines that you have a Change-in-Status Event that allows you to make an enrollment election and anytime you make a change that results in a contribution change. Refer to your enrollment materials for information concerning the contribution amount that applies to you. You also may obtain an electronic or printed personalized contribution statement any time through the Eligibility and Enrollment Vendor. These documents are

considered to be a component of your Summary Plan Description. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

How Contributions Are Made

Contributions are deducted from your paycheck. If your contributions are not deducted from your paycheck (for example, you are on a leave of absence (LOA)), you will be billed and direct payments will be required, generally through check or money order. If the Eligibility and Enrollment Vendor makes this service available, you may choose to have your contributions automatically withdrawn from your checking or savings account. If you are direct billed, the Eligibility and Enrollment Vendor may permit you to pay your contributions up to one year in advance. Contact the Eligibility and Enrollment Vendor to determine what options are available to you. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

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

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

Before-Tax and After-Tax Contributions

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

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

the Program are considered qualified under the AT&T FSA Plan. Refer to the AT&T FSA Plan SPD for more information on before-tax contributions and for a list of events that are considered qualified Change-in-Status Events.

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

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

Contribution Policy

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

Special contribution rules apply to Bargained Employees who transfer or change positions while employed under circumstances specified in the *Benefits Rules for Movement*. If you move between bargaining groups or transfer positions, contact the Eligibility and Enrollment Vendor.

Company Self-Funded Option

Employee Classification		Contribution Rules
Regular and Term Employee (less than 6 months Term of Employment)	Full-time or Part-time	You pay 100% of the monthly Cost of Coverage, until the 1st of the month in which you will achieve a Term of Employment of at least six months.
Regular and Term Employee (at least 6 months Term of Employment)	Full-time	Hired, rehired or transferred **on** or **before** June 3, 2013 You pay the following monthly contribution Jan. 1, 2014, through Dec. 31, 2014 **Individual:** $58 **Family:** $121 Jan. 1, 2015, through Dec. 31, 2015 **Individual**: $79 **Family:** $163; Jan. 1, 2016, through Dec. 31, 2016 **Individual:** $90 **Family:** $195

Employee Classification		Contribution Rules
		Hired, rehired or transferred after June 3, 2013, and through Dec. 31, 2013 You pay the following monthly contribution Jan. 1, 2014, through Dec. 31, 2014 **Individual:** $135 **Family:** $290 Jan. 1, 2015, through Dec. 31, 2015 **Individual:** $135 **Family:** $300 Jan. 1, 2016, through Dec. 31, 2016 **Individual:** $90 **Family:** $195
		Hired, rehired or transferred **on** or **after** Jan. 1, 2014 and before Jan. 1, 2015 You pay the following monthly contribution **Individual:** $135 **Family:** $290 Jan. 1, 2015, through Dec. 31, 2015 **Individual:** $135 **Family:** $300 Jan. 1, 2016, through Dec. 31, 2016 **Individual:** $150 **Family:** $320
		Hired, rehired or transferred **on** or **after** Jan. 1, 2015 You pay the following monthly contribution Jan. 1, 2015, through Dec. 31, 2015 **Individual:** $135 **Family:** $300 Jan. 1, 2016, through Dec. 31, 2016 **Individual:** $150 **Family:** $320
	Part-time (regardless of scheduled hours per week)	Hired on or before Dec. 31, 1980; Same as Full-time
	Part-time (25 or more scheduled hours per week)	Hired on or after Jan. 1, 1981; Same as Full-time

Employee Classification		Contribution Rules
	Part-time (at least 17 scheduled hours, but less than 25 scheduled hours per week)	Hired on or after Jan. 1, 1981; You pay 50% of the monthly Cost of Coverage.
	Part-time (less than 17 scheduled hours per week)	Hired on or after Jan. 1, 1981; You pay 100% of the monthly Cost of Coverage.
Temporary Employee	Full-time or Part-time	You pay 100% of the monthly Cost of Coverage regardless of Term of Employment.
Former Employees	Former Employee	If you are eligible for continued coverage, the amount you pay depends on the event that triggers Post-Employment Benefits. See the "Extension of Coverage - COBRA" section in this SPD if you are eligible for continued coverage under COBRA and the "When Coverage Ends" section if you are eligible for continued coverage under severance or other similar benefits. If you are an Eligible Former Employee, see the SPD for Eligible Former Employees for more information.
Some Employee classifications may not apply (for example, Term). See the "Eligible Employees" section for your specific eligibility requirements.		

Fully-Insured Managed Care Option

If you elect coverage under a Fully-Insured Managed Care Option and:

- You would be required to pay 100% of the monthly Cost of Coverage for the Company Self-Funded Option,
- You are required to pay 100% of the applicable monthly premium for the Fully-Insured Managed Care Option.
- You would not be required to pay 100% of the monthly Cost of Coverage for the Company Self-Funded Option,
- The following contribution rules apply:

Contribution Rules	
Fully-Insured Managed Care Option	• If the Cost of Coverage of the Fully-Insured Managed Care Option exceeds the Cost of Coverage for the same level of coverage for the Company Self-Funded Option, you will pay the excess of the Fully-Insured Managed Care Option Cost of Coverage over the Cost of Coverage of the Company Self-Funded Option. This is in addition to the monthly contribution you would pay if you were enrolled in the Company Self-Funded Option. • If the Cost of Coverage of the Fully-Insured Managed Care Option is equal to or less than the Company Self-Funded Option, you will pay the monthly contribution for the Company Self-Funded Option.

Surviving Dependents

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

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

Tax Consequences of Coverage for Partners and Their Dependents

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

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

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

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. If contributions are required, the Eligibility and Enrollment Vendor will send you a monthly bill. Payment is due on the first of the month for the following month of coverage. For example, the bill you receive on June 15 applies to coverage for the month of July. Payment is due by July 1.

If you have questions concerning billing or payment of your contribution, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

IMPORTANT: You have a 60-day grace period from the day your payment is due to make payment before coverage is terminated. Failure to pay all required contributions will result in loss of coverage retroactive to the last day of the month for which full payment was received. You may not be eligible to re-enroll until you return from your LOA. If you do not continue coverage under the Program while you are on LOA and you would like to re-enroll upon your return to work, you must contact the Eligibility and Enrollment Vendor to determine if you are eligible. If you are eligible to re-enroll, you will also receive enrollment materials from the Eligibility and Enrollment Vendor 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 through the direct billing process administered by the Eligibility and Enrollment Vendor. See the "Extension of Coverage — COBRA" section for more information about COBRA rights. Additional information on paying for COBRA coverage is provided in the "Paying for COBRA Continuation Coverage" subsection. See the "How Contributions are Made" section for details on the direct billing process. If you have questions concerning billing or payment of COBRA continuation coverage, you can contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

BENEFITS AT A GLANCE

KEY POINTS

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

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

- **A summary, not an exhaustive list, of the most commonly used medical and MH/SA Covered Health Services.** See the "What Is Covered" section for more detailed information on what is covered. Even if a Service is listed as a Covered Health Service, certain exclusions or limitations may apply that affect Benefits payable under the Program. Other Services are specifically excluded from coverage regardless of the circumstances. For information on what is not covered, as well as circumstances affecting whether a Service is covered, see the "Exclusions and Limitations" section.
- **A summary of limitations specific to the Covered Health Services in the table.** This information is not exhaustive. See the "What Is Covered" section for more detailed information on limitations to the Covered Health Services.
- **Cost-sharing information.** You and the Program share in the cost of care as summarized in the table(s) below. The following *Benefits at a Glance* table(s) provides information on how you and the Program share in the cost of the most commonly used Services. However,

circumstances specific to your situation may impact your level of cost sharing. To better understand these cost-sharing features and how they impact your Benefits, see the “Cost Sharing” section of this SPD.

- **Information on when Notification or Preauthorization is required.** The Program requires notification or Preauthorization for certain Services or circumstances. If you do not provide Notification or Preauthorization when it is required, your Benefits may be reduced or denied. The “Notification and Preauthorization Requirements” section of this SPD provides more detailed information.

This section does not include information on Prescription Drug coverage; see the “Prescription Drug Coverage” section. This section also does not include Benefits provided under any Fully-Insured Managed Care Options available under the Program. See the “Fully-Insured Managed Care Option” section for information.

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

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

Eligible Employees enrolled in a Health Care Network Option:

- If you are an Eligible Employee of a Participating Company and you are enrolled in a Health Care Network option see the following table.

	Network	Non-Network	ONA	Limitations and Exceptions
Notification and Preauthorization Requirements				
Notification and Preauthorization Requirements	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	

	Network	Non-Network	ONA	Limitations and Exceptions
Cost Sharing				
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	
Annual Deductible	Medical, including MH/SA For Individual and Family: $500/$1,000	Medical, including MH/SA For Individual and Family: $1,300/$2,600	Medical, including MH/SA For Individual and Family: $500/$1,000	Unless otherwise noted, the Annual Deductible applies
Annual Out-of-Pocket Maximum	Medical, including MH/SA For Individual and Family: $2,000/$4,000 Does not include deductible	Medical, including MH/SA For Individual and Family: $6,000/$12,000 Does not include deductible	Medical, including MH/SA For Individual and Family: $2,000/$4,000 Does not include deductible	
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	
Preventive Care Services				
Preventive Care	0% Coinsurance	Not covered	0% Coinsurance	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.

	Network	Non-Network	ONA	Limitations and Exceptions
Emergency Services				
Emergency Room (Emergency Medical Condition)	10% Coinsurance	10% Coinsurance	10% Coinsurance	
Ambulance Services (Emergency)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Non-Emergency Services				
Emergency Room (Non-Emergency)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Urgent Care Facility (Non-Emergency)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Ambulance Services (Non-Emergency)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Inpatient Services				
Facility Charge	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Room and Board	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Lab and X-Ray	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Physician and Surgeon Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Outpatient Services				
Office Visit				
Office Visit (Non-Specialist)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Office Visit (Specialist)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Outpatient Care				
Outpatient Surgery	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Outpatient Lab and X-Ray Services (excluding Preventive Care)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Outpatient Chemotherapy	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Mental Health and Substance Abuse Services				
Mental Health				
Mental Health Outpatient Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Mental Health Inpatient Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Substance Abuse				
Substance Abuse Outpatient Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Substance Abuse Inpatient Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	

	Network	Non-Network	ONA	Limitations and Exceptions
Family Planning/Maternity Services				
Office Visit (Pre/Postnatal)	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Hospital Delivery Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Infertility Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	Benefits limited to $20,000 per lifetime for Network, Non-Network and ONA combined, including Prescription Drugs
Rehabilitation Services				
Physical Therapy	10% Coinsurance	40% Coinsurance	10% Coinsurance	Limited to 40 visits per calendar year; limited to 52 visits in a calendar year if combined with Chiropractic visits. Visit limit is total for Network, Non-Network and ONA Services combined. These Physical Therapy limits do not apply to Children under age 18.
Occupational Therapy	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Speech Therapy	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Cardiac Rehabilitation Therapy	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Additional Services				
Acupuncture	Not covered	Not covered	Not covered	

	Network	Non-Network	ONA	Limitations and Exceptions
Chiropractic	10% Coinsurance	40% Coinsurance	10% Coinsurance	Limited to 40 visits per calendar year; limited to 52 visits in a calendar year if combined with Physical Therapy visits. Visit limit is total for Network, Non-Network and ONA Services combined
Durable Medical Equipment	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Home Health Care	10% Coinsurance	40% Coinsurance	10% Coinsurance	Non-Network/ONA: Limited to 200 visits in a calendar year, up to 80 of which may be home health aide Services and 120 of which may be skilled nursing visits. Four hours of home health aide Services will count as one visit. (120 days in facility. 80 visits to home or combined 200 visits.)
Hospice Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	
Organ and Tissue Transplant Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	Network/ONA: See *Appendix C* for additional Benefits that may be available if you use a Designated Network Provider.
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	10% Coinsurance	40% Coinsurance	10% Coinsurance	

Eligible Employees enrolled in a Preferred Provider Organization Option:

- If you are an Eligible Employee of a Participating Company enrolled in the Preferred Provider Organization option, see the following table.

	Network	Non-Network	Limitations and Exceptions
Notification and Preauthorization Requirements			
Notification and Preauthorization Requirements	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	
Cost Sharing			
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	
Annual Deductible	Medical, including MH/SA For Individual and Family: $500/$1,000	Medical, including MH/SA For Individual and Family: $1,300/$2,600	Unless otherwise noted, the Annual Deductible applies
Annual Out-of-Pocket Maximum	Medical, including MH/SA For Individual and Family: $2,000/$4,000 Does not include deductible	Medical, including MH/SA For Individual and Family: $6,000/$12,000 Does not include deductible	
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	
Preventive Care Services			
Preventive Care	0% Coinsurance	Not covered	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.

	Network	Non-Network	Limitations and Exceptions
Emergency Services			
Emergency Room (Emergency Medical Condition)	10% Coinsurance	10% Coinsurance	
Ambulance Services (Emergency)	10% Coinsurance	40% Coinsurance	
Non-Emergency Services			
Emergency Room (Non-Emergency)	10% Coinsurance	40% Coinsurance	
Urgent Care Facility (Non-Emergency)	10% Coinsurance	40% Coinsurance	
Ambulance Services (Non-Emergency)	10% Coinsurance	40% Coinsurance	
Inpatient Services			
Facility Charge	10% Coinsurance	40% Coinsurance	
Room and Board	10% Coinsurance	40% Coinsurance	
Lab and X-Ray	10% Coinsurance	40% Coinsurance	
Physician and Surgeon Services	10% Coinsurance	40% Coinsurance	
Outpatient Services			
Office Visit			
Office Visit (Non-Specialist)	10% Coinsurance	40% Coinsurance	
Office Visit (Specialist)	10% Coinsurance	40% Coinsurance	
Outpatient Care			
Outpatient Surgery	10% Coinsurance	40% Coinsurance	
Outpatient Lab and X-Ray Services (excluding Preventive Care)	10% Coinsurance	40% Coinsurance	
Outpatient Chemotherapy	10% Coinsurance	40% Coinsurance	
Mental Health and Substance Abuse Services			
Mental Health			
Mental Health Outpatient Services	10% Coinsurance	40% Coinsurance	
Mental Health Inpatient Services	10% Coinsurance	40% Coinsurance	
Substance Abuse			
Substance Abuse Outpatient Services	10% Coinsurance	40% Coinsurance	
Substance Abuse Inpatient Services	10% Coinsurance	40% Coinsurance	

	Network	Non-Network	Limitations and Exceptions
Family Planning/Maternity Services			
Office Visit (Pre/Postnatal)	10% Coinsurance	40% Coinsurance	
Hospital Delivery Services	10% Coinsurance	40% Coinsurance	
Infertility Services	Not covered	Not covered	
Rehabilitation Services			
Physical Therapy	10% Coinsurance	40% Coinsurance	
Occupational Therapy	10% Coinsurance	40% Coinsurance	
Speech Therapy	10% Coinsurance	40% Coinsurance	
Cardiac Rehabilitation Therapy	10% Coinsurance	40% Coinsurance	
Additional Services			
Acupuncture	Not covered	Not covered	
Chiropractic	10% Coinsurance	40% Coinsurance	Benefits for muscle manipulations and spinal adjustments are limited to $200 per calendar year.
Durable Medical Equipment	10% Coinsurance	40% Coinsurance	
Home Health Care	10% Coinsurance	40% Coinsurance	
Hospice Services	10% Coinsurance	40% Coinsurance	
Organ and Tissue Transplant Services	10% Coinsurance	40% Coinsurance	
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	10% Coinsurance	40% Coinsurance	

Your Program Coverage Overview

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

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

- The *Benefits at a Glance* table only provides a high-level summary of your Benefits. To best understand the full extent of Covered Health Services and any limitations or exclusions applicable to your Benefits, see the "What Is Covered" and "Limitations and Exclusions" sections of this SPD.
- You and the Program share the cost of most Covered Health Services. See the "Cost Sharing" section for information on how you and the Program share in this responsibility. The following are exceptions to the general cost-sharing provisions contained in this section of the SPD:
    - Preventive Care Services are covered at 100 percent of the Allowable Charge if these Services are provided by a Network Provider. However, the Program will pay no Benefits, and you will be responsible for the full cost of Services, if Preventive Care Services are provided by a Non-Network Provider. For information specific to your Preventive Care Services Benefits, see the *Benefits at a Glance* table and "Preventive Care Services" section.
    - Emergency Services are covered the same whether you receive care at a Network or Non-Network facility, as long as the Service is provided for an Emergency Medical Condition. See the "Definitions" section for the definitions of Emergency Services and Emergency Medical Condition. For information on your Benefits for Emergency Services, see the "Emergency Services" section.
- The Program gives you access to a Network of Physicians and other health care Providers to maximize your Benefits under the Program. You are not required to designate a Primary Care Physician to receive Program Benefits. However, if you use Network Providers, you will receive the Network level of Benefits and generally pay less out of pocket for Covered Health Services. Also, the Benefits Administrator and the Network Provider negotiate an agreed amount for the Provider's Services, and your Network Provider will not charge you for any amounts that are more than the Negotiated Rate. For more information, see the "What You Need to Know About Providers" section.
- If you receive Services from a Non-Network Provider, you generally will pay more for Covered Health Services because your portion of the cost sharing may be greater and Providers have not agreed to a Negotiated Rate for Covered Health Services. You also may be required to pay any amount above the Allowable Charge determined by the Benefits Administrator. For more information, see the "Non-Network Coverage" section.
- Services are not considered a Covered Health Service unless they are determined to be Medically Necessary. See the "Medically Necessary" section for more information.
- Some Services require Notification and/or Preauthorization for maximum coverage under the Program. See the "Notification and Preauthorization Requirements" section for information.

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

Conditions for Program Benefits

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

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

COST SHARING

KEY POINTS

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

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

This section describes cost-sharing features that are built into the Program. See the *Benefits at a Glance* table(s) for specific amounts. This section does not include cost sharing information for benefits provided under any Fully-Insured Managed Care Options available under the Program. See the “Fully-Insured Managed Care Option” section for information.

Annual Deductible

If you are enrolled in coverage under a Health Care Network or Preferred Provider Organization option, the following applies.

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

There are separate Network and Non-Network Annual Deductibles:

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

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

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

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

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

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

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

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

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

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

The following tables summarize what cost components do and do not apply to the Annual Deductible.

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

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

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

Coinsurance

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

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

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

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

For example, if the Program pays 90 percent of Allowable Charges if you use a Network Provider and 60 percent if you use a Non-Network Provider and you visit a Network Provider for a Covered Health Service, the Network Provider will accept a Negotiated Rate. If the Negotiated Rate is $10,000 and you have met your Annual Deductible, the Program will pay $9,000 (90% x $10,000). You will be responsible for the $1,000 Coinsurance amount (10% x $10,000).

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

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

Annual Out-of-Pocket Maximum for Participants Enrolled in the Health Care Network Option

The Annual Out-of-Pocket Maximum limits the amount you pay for Covered Health Services each year. Once your payments for Covered Health Services reach the applicable Annual Out-of-Pocket Maximum, the Program pays 100 percent of any Allowable Charges for most Covered Health Services for the rest of the year, unless you change your Program option. See the "Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum" section for more information. Notwithstanding the Annual Out-of-Pocket Maximum limit for the Program, the Allowable Charges for Eligible Expenses you pay out of pocket for Covered Health Services by Network Providers in a calendar year may not exceed the limit specified for each year by PPACA ($6,600 for individual coverage and $13,200 for family coverage in 2015). This overarching Annual Out-of-Pocket Maximum includes all Network Co-payments, Annual Deductibles, and Coinsurance for Essential Health Benefits (e.g., medical, mental health/substance abuse, prescription drug, non-excepted dental and vision) and must accumulate to a single overarching Annual Out-of-Pocket Maximum or have limits imposed on the component pieces that will not exceed the foregoing cap when combined.

If You Are Enrolled in Network Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	Network	Non-Network	ONA
Counts toward the Annual Out-of-Pocket Maximum?			
Amounts that exceed allowable charges for eligible expenses	No	No	No
Annual Deductible	No	No	No
Coinsurance	Yes	Yes	Yes
Contributions	No	No	No
Ineligible expenses	No	No	No
Non-Network Allowable Charges	No	Not applicable	Not applicable
Network Allowable Charges	Not applicable	No	Not applicable
Outpatient prescription drug expenses	No	No	No
Notice or preauthorization penalties	No	No	No
Balance-billed charges	No	No	No
Health care this plan doesn't cover	No	No	No

Annual Out-of-Pocket Maximum for Participants Enrolled in the Preferred Provider Organization Option

The Annual Out-of-Pocket Maximum limits the amount you pay for Covered Health Services each year. Once your payments for Covered Health Services reach the applicable Annual Out-of-Pocket Maximum, the Program pays 100 percent of Allowable Charges for *most* Covered Health Services for the rest of the year, unless you change your Program option. See the "Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Out-of-Pocket Maximum" section. Notwithstanding that the Annual out-of-Pocket Maximum limits for the Program do not include the Annual Deductible, the Network Allowable Charges for Eligible Expenses you pay out of pocket for a calendar year for Covered Health Services (not including Prescription Drugs in 2014) may not exceed the limit specified for each year by PPACA ($6,350 for individual coverage and $12,700 for family coverage in 2014).

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

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

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

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

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

Amounts that apply to the Network and Non-Network Annual Out-of-Pocket Maximum only include amounts you pay toward the cost of medical and MH/SA Eligible Expenses. Amounts you pay toward the cost of outpatient Prescription Drug Eligible Expenses do not apply to the Network and Non-Network Annual Out-of-Pocket Maximum.

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

	Network	**Non-Network**
Counts toward the Annual Out-of-Pocket Maximum?		
Amounts that exceed allowable charges for eligible expenses	No	No
Annual Deductible	No	No
Coinsurance	Yes	Yes
Contributions	No	No
Ineligible expenses	No	No
Non-Network Allowable Charges	No	No
Network Allowable Charges	Not applicable	Not applicable
Outpatient prescription drug expenses	No	No
Notice or preauthorization penalties	No	No
Balance-billed charges	No	No
Health care this plan doesn't cover	No	No

Allowable Charge for Eligible Expenses for Participants Enrolled in a Preferred Provider Organization or a Health Care Network Option

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

The Benefits Administrator determines the Allowable Charge for Eligible Expenses based on the type of Provider (Network or Non-Network) and whether or not this Program's coverage or Medicare is primary. A special provision applies for Emergency Services.

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

If this Program Is Primary	
Network Providers	**Non-Network Providers**
Negotiated Rate	• Reasonable & Customary rate (R&C)
For Emergency Services	
Network Providers	**Non-Network Providers**
Negotiated Rate	The highest of the: • Median Allowable Charge for Network Emergency Services; • Reasonable and Customary R&C (or similar amount determined using the Program's general method for determining payments for Non-Network Services); or • Amount that would be allowable under Medicare; but no more than the Provider bills for the Service. The Provider may bill you for the amount not covered by the Program.
If Medicare Is Primary	
• If Provider accepts Medicare assignment, then the Medicare Allowable Amount. • If Provider does not accept Medicare assignment, then the Medicare charge limit.	
If Another Coverage is Primary	
See the "Coordination of Benefits" section for more information.	

Benefit Maximums

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

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

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

MEDICAL BENEFITS

KEY POINTS

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

OVERVIEW

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

- ***Network vs. Non-Network Providers.*** *Even when you are enrolled in Network coverage, you are not required to use Network Providers. However, you generally pay more if you use Non-Network Providers, except for Emergency Services. Note: Emergency Services are paid at the same level regardless of the Provider’s Network status.*
- ***Network vs. Out-of-Network Area.*** *You are assigned Network coverage if your home ZIP code falls in the Network Area. If your home ZIP code does not fall in the Network Area, you are assigned Outside Network Area (ONA) coverage, but you may elect Network coverage.*
- ***Allowable Charge.*** *Program Benefits are based on the Allowable Charge, which is determined by the Benefits Administrator. Amounts above the Allowable Charge do not count toward the Annual Deductible or Annual Out-of-Pocket Maximum. See the “Cost Sharing” section for more information.*
- ***Shared Cost of Benefits.*** *Generally, you and the Program share the cost of Medical Benefits, including Mental Health/Substance Abuse Covered Health Services.*
- ***Annual Deductible.*** *Except for eligible Preventive Care Services, you must meet an Annual Deductible before the Program begins to pay Benefits. There are separate Network and Non-Network Annual Deductibles. Note: Deductibles and Out-of-Pocket Maximums start over each year.*
- ***Coinsurance.*** *After you meet the Annual Deductible, you and the Company share the cost of Covered Health Services in the form of Coinsurance. The amount you pay in Coinsurance has a limit each year (Annual Out-of-Pocket Maximum). There are separate Network and Non-Network Out-of-Pocket Maximums. Once you meet the applicable Annual Out-of-Pocket Maximum, the Program reimburses at 100 percent of the applicable Allowable Charges for the remainder of the year.*

- ***Preventive Care Services.*** *Eligible Preventive Care Services are covered at 100 percent of Allowable Charges and are not subject to an Annual Deductible or Coinsurance when you use Network Providers or if you are enrolled in ONA. If you are enrolled in Network coverage, Preventive Care Services generally are not covered when you use Non-Network Providers.*

- ***Notification and Preauthorization.*** *Some Services require you to notify the Benefits Administrator within a certain period of time before or after receiving care. Other Services require you to preauthorize care. For special Services associated with certain medical conditions (for example, transplants), you must obtain Preauthorization before receiving care. See the "Notification and Preauthorization Requirements" section for more information.*

- ***Covered Health Services.*** *This section of your Summary Plan Description (SPD) includes a list of medical and Mental Health/Substance Abuse Covered Health Services and restrictions on those Services, as well as a list of Services that are not covered by the Program. The lists are not exhaustive. Generally, a Covered Health Service is a Service that is Medically Necessary and appropriate for your condition, and that is not Experimental or Investigational or otherwise excluded.*

- ***Mental Health Services and Substance Abuse (MH/SA).*** *Eligible MH/SA Services generally are covered at the same level as other covered medical expenses, to the extent required by law. However, MH/SA Benefits are managed by a different Benefits Administrator than the Benefits Administrators for your Medical and Prescription Drug Benefits. For information on how to contact the medical, Prescription Drug or MH/SA Benefits Administrator, see the "Contact Information" section.*

What You Need to Know About Providers

The medical and MH/SA Benefits Administrators or their affiliates arrange for health care Providers to participate in a Network. There are separate Networks for Medical Benefits and MH/SA Benefits.

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

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

Do not assume that a Network Provider's agreement includes all Covered Health Services at Negotiated Rates. Some Network Providers contract to provide only certain Covered Health Services. For example, a Physician may participate in the medical Benefits Administrator's Network

for cardiology Services only and not for primary care. Contact your Benefits Administrator for information about the type of Covered Health Services offered by a Network Provider.

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

Medicare-Eligible Covered Persons

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

Note: If Services are not covered under Medicare, but are covered under this Program, the Program rules for determining Allowable Charges for Services not covered by Medicare apply if you are enrolled in coverage other than a Health Care Network or Preferred Provider organization option.

How Network Areas Are Determined

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

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

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

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

Network Benefits

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

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

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

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

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

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

> **IMPORTANT:** If you or your covered dependent are Medicare Eligible and Medicare is your primary coverage (see the "Coordination of Benefits" section), Benefits will be paid based on the Medicare assigned rate, whether or not you use a Network Provider.

Designated Network Providers

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

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

Non-Network Provider Benefits Paid as Network Benefits

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

Non-Network Coverage

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

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

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

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

See the "Cost Sharing" section for more information, and the *Benefits at a Glance* table for specific information about what the Program pays.

Outside Network Area (ONA) Coverage

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

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

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

You may verify a Provider's status by contacting the medical or MH/SA Benefits Administrator or visiting the applicable Benefits Administrator's website. See the "Contact Information" section for Benefits Administrator contact information.

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

Electing to Enroll in Network Coverage

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

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

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

Comparison of Network, Non-Network and ONA Benefits

The following table provides an overview of the differences in out-of-pocket expenses, Notification and Claim filing requirements and how Emergency Services are covered among Network, Non-Network and ONA levels of Benefits. This does not apply to Preventive Care; see

the separate "Preventive Care" subsection under the "What Is Covered" section for information on Preventive Care Benefits.

	Network Benefits (Network Provider Used)	Network Benefits (Non-Network Provider Used)	Outside Network Area (ONA) Benefits
Out-of-pocket expenses	Your out-of-pocket expenses are lower when you use Network Providers: • The Benefits Administrator and the Network Provider negotiate an agreed amount for the Provider's Services. The agreed amount is considered the Negotiated Rate for Program Benefits. • The Network level of Benefits pays a greater portion of the Allowable Charge determined by the Benefits Administrator, which is based on the Negotiated Rate. • Your Network Provider will not charge you for any amounts that are more than the Negotiated Rate.	Your out-of-pocket expenses are greater when you use Non-Network Providers: • Non-Network Providers generally do not agree to a Negotiated Rate for the Provider's Services; however, the Program only pays Benefits up to the Allowable Charge. • The Non-Network Provider has not agreed to accept a Negotiated Rate for the Provider's Services. This means that you must pay any amount above the Allowable Charge determined by the Benefits Administrator. • The amount to which your Coinsurance applies may be greater.	Your out-of-pocket expenses are lower when you use Network Providers: • The Benefits Administrator and the Network Provider negotiate an agreed amount for the Provider's Services. The agreed amount is considered the Negotiated Rate for Program Benefits. • Your Network Provider will not charge you for any amounts that are more than the Negotiated Rate. Your out-of-pocket expenses are greater when you use Non-Network Providers: • If a Negotiated Rate is not agreed upon, the Provider may charge you for any billed amounts that are more than the Allowable Charge determined by the Benefits Administrator.
See the Benefits at a Glance table following the "Conditions for Program Benefits" section for cost-sharing amounts.			

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

Comparison of Claims/Financial Responsibility

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

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

	Network	Non-Network	ONA (Network Provider Used)	ONA (Non-Network Provider Used)
Provider charge for Covered Health Service	$12,000	$12,000	$12,000	$12,000
Allowable Charge (determined by the Benefits Administrator)	$9,000	$10,500	$9,000	$10,500

	Network	Non-Network	ONA (Network Provider Used)	ONA (Non-Network Provider Used)
Percentage of Allowable Charge paid by the Program	90%	60%	90%	90%
Total amount paid by the Program	$8,100	$6,300	$8,100	$9,450
Mary’s percentage/Coinsurance of Allowable Charge	10%	40%	10%	10%
Amount exceeding Allowable Charge	$0	$1,500	$0	$1,500
Total amount Mary owes Provider	$900	$5,700	$900	$2,550

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

Choosing Your Providers

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

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

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

How Your Choice of Providers Affects Your Benefits

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

- **Network Providers.** Your medical or MH/SA Benefits Administrator has identified a group of Providers who are “in Network” and have agreed to provide Covered Health Services at a Negotiated Rate (or discounted rate). Generally, these Negotiated Rates are lower than what Non-Network Providers would charge. This means you pay less. The Network Provider will generally bill and be reimbursed by the Benefits Administrator.

- **Non-Network Providers.** When you receive Covered Health Services from a Non-Network Provider, the Provider’s fees are not subject to Negotiated Rates. The Program only pays up to the amount that the Benefits Administrator determines is the Allowable Charge for a given Service in your area. This means that if your doctor charges above this determined Allowable Charge, you may have to pay the remainder. In most cases, you also will have to file a Claim for Benefits with the Benefits Administrator.

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

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

Showing Your ID Card

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

Transition of Care

If you are enrolled in a Health Care Network, Consumer Driven Health Plan, or Preferred Provider Organization option, the following applies:

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

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

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

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

Non-MH/SA Transition of Care Procedures

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

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

- End-stage renal disease and dialysis (applies to the Physician or other Provider, or dialysis center), limited to 30 days.

- Nonsurgical cancer therapies, including chemotherapy and radiation, limited to 30 days or completion of the current cycle, whichever is longer.
- Pregnancy, through the postpartum follow-up visit.
- Symptomatic AIDS, limited to 30 days.
- Transplants (solid organ and bone marrow).

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

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

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

To find out the status on your transition of care request, contact the medical Benefits Administrator. See the "Contact Information" section for medical Benefits Administrator contact information.

MH/SA Transition of Care Procedures

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

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

Notification and Preauthorization Requirements

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

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

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

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

Notification and Preauthorization Process

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

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

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

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

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

Notification and Preauthorization Requirements Table

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

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

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

If you are enrolled in coverage under the Health Care Network option, the following table applies:

	Notification and Preauthorization Requirements	Timing	Penalties
Alternate Care in Lieu of Hospitalization	**Preauthorization**: Required	As soon as possible and before Services are received	Benefits will be denied
Cardiac Rehabilitation	**Preauthorization**: Required	Prior to receiving Services	Benefits payable will be reduced by 50%
Durable Medical Equipment (DME)	**Preauthorization**: Required	Prior to receiving DME or if a piece of equipment needs repair or replacement	Benefits will be denied
Emergency Room	**Notification**: Not required unless admitted. See the *Hospital Admission after an Emergency* row for more information.	See the *Hospital Admission after an Emergency* row for more information	See the *Hospital Admission after an Emergency* row for more information
Home Health Care	**Preauthorization**: Required	Prior to receiving Services	Benefits payable will be reduced by 50%
Hospital Admission after an Emergency	**Notification**: Required. See the "Notification and Preauthorization Requirements" section for more information.	Within 24 hours of Admission	Benefits payable will be reduced by 50%
Infertility	**Preauthorization**: Required	Prior to receiving any treatment, Services or supplies	Benefits will be denied

	Notification and Preauthorization Requirements	Timing	Penalties
Maternity Hospital Admission	**Notification**: Required. See the "Notification and Preauthorization Requirements" section for more information.	Two business days if the inpatient stay for the mother or newborn exceeds 48 hours for normal vaginal delivery or 96 hours for cesarean section	Benefits payable will be reduced by 50%
Organ and Tissue Transplant	**Preauthorization**: Required. There are specific guidelines regarding Benefits for transplant Services. In order to receive special Services you must contact the Medical Benefits Administrator. Additional Benefits are available for certain Programs, see *Appendix C* for more information.	As soon as the possibility of a transplant arises (and before the transplant center performs a pretransplantation evaluation)	Benefits payable will be reduced by 50%
Outpatient Procedures/Surgery	**Notification:** Required before outpatient surgery is performed	As soon as you know that outpatient surgery is required. A minimum of five to seven business days advance notice is preferred.	Benefits payable will be reduced by 50%
Private Duty Nursing	**Preauthorization**: Required	Prior to receiving Service	Benefits payable will be reduced by 50%
Scheduled Hospital Admission	**Notification:** Required	Before elective Admission (five to seven business days advance Notification is preferred)	Benefits payable will be reduced by 50%
Skilled Nursing Facility or Extended Care Facility	**Preauthorization**: Required	Prior to receiving Service	Benefits payable will be reduced by 50%
Surgery	**Notification:** Required for outpatient surgeries	As soon as you know that outpatient surgery is required. A minimum of five to seven business days advance notice is preferred.	Benefits payable will be reduced by 50%

Notification and Preauthorization Requirements

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

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

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

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

Notification and Preauthorization Process if You Are Enrolled in Coverage Under a Preferred Provider Organization or Indemnity Option

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

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

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

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

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

Notification and Preauthorization Requirements Table

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

Note: It is important to follow the procedures and timing noted below. Failure to provide Notification or receive Preauthorization may affect your Benefits. However, in an emergency, seek care immediately, then call your Physician as soon as reasonably possible for further assistance and directions on follow-up care. If you have any questions about the Notification or Preauthorization requirements, contact your Benefits Administrator at the telephone number on your ID card. Contact information is also located in the "Contact Information" section of this SPD.

If you are enrolled in coverage under a Preferred Provider Organization option, the following table applies:

	Notification and Preauthorization Requirements	Timing	Penalties
Air Ambulance or Air Transport for Non-Emergencies	**Notification**: Required	Prior to receiving Services	Benefits payable will be reduced by $250
Alternate Care in Lieu of Hospitalization	**Preauthorization**: Required	As soon as possible and before Services are received	Benefits will be denied
Ambulatory Surgical Centers	**Preauthorization**: Required	At least 10 days before a scheduled surgical procedure in an Ambulatory Surgical Center	Benefits payable will be reduced by $250
Emergency Room	**Notification**: Not required unless admitted. See the *Hospital Admission after an Emergency* row for more information.	See the *Hospital Admission after an Emergency* row for more information	See the *Hospital Admission after an Emergency* row for more information
Home Health Care	**Preauthorization**: Required	Prior to receiving Services	Benefits will be denied
Hospice	**Notification**: Required	Prior to receiving Services	Benefits will be denied
Hospital Admission after an Emergency	**Notification**: Required	Two business days after Admission or as soon as reasonably possible	Benefits payable will be reduced by $250
Maternity Hospital Admission	**Notification**: Required	Two business days or as soon as possible if the inpatient stay for the mother and/or newborn exceeds 48 hours for normal vaginal delivery or 96 hours for cesarean section	Benefits payable will be reduced by $250

	Notification and Preauthorization Requirements	Timing	Penalties
Organ and Tissue Transplant	**Notification**: Required. There are specific guidelines regarding Benefits for transplant Services. In order to receive maximum Benefits you must contact the Medical Benefits Administrator.	As soon as the possibility of a transplant arises (and before the transplant center performs a pretransplantation evaluation)	Benefits will be denied
Outpatient Procedures/Surgery	**Notification**: Required for certain procedures. See the "Notification and Preauthorization Requirements" section for a list of procedures requiring prior Notification.	At least 10 days before a scheduled surgical procedure	Benefits payable will be reduced by $250
Private Duty Nursing	**Notification**: Required	Prior to receiving Services	Benefits will be denied
Scheduled Hospital Admission	**Preauthorization**: Required	At least 10 business days before Admission	Benefits payable will be reduced by $250
Skilled Nursing Facility or Extended Care Facility	**Preauthorization**: Required	Prior to receiving Service	Benefits will be denied
Surgery	**Notification**: Required for certain outpatient procedures. See the "Notification and Preauthorization Requirements" section for a list of procedure requiring prior Notification.	At least 10 days before a scheduled outpatient surgical procedure	Benefits payable will be reduced by $250 *Note*: penalty is applied to the Surgeon/Professional Charge
Surgical Treatment for TMJ	**Notification**: Required	Prior to receiving Services	Benefits payable will be reduced by $250
For a complete list of Services not listed in this table, see the "Notification and Preauthorization Requirements" section below.			

Above you will find a description of the process for providing prior Notification to the Benefits Administrator when you are enrolled in the Preferred Provider Organization option. See the *Notification and Preauthorization Requirements* table above for a list of procedures, timing requirements and any penalties for failure to follow Notification and Preauthorization requirements.

Prior Notification Requirements

The Program requires you, your Provider or authorized representative to give prior Notification to your medical or MH/SA Benefits Administrator within the designated time frame before you receive certain Covered Health Services or Benefits will be reduced or denied. Also see the list below for certain Services requiring prior Notification when performed on an Outpatient basis.

In addition, although not required, there are some Covered Health Services for which advance Notification is recommended. Letting your medical or MH/SA Benefits Administrator know about

procedures before you receive them lets your Benefits Administrator assess if Preauthorization is required and ensures you are receiving the most appropriate Program Benefits.

Outpatient Procedures/Surgery that Require Prior Notification
The following medical procedures require prior Notification if you are enrolled in the PPO and Services are performed on an outpatient basis:

- Bunionectomy (repair of bunion deformity on great toe)
- Cardiac catheterization (diagnostic procedure passing a catheter into the heart through a blood vessel)
- Carpal tunnel repair (relief of nerve pressure in the wrist)
- Closed reduction of bone fracture
- Dilation and curettage (D&C or scraping of the uterus)
- Hemorrhoidectomy (removal of hemorrhoids)
- Inguinal hernia repair (repair of a tear in the muscle wall separating the groin and abdominal cavity)
- Lithotripsy (removal of kidney stone)
- Pilonidal cyst removal (removal of a cyst located near the base of the spine)
- Submucous resection (removal of a portion of the nasal septum)
- Stapedectomy (removal of the stapes bone of the ear)
- Tonsillectomy/adenoidectomy (removal of the tonsils/adenoids)
- Venography (X-raying of veins injected with dye)

Preauthorization Requirements for Participants Enrolled in a Preferred Provider Organization or an Indemnity Option

The Program requires you, your Provider or authorized representative to contact the Benefits Administrator before you receive certain Covered Health Services and obtain the Benefits Administrator's approval for the planned care. If you do not obtain Preauthorization when required, Benefits for the Covered Health Service will be reduced or denied.

Predetermination of Benefits

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

A predetermination of benefits is not required, nor is it considered a Pre-Service Claim as described in the "Pre-Service Claims" subsection of the "Claims for Benefits" section. A

predetermination is valid for 90 days from the date of the predetermination letter. Procedures not performed within this period require a new review.

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

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

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

Definition of Medically Necessary

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

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

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

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

Services Considered Not Medically Necessary

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

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

Examples of Services Considered Not Medically Necessary

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

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

The Benefits Administrator will determine whether hospitalization or other health care Services are Medically Necessary and therefore, eligible for payment. If you have any questions about

whether a Service is considered Medically Necessary, contact your Benefits Administrator before care is obtained. Care that is not Medically Necessary will not be covered.

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

Determination of Medically Necessary Covered Health Services

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

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

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

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

WHAT IS COVERED

KEY POINTS

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

> **IMPORTANT:** If you are enrolled in a Fully-Insured Managed Care Option, you are not eligible for Benefits under the Program as described in this section. See the “Fully-Insured Managed Care Option” section of this SPD for more information.

This section provides detailed information about the kinds of Medical Benefits, including Benefits for Mental Health/Substance Abuse Services, the Program provides. The term “Program,” when used in this section, does not include Fully-Insured Managed Care Options that are available under the Program. See the “Fully-Insured Managed Care Option” section for information. For specific information about what you pay for these Covered Health Services, see the *Benefits at a Glance* table. To better understand how to use this section and better understand what is covered, here is some important information:

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

Preventive Care Services

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

Preventive Care Services are those Services that are determined by the Benefits Administrator to provide preventive care and are included in the Benefits Administrator’s preventive care policy. The fact that a Service is coded by a Provider as preventive care does not determine whether the Service is covered as a Preventive Care Service. At a minimum, Preventive Care Services include the preventive care required pursuant to the provisions of the Patient Protection and Affordable

Care Act (PPACA). The Services covered as Preventive Care Services will change from time to time as new medical evidence emerges and evidence-based recommendations change.

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

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

Special coverage provisions apply to Preventive Care Services. Preventive Care Services are covered at 100 percent of the Allowed Amount without participant cost sharing, such as a Co-payment, Coinsurance or Annual Deductible, but only when you receive Preventive Care Services on an outpatient basis from a Network Provider. If you are enrolled in an Indemnity option or the Medicare Expense option, Preventive Care Services are covered at 100 percent of the Allowed Amount without participant cost sharing, such as a Co-payment, Coinsurance or Annual Deductible. Benefits for Preventive Care Services are subject to other Program requirements, such as setting and appropriateness. No coverage is provided for Preventive Care Services if you receive these Services from a Non-Network Provider, unless you are enrolled in coverage that does not utilize a Network, such as an indemnity or out-of-network area (ONA) option. If you are enrolled in coverage that does not utilize a Network, Preventive Care Services are covered at 100 percent of the Allowed Amount, regardless of the Network status of the Provider.

Preventive Care Transition of Care

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

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

Emergency Services

Emergency Room (Emergency Medical Condition)

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

Unless you are enrolled in coverage that does not utilize a Network, such as an Indemnity or Medicare Expense option, Emergency Services due to an Emergency Medical Condition that are provided by a Non-Network Provider will be covered at the Network level of Benefits, that is, the Network cost-sharing requirements will apply no matter where you receive treatment. See the "Cost Sharing" section for information. The Allowable Charge for covered Non-Network Emergency Services Benefits will be no less than the highest of:

- The median Allowable Charge for Network Emergency Services;
- Reasonable and Customary (R&C) (or similar amount determined using the Program's general method for determining payments for Non-Network Services); or
- Amount that would be allowable under Medicare, but in no event more than the billed charges.

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

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

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

Note: Anesthesia administered due to an Emergency Medical Condition will be covered as Emergency Services if you are enrolled in an Indemnity or Medicare Expense option.

Emergency Room (Nonemergency)

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

Conditions Suggesting the Need for Emergency Services	Conditions Suggesting the Need for Nonemergency or Routine Services
• An apparent heart attack, including chest pain extending to the arms and jaw • Shortness of breath or difficulty breathing • Excessive bleeding • Loss of consciousness • Convulsions • Symptoms of a stroke, including sudden paralysis and/or slurred speech, lack of responsiveness, severe headache • Severe or multiple Injuries, including fractures • Allergic reactions • Apparent poisoning	• Sprains, strains • Fevers • Bad cuts • Skin rashes • Excessive vomiting • Stomach pain or cramps • Prolonged diarrhea • Bad colds, sore throats, coughs • Minor burns • Swollen glands

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

Urgent Care Facility

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

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

Ambulance Services

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

- When the Ambulance Service is necessary to transport a person due to an Emergency Medical Condition.
- To move a Covered Person to the nearest Hospital qualified to provide Medically Necessary treatment.

- An ambulance may also be used for transportation between Hospitals or upon discharge from a local Hospital when the use of the ambulance is Medically Necessary.
- Transportation by air ambulance is a covered expense if ground Ambulance Service is not available or if air Ambulance Service is Medically Necessary.

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

Inpatient Services

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

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

Room and Board

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

Lab and X-Ray

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

Other Inpatient Services

- Biotech or biotechnology products. Benefits are available for medications administered in the Hospital.
- Dental Services (accident only). Accidental Injury to sound natural teeth and removal of bony impacted or partially bony impacted wisdom teeth and certain other dental surgeries when performed in a Hospital.
- Drugs (while in the Hospital). "Take-home drugs" filled at the Hospital Pharmacy are paid under the Prescription Drug coverage. See the "Prescription Drug Coverage" section for outpatient Prescription Drug Benefits information.
- Eyecare. Covered surgical care is paid for the surgeon and the facility charge subject to the Inpatient Admission cost-sharing requirements. Routine vision care, such as refraction, lenses and frames are not covered. However, the initial pair of glasses or contact lenses following cataract surgery will be considered a Covered Health Service.

- Gynecological care (nonroutine exam by an obstetrician or gynecologist). Surgical care and Hospital Admissions for obstetric or gynecological care are payable the same as any other Medically Necessary Service.
- Nursing Services (including private duty nursing). For the Services of licensed technical or professional medical personnel given in a Hospital.
- Physicians' Services.
- Prescribed drugs and medicines received in a Hospital, as well as surgical supplies such as bandages and dressings.
- Radiation Therapy.
- Radiology.
- Surgery. Surgical Benefits include inpatient surgery, including Physician Services and facility charges.
- Surgical procedures (multiple). The primary procedure is subject to the applicable cost-sharing requirements. The second and third procedures are covered at 50 percent and additional procedures at 25 percent.

Hospital Expenses

Note: If you are enrolled in a PPO option, the following applies to you.

As with all expenses, procedures performed in a Hospital must be determined to be Medically Necessary by the Benefits Administrator and be considered an Eligible Expense to be covered under the Program. In addition, to receive Benefits, you must receive Preauthorization in certain circumstances. See the "Notification and Preauthorization Requirements" section for a list of Services, procedures or supplies requiring Preauthorization. See the applicable *Benefits Administrator* table in the "Contact Information" section for contact information.

Covered Hospital expenses include, but are not limited to:

- Ward or Semi-private Rooms.
- Rooms for special care, including intensive care, cardiac care and isolation rooms.
- Private rooms, up to the Semi-private Room rate.
- Special diets.
- General nursing care.
- Routine nursery care of a newborn infant during the mother's covered hospitalization.
- Use of operating, delivery, recovery, and treatment rooms and equipment.
- All FDA-approved drugs and medicines for use in the Hospital.
- Dressings, splints, casts and necessary central supply items.
- X-ray examinations, X-ray therapy and radiation therapy and treatment.

- Laboratory tests that are not duplications of tests done before Admission and paid by the Program, unless the applicable Benefits Administrator determines that duplicate tests are Medically Necessary.
- CAT scans and nuclear medicine.
- Oxygen and oxygen therapy, including the use of equipment for its administration.
- Electrocardiograms and electroencephalograms.
- Physical and Occupational Therapy.
- Anesthetics and their administration.
- Processing and administering blood and blood plasma.
- Use of heart-lung and kidney machines.

In-Hospital Physician or Specialist Visits

In-Hospital Physician or specialist visits are covered for each medical specialty. The Program will not cover Physician or specialist visits for any of the following:

- Pre- or postoperative treatments
- Dental treatments
- Eye exams or eyeglass fittings

Pre-Admission Hospital Testing

Generally, pre-Admission tests are required before you are admitted into a Hospital and are performed in an outpatient setting, such as a Hospital outpatient department or Ambulatory Surgical Center. These Services are covered by the Program if:

- A resulting hospitalization is Medically Necessary and a bed reservation has been made before the testing is performed.
- The tests are Medically Necessary and consistent with the diagnosis and treatment of the condition.
- The Admission is not canceled or postponed (unless this happens as a result of a second opinion, test results or other medical reasons).
- The tests are not later repeated in the Hospital after you are admitted (unless repetition of the tests is Medically Necessary).

Dental Hospitalization

Hospital expenses are covered if you are hospitalized for dental care because:

- You experience an accidental bodily Injury.
- A Physician, other than your dentist, certifies that hospitalization is necessary to ensure proper medical care because of a specific nondental impairment.

Outpatient Services

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

Office Visits

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

Outpatient Care

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

- Surgeon’s or assistant surgeon’s fees. Surgery done in the office setting is subject to the applicable cost-sharing requirement. An assistant surgeon must be under the direction of a surgeon.
- Surgical procedures (multiple). The primary procedure is subject to the applicable cost-sharing requirements. The second and third procedures are covered at 50 percent and additional procedures at 25 percent.
- Urgent Care (walk-in) Facility. See the “Urgent Care Facility” section above for information.

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

Mental Health and Substance Abuse (MH/SA) Services

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

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

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

MH/SA Professional Services

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

- Clinical laboratory Services.*
- Consultation to evaluate a Covered Person’s condition.
- Crisis intervention Services.
- Detoxification, including:
    - Physical or mental examination.
    - Administration of psychotropic drugs.
    - Consultation for further evaluation.
- Electroconvulsive shock therapy (ECT) and electrophysiological testing.
- Individual, family or group psychotherapy Counseling.

- Initial assessments of conditions related to alcohol and substance abuse.
- Physical or mental examinations for assessment and diagnosis.
- Psychotropic drugs and medicines and their administration are covered as an inpatient. Outpatient psychotropic drugs and medicines and their administration are covered under the Prescription Drug Benefit. See the "Prescription Drug Coverage" section for information on Benefits and cost sharing.
- Psychological testing, including charges for related materials.
- X-rays and other Diagnostic Services.*

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

MH/SA Inpatient Hospital Care

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

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

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

MH/SA Emergency Services

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

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

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

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

Family Planning/Maternity Services

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

Family Planning/Maternity Services

Note: If you are enrolled in a PPO option, the following applies to you.

Family Planning

- Initial male or female sterilization procedures and their reversal.

Maternity Services

- Services performed on or after the date the mother becomes covered under this Program, even if the Pregnancy began before the mother was covered.

- Prenatal and postnatal care. In addition, see the “Newborns’ and Mothers’ Health Protection Act” section of this SPD for information on your rights regarding Hospital stays after normal vaginal delivery or cesarean section.
- Delivery charges, cesarean section, ectopic Pregnancy, miscarriage or abortion (voluntary or therapeutic).
- Circumcision of a baby if performed by a Physician or surgeon.
- Nurse-Midwives, if the midwife is permitted to practice independently of a Physician by local state regulations.
- One pediatric examination of the newborn and nursery charges during the mother’s Hospital stay. If the newborn needs specific treatment or examinations for medical reasons, the Program covers the newborn as an individual dependent.

> **IMPORTANT:** Your newborn is eligible for coverage at birth, but you must take the necessary steps to enroll the newborn with the Eligibility and Enrollment Vendor within the time frame required to receive Program Benefits. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

Rehabilitation Services

- Cardiac rehabilitation: Rehabilitation Services must be performed by a licensed therapy Provider under the direction of a Physician.
- Occupational Therapy: Medical care and treatment by an occupational therapist.
- Physical Therapy.
- Speech Therapy.
- Vision therapy. For evaluating and developing a plan of treatment for the training by an optometrist or orthoptic technician. Routine vision care, such as eye refractions, lenses and frames, or contact lenses, is not covered under the Program.

Rehabilitation Services

Note: If you are enrolled in a PPO option, the following applies to you.

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

- Cardiac rehabilitation
- Occupational Therapy
- Physical Therapy
- Speech Therapy

There is no reimbursement for therapy that is Educational in nature, such as treating a learning disability. Therapy that is for maintenance after the optimum level of improvement has been reached is not covered.

Additional Services

Alternate Care

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

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

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

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

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

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

- A normal requirement for payment of Benefits under the Program is not met (e.g., the patient is no longer eligible to participate).
- Alternate Care is not being provided by duly licensed Providers within the scope of their license.
- Alternate Care is determined not to be a Covered Health Service or is otherwise excluded under the Program.

- Payment of Alternate Care Benefits is not cost effective, as determined in the sole discretion of the Benefits Administrator or its designee.

- Any established durations or other limitation set forth in the Alternate Care Plan agreement has been met or exceeded.

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

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

Anesthesia Services

If you are enrolled in a Preferred Provider Organization option, the administration of anesthesia is covered, either in or out of the Hospital, if performed by a Physician or qualified anesthesiologist other than the Physician performing the surgery or his/her assistant. Anesthesia administered due to an Emergency Medical Condition before a Hospital Admission will be covered as Emergency Services. See the "Emergency Services" section for more information.

Chiropractic Treatments

- Outpatient Services by a Physician, including a licensed chiropractor or naturopath. If you are enrolled in coverage under a Preferred Provider Organization, Chiropractic Services must be performed by a licensed chiropractor, osteopath or naturopath and include chiropractic adjustments and manipulations.

Durable Medical Equipment

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

- An appliance to replace a lost body organ or part to help a disabled person return to functioning capacity, for example, an artificial limb or eye. Only the charge for the first appliance in the patient's lifetime is covered for each body organ or part, except for replacements needed due to a change in the patient's physical condition (including normal physical growth).

- Custom-made orthotics.

- Oxygen and the charges for giving it, including rental of required equipment.

- Purchase of required minor equipment and supplies (including, but not limited to, nebulizers, canes, trusses, crutches, surgical belts and supports and special corsets).

Gender Dysphoria (Reassignment) Treatment

To be covered under the Program, the gender dysphoria (reassignment) treatment must be Medically Necessary. The determination of whether the treatment is Medically Necessary will be made by the Benefits Administrator based on generally accepted medical standards of care such as the *Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders*.

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

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

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

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

Hearing Benefit

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

- A hearing test/exam, when Medically Necessary. Associated office visits, exams and tests are not subject to the maximum dollar amount.
- Reimbursement of up to $1,000 of expenses incurred to purchase a Medically Necessary hearing aid appliance(s) in any rolling 36-month period.*
- Reimbursement for the cost of repair of your hearing aid appliance. The cost for the repair does not count toward the maximum dollar amount.

**Note: The Program will cover the first hearing aid following ear surgery or Injury, and it is not subject to the maximum dollar amount. Batteries for hearing aid appliances are not eligible for*

reimbursement. See the How the Rolling 36-Month Period Is Calculated table for more information.

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

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

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

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

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

How the Rolling 36-Month Period Is Calculated Hearing appliances (hearing aids) are subject to a maximum dollar amount within a 36-month rolling period for eligible Covered Persons under the Program. The example below shows how the reimbursement formula works.		
Date	**What Happened**	**Result**
Jan. 5, 2010	Hearing appliance purchased at $350. The 36-month rolling period for the $1,000 hearing appliance Benefits begins.*	Total Benefits used: $350 Total Benefits remaining through Jan. 4, 2013: $650
April 1, 2012	Hearing appliance purchased: $350.	Total Benefits used: $700 Total Benefits remaining through Jan. 4, 2013: $300
Jan. 5, 2013	A new 36-month rolling period begins.	The hearing appliance reimbursement amount is reset to $1,000
March 5, 2015	Hearing appliance purchased at $500. A new 36-month rolling period begins.	Total Benefits used: $500 Total Benefits remaining through March 4, 2018: $500
**The $1,000 is calculated beginning from the first date of Service indicated on the bill. It does not reset until 36 months later.*		

Home Health Care

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

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

Hospice Care

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

Medical Equipment (Rentals or Purchase)

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

Organ or Tissue Transplants

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

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

Organ Transplants

Note: If you are enrolled in coverage under a Preferred Provider Organization option, the following applies to you:

Type A Procedures

Type A procedures include cornea, kidney, heart valve, tissue and bone marrow transplants must be preauthorized by the medical Benefits Administrator. In addition, procedures must be performed at a Designated Network Provider.

Coverage for Type A procedures is determined as follows:

- If the recipient and donor are both covered by the Program, both patients will receive Benefits.
- If only the recipient is covered by the Program, the donor and recipient will receive Benefits from the Program to the extent that Benefits to the donor are not provided by another plan.
- If the donor is covered by the Program and the recipient's plan does not provide for the donor's expenses, the Program will cover the donor's expenses only. The recipient will not receive any Program Benefits.

> **IMPORTANT:** Type A Procedures must receive Preauthorization to be covered and must be performed at a Designated Network Provider. See the "Notification and Preauthorization Requirements" section for information.

Type B Procedures

Type B procedures include human heart, liver, heart/lung, pancreas/kidney, pancreas and isolated or bilateral organ transplants and must be preauthorized by the medical Benefits Administrator. In addition, procedures must be performed at a Designated Network Provider.

Covered Type B procedures include:

- The evaluation of the donor organ.
- The removal of the organ from the donor.
- Transportation of the organ to the operation location (if within the United States or Canada).
- Patient expenses up to a maximum of $5,000 for transportation and $5,000 for lodging provided the patient resides more than 50 miles from the Designated Network Provider. Eligible Expenses can also include transportation and lodging expenses for more than one person, provided you do not exceed the maximums. Those eligible to accompany the patient are not limited to family members. This reimbursement amount is separate from your cost-sharing requirements described in the "Cost Sharing" section and the *Benefits at a Glance* table of the SPD.

> **IMPORTANT:** Depending on the circumstances, travel and lodging benefits may be taxable compensation under the Internal Revenue Code. Contact the Benefits Administrator for further information.

- To be eligible for coverage for a Type B procedure:
  - You must face a high risk of death if the procedure is not done.
  - You must not have another diagnosed terminal Illness.
- Certain other requirements must be met as determined by the medical Benefits Administrator, such as sufficiently high survival rates for patients undergoing the procedure at that Hospital, or for the transplant team requesting to perform surgery.

The Program will not cover the following expenses:

- Services unrelated to the transplant or to the diagnosis or treatment of an Illness resulting directly from the transplant.
- Cardiac rehabilitation Services, unless you receive treatment immediately after you are discharged from the Hospital.
- Your Physician's travel time and any other related expenses.
- Experimental drugs that have not been approved by the FDA.

> **IMPORTANT:** Type B procedures performed by a Non-Network Provider or at a Non-Network facility are not covered by the Program, except in the case of the ONA Option. Also, all Type B Procedures must receive Preauthorization to be covered and must be performed at a Designated Network Provider, except in the case of the ONA Option. See the "Notification and Preauthorization Requirements" section for information.

Prosthetics

Note: If you are enrolled in coverage under a Preferred Provider Organization option, the following applies to you:

- Implantations of temporary prosthetic devices that are external and removable, and permanent internal devices such as heart pacemakers.
- Initial purchase of prosthetic limbs, eyes and other devices that replace parts of the body and attach to the body (excluding natural teeth and gums, unless there is an accidental Injury to natural teeth).

Skilled Nursing Facility

Skilled nursing Services must be in lieu of an inpatient Hospital stay. Benefits include room and board charges for a Semi-private Room or an intensive care unit. If you are enrolled in coverage under a Preferred Provider Organization option, skilled nursing services are covered if you are transferred directly to a facility from a Hospital and a Physician prescribes skilled nursing services. See the "Notification and Preauthorization Requirements" section for information.

EXCLUSIONS AND LIMITATIONS

KEY POINTS

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

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

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

This list does not include exclusions for outpatient Prescription Drug expenses. See the Prescription Drug “Exclusions and Limitations” section for a list of Prescription Drug exclusions. This section also does not include exclusions and limitations information provided under any Fully-Insured Managed Care Options available under the Program. See the “Fully-Insured Managed Care Option” section for information.

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

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

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

General Health Care Exclusions

- Charges for nontreatment purposes, including missed appointments, room or facility reservations, completion of Claim forms or record processing.
- Expenses for services that exceed the Allowable Charge or any specified limitation or penalty imposed under the Program.
- Claims filed more than one year after the date of Service if the Program is your only medical coverage, or two years after the date of Service if your Claim is coordinated with another coverage that has primary responsibility.
- Claims filed more than two years after the date of Service if you are enrolled in the Medicare Indemnity, SelectMed Medicare Indemnity or Medical Expense Program option.

- Expenses for a Covered Person (including Hospital confinement) incurred before the individual was covered under the Program.

- Services resulting from war or intentional armed conflict.

- Services for which a Covered Person is not required to make a payment (such as for professional courtesy) or for which a Covered Person would have no legal obligation to pay in the absence of this or any other similar coverage; for example, services provided by the federal or any state government or agency or subdivisions thereof.

- Services resulting from a work-related Injury or Illness covered under workers' compensation.

Specific Health Care Exclusions

Alternative Treatments

- Acupuncture.

Dental

- Routine dental care.

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

Devices and Appliances

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

- Post-mastectomy bras.

Foot Care

- Routine foot care, except for persons diagnosed with diabetes.

- Orthopedic shoes are not covered unless for a Child through the age of 12.

Mental Health/Substance Abuse (MH/SA)

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

- Any testing, evaluation, consultation, therapy, services, supplies or treatment that are covered as benefits under a plan or other coverage that is primary to coverage under the Program. See the "Coordination of Benefits" section for further information on what coverage is primary.

- Any testing, therapy, service, supply or treatment of organic disorders, dementia and primary neurologic/neurodevelopment/neurocognitive disorders except for associated treatable and acute behavioral manifestations.

- Any testing, evaluations, consultations, therapy, rehabilitation, remedial education, services, supplies or treatment for developmental disabilities, communication disorders or learning disabilities available from or through the educational system (whether public, parochial or private), and/or required to be made available from or through the educational system

pursuant to Public Law 94-142, regardless of whether or not there is any cost to the Covered Person or the Covered Person takes advantage of such testing, rehabilitation, remedial education, services or treatment.

- Any testing, evaluation, consultation, therapy, services, supplies or treatment for personal or professional growth and development.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment relating to employment, regardless of whether Investigational or pre- or post-employment.
- Any testing, therapy, service, supply or treatment that does not meet national standards for mental health professional practice or that have not been found to be efficacious or beneficial by one or more of the plans or its designees or authorized management entity's clinical quality or review committees based on a review of peer-reviewed literature and clinical information available.
- Any testing, therapy, service, supply or treatment provided as a result of any workers' compensation law or similar legislation or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof (exclusive of Medi-Cal/Medicaid) or caused by the conduct or omission of a third party for which the Covered Person has a claim of damages or relief, unless the Covered Person provides the Program or its designee with a lien against such claim for damages or relief in a form and manner satisfactory to the Program and its designee.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment provided by the Covered Person's parent, siblings, Child(ren), current or former Spouse, or current or former Partner.
- Court-ordered psychiatric or substance abuse evaluation, treatment and testing except when the Program or its designee determines that such services are Medically Necessary for the treatment of a DSM-IV mental health diagnosis according to established clinical criteria and clinical policies of the Program or its designee.
- Custodial Care. Defined as any services, supplies, care or treatment rendered to a Covered Person who:
    - Is disabled mentally or physically as a result of a DSM-IV-TR (or ICD-9) MH/SA diagnosis and such disability is expected to continue and be prolonged.
    - Requires a protected, monitored or controlled environment whether inpatient, outpatient or at home.
    - Requires assistance with activities of daily living.
    - Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the Covered Person to function outside the protected, monitored or controlled environment.
- Experimental or Investigational Services, including testing, therapy, Service, supply or treatment defined as an unproven therapy or treatment that may or may not be superior to a current "gold standard" therapy and that meets one or more of the following criteria:
    - Not generally accepted by the medical community as effective and proven.

    - Not recognized by professional medical organizations as conforming to accepted medical practice.
    - Not approved by the FDA or other requisite government body.
    - In clinical trials or needs further study.
    - Rarely used, novel or unknown and lacks authoritative evidence of safety and efficacy.
- Inpatient Prescription Drugs not dispensed as part of the treatment for a DSM-IV mental health diagnosis in the course of a preauthorized covered inpatient Admission.
- Outpatient Prescription Drugs.
- Private duty nursing except when preauthorized by the Program or its designee as Medically Necessary.
- Psychological testing, except when preauthorized as Medically Necessary by the Program or its designee.
- Services, supplies or treatment for or related to education or training for professional licensure, certification, registration or accreditation.
- Treatment or consultations provided via telephone, electronic transmission or other non-in-person modalities, unless determined as Medically Necessary.

Personal Care, Comfort or Convenience

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

Physical Appearance

- Wigs and wig styling.

Procedures and Treatments

- Autologous blood donation and storage.
- Charges for procedures, treatment methods, drugs or devices determined by the appropriate Benefits Administrator to be Experimental or Investigational. When a Covered Person is enrolled in a clinical trial, this exclusion does not apply to routine patient costs for services provided in connection with the clinical trial consistent with the coverage provided under the Program that are typically covered for a Covered Person who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Experimental, Investigational or Unproven Service itself; 2) Services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a Service that is inconsistent with the generally accepted and

established standards of care for a particular diagnosis otherwise covered under the Program.

- Cosmetic procedures (unless due to accidental Injury or functional impairment from a birth defect or disease, or breast reconstruction surgery as provided by law) as described in the “What Is Covered” section are excluded from coverage.

Provider Services

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

Reproduction

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

Transplants

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

Types of Care

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

Vision

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

All Other Exclusions

- Charges for custodial or respite care, or day care for Child(ren) or adults whether in the home or in a facility.
- Charges for education, training and bed and board while confined in an institution that is mainly a school or other institution for training or a place for the aged, or a nursing home.
- Expenses for Educational therapy, marital Counseling and sex therapy.
- Immunizations, unless otherwise specified in the “What Is Covered” section.
- Paternity testing to establish parenthood.
- Private duty nursing unless preauthorized by the Benefits Administrator.

- Tests for premarital or pre-employment examinations.
- Therapeutic massage and general massages, including services provided by a health spa.

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

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

General Health Care Exclusions for Participants Enrolled in the Preferred Provider Organization Option

- Charges for nontreatment purposes, including missed appointments, room or facility reservations, completion of Claim forms or record processing.
- Charges for Christian Science services.
- Charges submitted after the 24-month Claim submission time limit.
- Expenses for services that exceed the Allowable Charge or any specified limitation or penalty imposed under the Program.
- Expenses incurred before an individual becomes eligible for Program participation.
- Services for any Illness contracted or Injury sustained as a result of war, declared or undeclared, or any act of war.
- Services for which a Covered Person is not required to make a payment (such as for professional courtesy) or for which a Covered Person would have no legal obligation to pay in the absence of this or any similar coverage.
- Services provided by the federal or any state government or any agency or subdivisions thereof.
- Services for any Illness or Injury arising out of or in the course of employment for which benefits are available under any workers' compensation law or other similar laws whether or not you make a claim for such compensation or receive such benefits.

Specific Health Care Exclusions

Dental

- Expenses covered under the dental programs.
- Treatment of temporomandibular joint syndrome (TMJ) with intra-oral prosthetic devices or any other method that alters the vertical dimension or treatment of TMJ not caused by documented organic joint disease or physical trauma.

Devices, Appliances and Prosthetics Drugs

- Batteries.
- Procurement or use of special braces, splints, appliances, ambulatory apparatus, specialized equipment, battery or atomically controlled implants except as specifically provided in the Program.

Drugs

- Blood derivatives that are not classified as drugs in the official formularies.

Foot Care

- Routine foot care, except for persons diagnosed with diabetes.
- Treatment of flat feet and corrective shoes.

Mental Health/Substance Abuse (MH/SA)

- Any nonprescription or over-the-counter drug, supplement or other medicinal treatment.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment that are covered as benefits under a plan or other coverage that is primary to coverage under the Program. See the "Coordination of Benefits" section for further information on what coverage is primary.
- Any testing, therapy, service, supply or treatment of organic disorders, dementia and primary neurologic/neurodevelopment/neurocognitive disorders except for associated treatable and acute behavioral manifestations.
- Any testing, evaluations, consultations, therapy, rehabilitation, remedial education, services, supplies or treatment for developmental disabilities, communication disorders or learning disabilities available from or through the educational system (whether public, parochial or private) and/or required to be made available from or through the educational system pursuant to Public Law 94-142, regardless of whether or not there is any cost to the Covered Person or the Covered Person takes advantage of such testing, rehabilitation, remedial education, Services or treatment.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment for personal or professional growth and development.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment relating to employment, regardless of whether Investigational or pre- or post-employment.
- Any testing, therapy, service, supply or treatment that does not meet national standards for mental health professional practice, or that have not been found to be efficacious or beneficial by one or more of the plans or its designees or authorized management entity's clinical quality or review committees based on a review of peer-reviewed literature and clinical information available.
- Any testing, therapy, service, supply or treatment provided as a result of any workers' compensation law or similar legislation or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof (exclusive of Medi-Cal/Medicaid) or caused by the conduct or omission of a third party for which the Covered Person has a claim of damages or relief, unless the Covered Person

provides the Program or its designee with a lien against such claim for damages or relief in a form and manner satisfactory to the Program and its designee.

- Any testing, evaluation, consultation, therapy, services, supplies or treatment provided by the Covered Person's parent, siblings, Child(ren), current or former Spouse, or current or former Partner.
- Court-ordered psychiatric or substance abuse evaluation, treatment and testing except when the Program or its designee determines that such services are Medically Necessary for the treatment of a DSM-IV mental health diagnosis according to established clinical criteria and clinical policies of the Program or its designee.
- Custodial Care. Defined as any services, supplies, care or treatment rendered to a Covered Person who:
    - Is disabled mentally or physically as a result of a DSM-IV-TR (or ICD-9) MH/SA diagnosis and such disability is expected to continue and be prolonged.
    - Requires a protected, monitored or controlled environment whether inpatient, outpatient or at home.
    - Requires assistance with activities of daily living.
    - Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the Covered Person to function outside the protected, monitored or controlled environment.
- Experimental or Investigational Services, including testing, therapy, service, supply or treatment defined as an unproven therapy or treatment that may or may not be superior to a current "gold standard" therapy and that meets one or more of the following criteria:
    - Not generally accepted by the medical community as effective and proven.
    - Not recognized by professional medical organizations as conforming to accepted medical practice.
    - Not approved by the FDA or other requisite government body.
    - In clinical trials or needs further study.
    - Rarely used, novel or unknown and lacks authoritative evidence of safety and efficacy.
- Inpatient Prescription Drugs not dispensed as part of the treatment for a DSM-IV mental health diagnosis in the course of a preauthorized covered inpatient Admission.
- Outpatient Prescription Drugs.
- Private duty nursing, except when preauthorized by the Program or its designee as Medically Necessary.
- Psychological testing, except when preauthorized as Medically Necessary by the Program or its designee.

- Services, supplies or treatment for or related to education or training for professional licensure, certification, registration or accreditation.
- Treatment or consultations provided via telephone, electronic transmission or other non-in-person modalities, unless determined as Medically Necessary.

Nutrition

- Vitamins, food and food supplements used as dietary supplements.

Personal Care, Comfort or Convenience

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

Physical Appearance

- Wigs and wig styling.

Procedures and Treatments

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

Reproduction

- Charges for assisted reproductive procedures, including, but not limited to, in vitro fertilization, artificial insemination, GIFT or ZIFT (intrafallopian transfer) procedures.

Transplants

- Organ or tissue transplants or multiple organ transplants other than those listed in the "What Is Covered" section.
- Type B procedures as described in this SPD that are not performed by a Designated Network Provider.

Vision

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

All Other Exclusions

- Adult physical exams and routine gynecological exams except for those specifically described under the "Preventive Care Services" subsection in the "What Is Covered" section.
- Anesthesia given for a procedure not covered by the Program.
- Approved Home Health Care Agency, Skilled Nursing Facility, private duty nursing, Hospice care, psychiatric or psychological care and Counseling, substance abuse care or organ transplant procedures not preauthorized by the appropriate Benefits Administrators.
- Charges for convalescent, custodial or respite care, or day care, or sanitarium care or rest cures for Child(ren) or adults whether in the home or in a facility.
- Charges for education, training and bed and board while confined in an institution that is mainly a school or other institution for training or a place for the aged, or a nursing home.
- Charges for Hospital Admission, facility or professional care incurred as part of a controlled Investigational trial, unless otherwise payable by the Program.
- Charges for inpatient care of substance abuse if Outpatient Care would have been appropriate.
- Charges for routine assistance in daily living or supportive care for the convenience of the patient or other family member.
- Charges for Services received at health resorts, rest homes or nursing homes.
- Expenses for Educational therapy, marital Counseling and sex therapy.
- Hospital emergency room facility charges for care that is not an emergency.
- Hospitalization that is primarily for observation or for diagnostic studies that could be safely done in another setting on an outpatient basis.
- Hospital Admissions to observe or evaluate a medical condition that could have been provided safely and adequately in another setting such as a Hospital's outpatient department.

- Hospitalization or Admission to a Skilled Nursing Facility, nursing home or other facility for the primary purpose of Custodial Care, convalescent care, rest cures or domiciliary care to the patient, or because care in the home is not available or unsuitable.
- Continued inpatient Hospital care when the patient's medical symptoms and condition no longer require continued stay.
- Maintenance Occupational Therapy, maintenance Physical Therapy and maintenance Speech Therapy except as specifically mentioned in this SPD.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems, attention disorder, conceptual handicap or other learning disabilities or mental retardation.
- Paternity testing to establish parenthood.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide Services for the convenience of the patient or his or her family.
- Private duty nursing unless preauthorized by the Benefits Administrator.
- Premarital examinations.
- Routine physical exams except for those covered under the "Preventive Care Services" subsection in the "What Is Covered" section.

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

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

PRESCRIPTION DRUG COVERAGE

KEY POINTS

- *The Prescription Drug Benefit covers many, but not all, Prescription Drugs currently on the market.*
- *The Prescription Drug Benefit level of coverage depends on where you purchase your Prescription Drug and the type of Prescription Drug you receive.*
- *The Retail Prescription Drug Service is used for a short-term prescription supply (up to a 30-day supply).*

- *The Mail Order Prescription Drug Service is used for a long-term prescription supply (generally, up to a 90-day supply).*
- *The Prescription Drug Benefit imposes special rules for filling and refilling prescriptions for Specialty Prescription Drugs.*

Benefits at a Glance

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

If you are enrolled in a Fully-Insured Managed Care Option, you are not eligible for the Prescription Drug Benefits described in this section. Contact your Fully-Insured Managed Care Option Benefits Administrator for information about Prescription Drug coverage.

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

	Network Retail Pharmacy	**Non-Network Retail Pharmacy**	**Mail Order**
Cost and Coverage			
Annual Deductible	Not applicable	Not applicable	Not applicable

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Annual Out-of-Pocket Maximum	Individual and Family: $900/$1,800 • Combined with Mail Order Prescription Drug Service. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. Expenses that do not apply to the Annual Out-of-Pocket Maximum • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic Drug penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy.	Not applicable	Individual and Family: $900/$1,800 • Combined with Network Retail Pharmacy. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. Expenses that do not apply to the Annual Out-of-Pocket Maximum • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic Drug penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy.
Supply Limit	Up to a 30-day supply	Up to a 30-day supply	Up to a 90-day supply
Generic Drug	$10 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	$20 Co-payment per prescription

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Preferred Brand Drug	$30 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	$60 Co-payment per prescription
Non-Preferred Brand Drug	$60 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	$120 Co-payment per prescription
Co-payment Exceptions	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.
Other Requirements			
Mandatory Generic/Brand Restriction	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.
Mandatory Mail	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.
Rx Clinical Programs	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Specialty Pharmacy	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail. See the "Specialty Prescription Drug Services" section for Co-payment information.	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail. See the "Specialty Prescription Drug Services" section for information.	Specialty Prescription Drugs are automatically processed through the Specialty Pharmacy when you use the Prescription Drug Benefits Administrator's Mail Order Prescription Drug Service. See the "Specialty Prescription Drug Services" section for Co-payment information.

For more information about the Prescription Drug Benefit, see the:

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

Cost Sharing

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

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

Co-payments

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

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum limits the amount you pay for Prescription Drugs each year purchased from a Network Retail Pharmacy or through the Mail Order or Specialty Drug Programs.

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

Once you meet your Out-of-Pocket Maximum, the Program will pay 100% toward the expense that would have applied toward your Out-of-Pocket Maximum. You will still be responsible for any expenses that would not have applied toward the Out-Of-Pocket Maximum. Notwithstanding the Annual Out-of-Pocket Maximum limit for the Program, the Allowable Charges for Eligible Expenses you pay out of pocket for Covered Health Services in a calendar year may not exceed the limit specified for each year by PPACA ($6,600 for individual coverage and $13,200 for family coverage in 2015). This overarching Annual Out-of-Pocket Maximum includes all Network Co-payments, Annual Deductibles, and Coinsurance for Essential Health Benefits (e.g., medical, mental health/substance abuse, prescription drug, non-excepted dental and vision) and must accumulate to a single overarching Annual Out-of-Pocket Maximum or have limits imposed on the component pieces that will not exceed the foregoing cap when combined.

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

Prescription Drug Coverage

Covered and Excluded Medications

The Prescription Drug Program offers coverage of drugs that are:

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

The Prescription Drug Benefit covers many, but not all, Prescription Drugs currently on the market. For information about Prescription Drugs covered under the Prescription Drug Program, see the "What Is Covered" and "What Is Not Covered" subsections of this "Prescription Drug Coverage" section. For information about coverage of a specific Prescription Drug, contact the Prescription Drug Benefits Administrator. See the "Contact Information" section for contact information.

Classification of Prescription Drugs

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

Generic Drugs

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

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

Brand-Name Drugs

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

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

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

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

Preferred Brand-Name Drug

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

Non-Preferred Brand Drug

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

Brand-Name Drugs Purchased When a Generic Drug Is Available

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

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

Brand-Name Drugs Purchased When a Generic Drug Is Unavailable

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

Brand-Name Drugs When Medically Necessary

If a Brand-Name Drug is Medically Necessary, your Prescriber must indicate this on the prescription; otherwise a Generic Drug will be dispensed. Since a Brand-Name Drug is not usually Medically Necessary, the Pharmacist may contact your Prescriber even if the prescription indicates to dispense the Brand-Name Drug. If the Prescriber does not approve the change to a Generic

Drug, your prescription will be filled as originally written with the Brand-Name Drug. See the "Cost Sharing" section for cost share information.

Generic/Brand-Name Exception

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

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

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

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

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

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

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

Medication Management Services

The Prescription Drug Benefits Administrator uses Medication Management Services to promote the safe and effective use of Prescription Drugs. These Services are centered on Evidence-based Medical Guidelines and include:

- Drug Utilization Review – A safety feature that checks each new prescription against a record of your other Prescription Drugs and alerts the Pharmacist to potential drug interactions and other medication-related concerns.

- Specialty Pharmacy Services – A program to provide medications that treat complex conditions and usually require special handling. See the “Specialty Prescription Drug Services” section.
- Prescription Drug Coverage Review – A program that uses Evidence-based Medical Guidelines specifications to review if drug dosage and duration prescribed for certain conditions is appropriate.

Prescription Drug Benefits Administrator

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

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

Filling Your Prescriptions

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

The Prescription Drug Benefit consists of the following Services:

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

Retail Prescription Drug Services

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

Network Pharmacy

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

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

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

Non-Network Pharmacy

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

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

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

Mail Order Prescription Drug Services

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

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

Filling Initial Prescriptions Under the Mail Order Prescription Drug Service

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

- **Refilling Prescriptions.** There are several ways to refill your Mail Order Prescription Drug. Contact the Prescription Drug Benefits Administrator for instructions. See the *Prescription Drug Benefits Administrator* table in the "Contact Information" section for contact information.

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

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

> **IMPORTANT:** Prescription Drugs will not be filled or refilled under the Mail Order Prescription Drug Service if any of the following apply:
>
> (1) The prescription was written more than 12 months before it was filled.
>
> (2) The time permitted under applicable state law for controlled substances has expired.
>
> (3) The Prescription Drug is prohibited by applicable law or regulation.
>
> Pharmacies are required by law to dispense no more than the exact quantity prescribed by the Prescriber. To order refills of a medication, the Prescriber must indicate on the prescription that you can order refills.
>
> Once you purchase a Prescription Drug at a Retail Pharmacy or processing has begun through the Mail Order Prescription Drug Service, it cannot be canceled or returned. Federal and state laws require that returned medications be destroyed and cannot be restocked. As a result, once the Pharmacist has dispensed the drug, the order cannot be canceled and you are responsible for the full Co-payment. The Prescription Drug Benefit covers many, but not all, Prescription Drugs currently on the market. For information about your Prescription Drug cost under the Program, contact the Prescription Drug Benefits Administrator. See the “Contact Information” section for contact information.

Replacement/Early Refill Policy

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

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

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

Specialty Prescription Drug Services

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

Some key characteristics of specialty drugs include:

- Need for frequent dosage adjustments and drug monitoring.
- Cause more severe side effects than traditional drugs.
- Need special storage, handling and/or administration.

- Have a narrow therapeutic range.
- Require periodic laboratory or diagnostic testing.

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

If you or your covered dependent receives a Prescription Drug from a Specialty Pharmacy, you will be assigned to a clinician-led care team that will contact you to:

- Provide education on how to take your medication correctly;
- Review how to safely store and handle your medication;
- Remind you when it is time to refill your medication;
- Confirm how much medication you have on-hand before scheduling the next shipment;
- Troubleshoot any side effects you may experience; and
- Identify potential treatment issues and coordinate with your Prescriber.

Guidelines for Purchasing Specialty Prescription Drugs

- You may fill your first prescription for a Specialty Prescription Drug at a Network Retail Pharmacy.
- You must use the Specialty Prescription Drug Service for subsequent purchases of your Specialty Prescription Drug to receive coverage under the Prescription Drug Benefit. Except for the first Fill at a Network Retail Pharmacy, subsequent Fills of your Specialty Prescription Drug will not be covered under the Prescription Drug Benefit even if you use a Network Retail Pharmacy. The one-time exception applies to each Specialty Prescription Drug you purchase. Any Specialty Prescription Drug that is not covered because it was not purchased through the Specialty Prescription Drug Service will not apply toward any applicable cost share. See the "Cost Sharing" section for your cost share requirements.
- The Specialty Prescription Drug reimbursement limitation applies to all Specialty Prescription Drugs, including Specialty Prescription Drugs self-administered in your home. You must obtain self-administered Specialty Prescription Drugs through the Specialty Prescription Drug Service or it will not be covered by the Prescription Drug Program, and you will be responsible for 100% of the cost of the specialty medication.
- The Specialty Prescription Drug reimbursement limitation will apply to all Specialty Prescription Drugs — including Specialty Prescription Drugs obtained through a doctor's office, inpatient/outpatient facility and administered in the doctor's office, inpatient/outpatient facility.

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

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

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

Pharmacy Choice Can Affect Your Prescription Drug Benefits

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

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

Prescription Drug Benefit Coverage and Medicare Part D

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

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

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

What Is Covered

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

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

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

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

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

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

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

Personal-Choice Drugs

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

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

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

Preventive Care Drugs

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

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

Preventive Care Drugs currently include:

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

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

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

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

What Is Not Covered

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

Exclusions and Limitations	
Exclusions and Limitations:	Notes
Allergy serums	
Amounts above the Allowable Charge	
Anti-wrinkle agents	
Any drug or medicine not Medically Necessary for the treatment of your condition	
Any prescription refill in excess of the number of refills specified by the Provider or any refill requested after one year from the Provider's original order	
Batteries	
Charges for over-the-counter medications and pharmaceutical purchases	Except insulin, Diabetic Supplies, hypodermic needles and syringes prescribed by a Prescriber for use with covered injectables and medications. The Program also covers certain over-the-counter medications that are considered preventive if a prescription is provided. See the "Preventive Care Drugs" section for more information about preventive medications.

Exclusions and Limitations	
Exclusions and Limitations:	Notes
Charges for the administration or injection of any drug	May be covered under Medical. Not covered under the Prescription Drug Program. See the "What Is Covered" subsection in the "Medical and Mental Health/Substance Abuse Coverage" section.
Cosmetic Botox	
Depigmenting Agents	
Diet and weight loss medications	
Drugs in excess of the day supply limit for drugs purchased at a Retail Pharmacy or through the Mail Order Prescription Drug Service	Except for Seasonale, Seasonique or their generic equivalent (Mail Order only). See the Supply Limit in the "Benefits at a Glance" section.
Drugs paid for by any local, state or federal government agency	Except Medicaid programs or where otherwise required by law
Drugs that are not federal legend drugs (that is, over-the-counter drugs)	The Program also covers certain over-the-counter medications that are considered Preventive Care Drugs if a prescription is provided. See the "Preventive Care Drugs" section for more information about preventive medications.
Elastic bandages and supports	
Erectile dysfunction medications	
Fertility medications	For the Company Self-Funded POS Option: Not covered in excess of $20,000 lifetime maximum Benefit (combined with Medical). For the Company Self-Funded PPO Option: Not covered.
Generic Zyban and Chantix	Not covered after two 12-week cycles per year are exhausted
Hair growth stimulants	
Hair removal agents	
Immunization agents, vaccines, biologicals, blood or blood plasma	May be covered under Medical. See the "What Is Covered" subsection in the "Medical and Mental Health/Substance Abuse Coverage" section.
Influenza treatment	Except Tamiflu. Flu shots may be covered under Medical.
Injectable medications that cannot be self-administered	Unless classified as a Specialty Prescription Drug or covered under the Medical portion of the Program. See the "What Is Covered" subsection in the "Medical and Mental Health/Substance Abuse Coverage" section.
Insulin Pumps	May be covered under the Medical portion of the Program. Not covered under the Prescription Drug Program.
Lancet devices	
Maintenance Drugs not purchased through the Prescription Drug Benefits Administrator's Mail Order Program	Except for the first two Fills of a prescription for the Maintenance Drug at a Network Retail Pharmacy
Medical supplies (for example, bandages, braces and splints, appliances, devices, heat lamps and artificial appliances)	

Exclusions and Limitations	
Exclusions and Limitations:	Notes
Medication taken or administered to a patient in an institution that operates or houses a facility dispensing pharmaceuticals on its premises (including take-home medication)	
Medications for which the cost is recoverable under any workers' compensation or occupational disease law, state or government agency, or medications for which no charge is made to the participant	
Multiple and nontherapeutic vitamins, dietary supplements and health and beauty aids	Except vitamins that require a prescription if classified as preventive medication. See the "Preventive Care Drugs" section for more information about preventive medications.
Nutritional dietary supplements administered intravenously or through a gastrointestinal tube	May be covered under Medical. Not covered under the Prescription Drug Program. See the "What Is Covered" subsection in the "Medical and Mental Health/Substance Abuse Coverage" section.
Oral nutritional and diet supplements	Except if classified as preventive medication. See the "Preventive Care Drugs" section for more information about preventive medications.
Ostomy and irrigation supplies	
Over-the-counter topical fluoride products	
Personal-Choice Drugs	Discounts may be available. See the "Personal-Choice Drugs" section for more information.
Prescription devices	Except for covered Diabetic Supplies
Prescriptions for which primary coverage is provided by another plan	See the "Coordination of Benefits" section for information.
Products not requiring a prescription by law	
Respiratory therapy supplies	
Sales or use tax imposed by some states or municipalities or parishes	
Smoking deterrents, including nicotine products such as nicotine gum and nicotine patches	Except for generic Zyban and Chantix and other generic over-the-counter nicotine replacement products such as gum, patches and lozenges. See the "Generic Zyban and Chantix" section in this table.
Specialty Prescription Drugs	Not covered through Retail Pharmacies, except for the initial purchase of a Specialty Prescription Drug. See the "Specialty Prescription Drug Services" section.
Specialty Prescription Drugs in excess of day supply limit for drugs purchased through the Specialty Prescription Drug Service	Except if the drug is a Specialty Prescription Drug for which the Program allows an extended days' supply. See the "Specialty Prescription Drug Services" section.
Support garments, and other nonmedicinal substances, regardless of intended use	
Therapeutic devices or appliances	May be covered under Medical. Not covered under the Prescription Drug Program.

Exclusions and Limitations	
Exclusions and Limitations:	Notes
Topical retinoids	For Covered Persons age 26 and older, except with a diagnosis of adult acne.
Vitamins	Except vitamins that require a prescription or if covered as preventive medication. See the "Preventive Care Drugs" section for more information about preventive medications.
Zyban (brand name only)	Diagnosis required for coverage

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

- Drugs that do not meet all requirements for coverage under the Prescription Drug Program.
- Drugs labeled "Caution — limited by Federal law to Investigational use" and Experimental drugs, even though a charge is made to the individual. Whether a drug is determined to be Investigational, Experimental or unproven to be safe and effective is within the discretion of the Prescription Drug Benefits Administrator.
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or medication furnished by any other drug, medical Service, individual or entity for which no charge is made to the Participant.
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, Skilled Nursing Facility, convalescent Hospital, nursing home or similar institution that operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals. *(Note: these will generally be covered by the Program's medical Benefits.)*
- Any medicine not prescribed by your Prescriber.
- Any prescription refilled in excess of the number of refills specified by the Prescriber or any refill dispenses after one year from the Prescriber's original order.
- Charges for the administration or injection of any drug.

CLAIMS AND APPEALS PROCEDURES

KEY POINTS

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

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

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

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

CLAIMS FOR ELIGIBILITY

KEY POINTS

- *If your or your dependent's enrollment in the Program is denied, you may file a written Claim for Eligibility with the Eligibility and Enrollment Vendor.*
- *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 Eligibility and Enrollment Vendor to attempt to resolve the issue. See the *Eligibility and Enrollment Vendor* 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 Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor at the address listed in the "Contact Information" section. To submit a Claim for Eligibility you must file a completed Claims Initiation Form (CIF) or other written document asserting your Claim, along with any supporting documentation, with the Eligibility and Enrollment Vendor. A CIF is available from the Eligibility and Enrollment Vendor on request.

The Eligibility and Enrollment Vendor will notify you of its decision within 30 days of the date it receives your Claim for Eligibility. The Eligibility and Enrollment Vendor may extend this period once (for up to 15 days) if it determines that 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 Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Eligibility and Enrollment Vendor 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	
Eligibility and Enrollment Vendor decides on Claim	30 days	From the date the Eligibility and Enrollment Vendor receives your initial Claim for Eligibility
Time period is extended if Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor	45 days	From the date you receive notice from the Eligibility and Enrollment Vendor stating that additional information is needed

What Happens If Your Claim for Eligibility Is Denied

Your Claim for Eligibility is denied when the Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor within 180 days of receipt of the denial notice. A special form is not required; however, you may contact the Eligibility and Enrollment Vendor and obtain an Appeal form. A service representative also can provide the appropriate address to direct your Appeal.

See the *Eligibility and Enrollment Vendor* 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

Eligibility and Enrollment Appeals Committee (EEAC) members, 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 EEAC will not afford deference to the denied Claim.

The EEAC will notify you of its decision within 60 days of the date of receipt of your Appeal. The EEAC 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 EEAC'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 EEAC'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 EEAC 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
Eligibility and Enrollment Appeals Committee (EEAC) decides on Appeal	60 days	From the date the EEAC receives your Appeal
Time period is extended if EEAC determines special circumstances require more time	Up to 60 days	After the initial 60-day period

External Review Process for Certain Eligibility Claims

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

CLAIMS FOR BENEFITS

KEY POINTS

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

How to File a Claim for Benefits

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

The following are not considered a Claim for Benefits:

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

If you are enrolled in a Fully-Insured Managed Care Option, you must use the Fully-Insured Managed Care Option's procedures for filing Claims for Benefits and Appeals. For information concerning these procedures, contact the Fully-Insured Managed Care Option administrator or refer to your Evidence of Coverage (EOC).

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

- If you receive Services from a Network Provider, Retail Pharmacy, Mail Order Prescription Drug Service or Specialty Drug Program, your Claim for Benefits generally will be filed by the Provider. The Program pays these Providers directly. You are responsible for meeting the Annual Deductible and for paying Coinsurance or applicable Co-payments to these Providers at the time of Service or when you receive a bill from the Provider. If a Network Provider sends you a bill for the balance owed for any Service (other than an Annual Deductible, Coinsurance or Co-payment), contact the Benefits Administrator.
- If you receive Services from a Non-Network Provider or you fill a prescription at a Non-Network Retail Pharmacy, you are responsible for filing a Claim for Benefits or making sure the Provider submits a Claim for Benefits on your behalf in the required format. See the "Information to Include in Your Claim" section for more details.

Claim Filing Limits

You or your Provider must submit your Claim for Benefits within one year of the date of service or the date the prescription was provided if the AT&T East Medical Program is your only medical coverage. If your Claim for Benefits is coordinated with other coverage, such as Medicare, you must submit your Claim within two years of the date of service or the date you receive the prescription.

If a Non-Network Provider or a Non-Network Retail Pharmacy submits a Claim for Benefits on your behalf, you are responsible for the timeliness of the Claim for Benefits and these timing requirements still apply. If you or your Provider do not file a Claim for Benefits within this time period, Benefits will be denied or reduced at the Benefits Administrator's discretion. If your Claim for Benefits relates to an inpatient stay, the date of Service is the date your inpatient stay ends.

Information to Include in Your Claim for Benefits

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

<table>
<tr><th>Medical Claim Requirements
(including MH/SA Claims)</th><th>Prescription Drug Claim Requirements</th></tr>
<tr><td>
• Employee’s or former Employee’s name and address
• Patient’s name, age and relationship to the Employee or former Employee
• Member number stated on your ID card
• Itemized bill from your Provider that includes the following:
  • Patient diagnosis
  • Date(s) of Service
  • Procedure code(s) and descriptions of Service(s) rendered
  • Charge for each Service provided
  • Service Provider’s name, address and tax identification number
• Date the Injury or Illness began
• Statement that indicates if you are enrolled for other coverage. If so, you must include the name of the other carrier(s)
As part of the Claim for Benefits, the Benefits Administrator may require the individual who received Services to have an examination performed by an appropriate agent or independent contractor as often as the Benefits Administrator determines necessary.
</td><td>
You must include all original receipts (including proof of purchase) for your Claim to process. Cash register receipts will only be accepted for Diabetic Supplies. The minimum information required is:
• Patient name
• Date of Fill
• Total charge
• Prescription number
• Metric quantity
• Pharmacy name and address
• Medicine NDC number
• Days supply
• Pharmacy NCPDP/NABP number
</td></tr>
</table>

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 unless either:

- The Provider notifies the Benefits Administrator that you authorized payment directly to the Provider.
- You make a written request for payment to be made directly to the Provider or Retail Pharmacy when you submit your Claim for Benefits.

The Benefits Administrator will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers.

Benefit Determinations

Post-Service Claims

A Post-Service Claim is a Claim for Benefits you or your Provider file after Services have been received. If your Post-Service Claim is denied, in whole or in part, the Benefits Administrator will provide you a written notice of its determination within 30 days of receipt of the Claim for Benefits. The Benefits Administrator may extend this period once (for up to 15 days) if it determines that special circumstances require more time to decide your Claim for Benefits. If this happens, you will receive a written notice of the special circumstances requiring the extra time prior to the lapse of the 30-day period as well as the date by which you should expect a response.

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

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

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

Pre-Service Claims

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

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

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

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

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

Urgent Care Claims That Require Immediate Action

An Urgent Care Claim is a Claim for Benefits or Services for which the Program requires you to obtain Preauthorization before the Covered Person receives medical care and a delay in receiving the Service could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim for Benefits. The Benefits Administrator will defer to your attending Provider's determination that your Claim is an Urgent Care Claim within the meaning described above. In these situations:

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

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

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

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

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

Concurrent Care Claims

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

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

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

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

What Happens If Your Claim for Benefits Is Denied

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

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

- Information sufficient to identify the Claim (including the date of Service, the health care Provider), the Claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program’s terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your Claim for Benefits acceptable and the reason the information is needed.
- A description of the Program’s Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

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

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

> **IMPORTANT:** If your Claim for Benefits is denied on the basis of eligibility to enroll or participate in the Program, you should follow these procedures; however, your Appeal must be filed with the Eligibility and Enrollment Vendor. (See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section.)

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

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

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

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

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

How to File an Appeal for Benefits

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

- Your name
- Patient's name and patient's identification number from his or her medical ID card
- Dates of Service

- Provider's name
- A summary of the issue, including the reason you believe the Claim for Benefits should be paid
- All relevant documents, such as letters, Explanation of Benefits (EOBs) and statements

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

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

Internal Appeals

Your Appeal will be assigned to a qualified individual or committee who has had no involvement with the denial of your Claim for Benefits. If your Appeal is related to clinical matters, the review will include a consultation with a health care professional who has appropriate expertise in the field and who was not involved in the denial of your Claim for Benefits. The Benefits Administrator can also seek the expertise of other medical professionals to resolve your Claim. You must consent to this referral and to sharing your pertinent medical information.

Pre-Service and Post-Service Claim Appeals

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

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

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

Urgent Care Appeals That Require Immediate Action

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

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

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

- Information sufficient to identify the Claim (including the date of Service, the health care Provider, the Claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your Claim.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program's terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

IMPORTANT: Contact the Benefits Administrator for a copy of the Program's external review procedures.

External Review

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

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

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

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

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

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

Expedited

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

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

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

COORDINATION OF BENEFITS

KEY POINTS

- *Coordination of Benefits (COB) applies when you have health coverage under more than one plan.*

- *The COB rules describe how Program Benefits are determined and which Coverage Plan will pay first.*
- *Special COB rules apply if you are Medicare Eligible.*

Determining Which Plan or Program Pays First

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

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

- **Continuation coverage.** If you are covered under any federal or state provided right of continuation coverage and also covered under another Coverage Plan, the Coverage Plan covering you as an Employee, member, subscriber, retiree or Eligible Former Employee (or as that person's dependent) is primary and the continuation coverage is secondary. If the other Coverage Plan does not have this rule and the Coverage Plans do not agree on the order of Benefits, this rule does not apply.
- **Longer or shorter length of coverage.** The Coverage Plan that covers you as an Employee, member, subscriber or Eligible Former Employee longest is primary.

If the preceding rules do not determine the primary Coverage Plan, the Coverage Plans (as defined in this section) share the Allowable Charges equally. For the PPO Option, this Program will not pay more than it would have paid if it was the primary Coverage Plan. For the HCN Option, the sum of all Benefits payable from this Program and the primary Coverage Plan will not exceed actual Allowable Charges incurred.

COB for Eligible Dependent Child(ren)

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

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

How COB Works

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

- Determine the Benefits the Program would pay if it were primary, however, if a negotiated rate applies to the Service, special rules apply to determine the Allowable Charge for the Service under the Program. Contact the Benefits Administrator if you have questions.
- For the PPO Option, determine the difference between what the Program would have paid if it were primary and Benefits due from all Coverage Plans that are primary. If this Program would have paid more, this Program will pay the difference. Total Benefits under this Program plus those of primary Coverage Plans may be less than 100 percent of total Allowable Charges. For the HCN Option, determine if total Benefits payable (before applying COB rules) under this Program and other Coverage Plans is more than 100 percent of actual Allowable Charges. If so, this Program reduces its Benefits so that the

sum of all Benefits payable from this Program and the primary Coverage Plan do not exceed Allowable Charges incurred.

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

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

KEY POINTS

➢ *Eligibility for Medicare can affect your Benefits under the Program.*

- *Once you or your Eligible Dependent is Medicare Eligible you must enroll in Medicare Parts A and B or your Medical Benefits may be substantially reduced.*
- *The Program may reimburse all or a portion of the monthly premium you pay for Medicare Part B coverage, if eligible, but you must enroll for reimbursement.*

Your Program Benefits are affected when you or your dependent become Medicare Eligible. The affects may include the following:

- Generally, Eligible Former Employees and dependents who are eligible for Medicare due to age are not eligible to continue Program Benefits after becoming Medicare Eligible. See the "Eligibility and Participation" section for further information.
- Eligible Former Employees and dependents who are eligible for Medicare due to a reason other than age will continue to be eligible for Program Benefits.
- For Medicare Eligible individuals who are enrolled in coverage under this Program, Program Benefits become secondary to Medicare after you leave employment and you must enroll in Medicare Parts A and B to receive the maximum coverage for your medical expenses.
- Certain Program options are not available when you become Medicare Eligible. For Program options available to Medicare Eligible participants, see the "Eligibility and Participation" section.
- Medicare eligibility may affect your monthly contributions for Program Benefits. For more information, see the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.
- For the impact on Program Benefits and the steps you must take if you are Medicare Eligible, see the "Medicare Parts A and B" section.

If within the next six months you or a covered dependent will become Medicare Eligible, either due to age or disability, or are planning to leave your employment, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Medicare Parts A and B

Impact of Medicare Parts A and B on Program Benefits

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

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

<table>
<tr><th>Circumstances</th><th>Additional Conditions</th><th>Primary Payer</th><th>Secondary Payer</th></tr>
<tr><td>Age-based Medicare entitlement for you or your Spouse or dependent + coverage under the Program due to current active employment status</td><td>Employer has 20 or more Employees</td><td>Program</td><td>Medicare</td></tr>
<tr><td>Age-based Medicare entitlement + coverage under the Program due to COBRA</td><td>N/A</td><td>Medicare</td><td>Program</td></tr>
<tr><td>Disability-based Medicare entitlement for you or your Partner or dependent + coverage under the Program due to current active employment status of a family member</td><td>Employer has 100 or more Employees</td><td>Program</td><td>Medicare</td></tr>
<tr><td>Disability-based Medicare entitlement + coverage under the Program due to eligibility for long-term disability or COBRA</td><td>N/A</td><td>Medicare</td><td>Program</td></tr>
<tr><td rowspan="2">End-Stage Renal Disease (ESRD)-based Medicare eligibility or entitlement + coverage under the Program (including coverage due to current active employment status, Eligible Former Employee status or COBRA)</td><td>First 30 months of Medicare eligibility or entitlement</td><td>Program</td><td>Medicare</td></tr>
<tr><td>After 30 months of Medicare eligibility or entitlement</td><td>Medicare</td><td>Program</td></tr>
</table>

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

While in some cases the Eligibility and Enrollment Vendor, the Company or a Benefits Administrator may be aware of your pending eligibility for Medicare and the Eligibility and Enrollment Vendor may send you materials regarding enrolling, it is your responsibility to enroll in Medicare when you first become eligible for Medicare as your primary coverage and notify the Eligibility and Enrollment Vendor of your enrollment. This includes eligibility based on disability as well as age. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

What are the consequences of not enrolling in Medicare when you are eligible? Here’s an example.

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

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

	Mike Pays	Medicare Pays	Program Pays
Medicare Part B deductible	$162		
Medicare Part B Coinsurance		$3,870.40 80% of $4,838 ($5,000 expense – $162 deductible = $4,838)	
Difference between Program deductible and Medicare deductible	$238		
Program Coinsurance			$656.64 90% of $729.60 ($5,000 – $3,870.40 – $400 = $729.60)
Participant balance	$72.96 ($5,000 – $162 – $3,870.40 – $238 – $656.64)		
TOTAL	$472.96	$3,870.40	$656.64

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

	Mike Pays	Medicare Pays	Program Pays
Medicare Part B Coinsurance, if enrolled		$3,870.40 80% of $4,838 ($5,000 expense – $162 deductible = $4,838)	
Program deductible	$400		
Program Coinsurance			$0
Balance	$4,600 ($5,000 – $400)		
TOTAL	$5,000	$0	$0

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

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

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

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

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

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

If you are not automatically enrolled for Part A or Part B, you must enroll when you are first eligible or during a Medicare enrollment period. If you do not enroll during your initial Medicare enrollment period or you opt out of coverage, you may be subject to Medicare late enrollment penalties. These late enrollment penalties do not apply if you are eligible for enrollment during a Medicare special enrollment period. See the "Medicare Enrollment Periods and Late Enrollment Penalties" and "Medicare Special Enrollment Periods" sections for more information about these penalties and periods.

Medicare Enrollment Periods and Late Enrollment Penalties

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

Medicare Special Enrollment Period

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

Note: For Medicare eligibility coverage and enrollment periods, the term Spouse applies only to a person of the opposite sex who is a husband or wife.

A special enrollment period also applies to Medicare Advantage coverage, also known as Medicare Part C. See the "More Information about Medicare" section for assistance with Medicare questions.

For special enrollment periods that apply to Medicare Part D, see the "Enrollment in Medicare Part D" section.

If You Work Past the Age of 65

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

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

If You Become Disabled Before the Age of 65

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

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

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

If you are planning to retire or terminate employment and you will be eligible for continued coverage under the Program, your covered dependent should enroll in Medicare before you terminate employment to receive the maximum coverage for your Medicare-eligible expenses. When you have terminated employment, your termination may impact your dependent's eligibility for coverage under the Program. If you have terminated employment but are receiving coverage under the Program for any reason, Medicare will become primary for any covered dependent who is eligible for Medicare. This will affect their Program coverage. See the "Impact of Medicare Parts A and B on Program Benefits," "Medicare Enrollment Periods and Late Enrollment Periods" and

"Medicare Special Enrollment Period" sections for information. You must also notify the Eligibility and Enrollment Vendor of your covered dependent's Medicare eligibility to ensure that your contributions reflect your covered dependent's Medicare status.

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

If You Are Enrolled in a Fully-Insured Managed Care Option

If you are enrolled in a Fully-Insured Managed Care Option, and you or your covered dependent is eligible or will soon become eligible for Medicare Parts A, B or D, your Program Benefits through the Fully-Insured Managed Care Option may be affected. Contact the Eligibility and Enrollment Vendor or your Fully-Insured Managed Care Option administrator for more information on how your eligibility for Medicare affects your eligibility for Program coverage and/or your benefits. For the Fully-Insured Managed Care Option administrator, refer to the toll-free number on your Program identification card. For the Eligibility and Enrollment Vendor, see the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

If You Have End-Stage Renal Disease (ESRD)

If you or your dependent has ESRD you may be eligible for Medicare before age 65 even if you are not disabled; for example, if you are receiving dialysis or require a kidney transplant.

If you are eligible for Medicare solely on the basis of ESRD and are enrolled in Program coverage, your Program coverage will be primary to Medicare for a period of 30 months, after which Medicare will provide primary coverage, even if you are Actively at Work. This is known as the coordination period.

Enrollment in Medicare Parts A and B is not automatic. You must actively enroll to have coverage. If you or your dependent does not enroll when eligible for Medicare as your primary coverage due to ESRD, Program Benefits will be affected in the same manner as if you became Medicare Eligible due to age. See the "Impact of Medicare Parts A and B on Program Benefits" section for information.

If you have questions regarding Program coverage, contact the medical Benefits Administrator. If you have questions concerning Medicare coverage, refer to the "Medicare & You" handbook. If you or your dependent is eligible for Medicare, you will receive a copy of this handbook in the mail every year from Medicare.

If You Have Other Group Health Insurance

If you or your dependent is enrolled in Medicare and you have other group health insurance (not individual insurance), it is important to determine whether Medicare is primary to either or both group coverages. If Medicare is primary to both, Medicare will pay benefits first. After Medicare pays, the Program and the other group health insurance plan will coordinate payment of benefits between them, based on the Coordination of Benefit (COB) rules. See the "Coordination of Benefits" and "Impact of Medicare Parts A and B on Program Benefits" sections for more information. If Medicare is primary to the Program (for example, you are a former Employee) but secondary to the other group health coverage (for example, the coverage is through your current employer), the other group coverage is primary and pays first, Medicare pays second and the Program third.

Be sure to notify your health care Providers about your other coverage to ensure that your bills are paid correctly and without delay.

Medicare Crossover Program

The Medicare crossover program is an electronic Claim-filing service set up by Medicare. This program electronically transmits Medicare Parts A and B Claims processed by Medicare to other group health insurance plans for processing. This eliminates the need for you to send a copy of the Provider's bill and the Explanation of Medicare Benefits (EOB) to your medical Benefits Administrator when filing a Claim for Benefits.

Once you elect Medicare crossover, you should allow 30-60 days from the set-up date for the crossover to start. Your EOB will indicate whether the Claim was electronically sent to the medical Benefits Administrator. Until this message appears, you must continue to file secondary Claims with the Benefits Administrator. Once the crossover starts, when Medicare processes a Claim, it is automatically forwarded electronically via the crossover program to the medical Benefits Administrator for processing. You should allow 30 days for Medicare to process the Claim and to electronically transmit the Claim to the medical Benefits Administrator for processing.

The Medicare crossover program links Medicare (all states; Washington, D.C.; Guam; Puerto Rico and U.S. Virgin Islands) to the medical Benefits Administrator.

> **IMPORTANT:** If you do not want to participate in the Medicare crossover program, contact the medical Benefits Administrator to make your request. Changes in the Medicare crossover program are sent to Medicare, but may take 4-6 weeks before the change becomes effective. Retroactive requests are not available.

More Information on Medicare

Benefits Administrator

If you have questions on how Medicare affects your Program Benefits, contact your medical Benefits Administrator at the toll-free number on your Program identification card. The medical Benefits Administrator is available to help you understand how your Medicare and Program Benefits are coordinated and how that affects your Program Benefit as a whole.

If you have questions on how Medicare eligibility affects your eligibility for Program Benefits, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Assistance with Medicare Questions

If you need assistance in understanding Medicare's rules and regulations, you may contact Medicare toll-free at **800-MEDICARE** (**800-633-4227**) or at **medicare.gov**. You can refer to the "Medicare & You" handbook, which is available from Medicare. This handbook will help you understand Medicare.

You may also contact the Social Security Administration toll-free at **800-772-1213** or call your local Social Security Administration office. To find your local Social Security office, call **800-722-1213**. If you have access to the Internet, you may go to **ssa.gov**.

MEDICARE PART D

KEY POINTS

- *Medicare Part D is a voluntary Prescription Drug Benefit available to Medicare-Eligible individuals.*
- *Unlike Medicare Parts A and B, as an Active Employee, you are not required to enroll in Medicare Part D when Medicare coverage is primary.*

Coverage Under Medicare Part D

You and your dependents are eligible for Prescription Drug coverage under a Medicare Part D plan if you or your dependents are entitled to benefits under Medicare Part A and/or enrolled in Part B.

All Medicare Part D Prescription Drug plans provide at least a standard level of Prescription Drug coverage set by Medicare. Some plans may offer more Prescription Drug coverage for a higher monthly premium.

You may obtain the Medicare Part D Prescription Drug benefit through two types of private plans:

- You can join a Medicare Part D Prescription Drug plan for Prescription Drug coverage only; or
- You can join a Medicare Advantage plan that covers both medical Services and Prescription Drugs.

If you are considering joining a Medicare Part D Prescription Drug plan, you should compare your current Program Prescription Drug coverage, including which Prescription Drugs are covered and at what cost, with the coverage and costs of the Medicare Part D plans offering Prescription Drug coverage in your area.

Enrollment in Medicare Part D

Each year, Medicare Part D Prescription Drug plans offer an enrollment opportunity from Oct. 15 through Dec. 7. If you or your dependents are eligible for Medicare Part D, then you are eligible to enroll.

In addition, you and your dependents may be eligible for a two-month special enrollment period to join a Medicare Part D Prescription Drug plan if:

- You or your dependents lose creditable Prescription Drug coverage, through no fault of your own; or
- You or your dependents drop noncreditable Prescription Drug coverage.

If You Enroll in Medicare Part D

If you and your dependents enroll in a Medicare Part D Prescription Drug plan, your coverage under the Program may be affected. For example, if you currently have Prescription Drug coverage under the Program and also enroll in a Medicare Part D Prescription Drug plan, coverage provided under the Program and the Medicare Part D Prescription Drug plan may be

coordinated. See the "Coordination of Benefits" section for information on Coordination of Benefits.

In addition, if you decide to enroll in a Medicare Part D Prescription Drug plan and drop your current coverage under the Program, you and your dependents may not be able to get this coverage back.

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

You Are Not Required to Enroll in Medicare Part D

As an Active Employee, you are not required to enroll in Medicare Part D to continue to obtain Prescription Drug Benefits under the Program; however, your decision to enroll or not to enroll may affect your Medicare Part D premiums in the future.

“Creditable coverage” means that Program Prescription Drug Benefits pay out at least as much as the standard coverage available through a Medicare Part D Prescription Drug plan. “Noncreditable coverage” is Prescription Drug coverage that, on average, does not pay out as much as the standard coverage available through Medicare Part D.

- If Prescription Drug coverage under the Program is considered “creditable,” then you may keep Prescription Drug coverage under the Program and not pay a higher Medicare Part D premium if you later decide to join a Medicare Prescription Drug plan.
- If Prescription Drug coverage under the Program is considered “noncreditable,” you may pay a higher Medicare Part D premium (a penalty) if you do not enroll in a Medicare Part D Prescription Drug plan when you first become eligible.

If you are eligible for Medicare, you will receive a Creditable Coverage Disclosure Notice annually describing if the Prescription Drug coverage options available to you under the Program are creditable. For more information about whether Prescription Drug coverage under the Program is creditable or noncreditable, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

Reimbursement of Medicare Part D Premiums

You are responsible for the full and timely payment of any Medicare Part D Prescription Drug coverage premiums to the private plan you choose or Medicare. The Program does *not* offer reimbursement of Medicare Part D premiums.

Medicare Part D Low Income Assistance

If you have limited income and resources, extra help paying for Medicare Part D Prescription Drug coverage is available. For information about this extra help:

- You may contact Medicare at **800-MEDICARE** (**800-633-4227**) or on the Internet at **medicare.gov**.
- You may contact the Social Security Administration at **800-772-1213** (TTY **800-325-0778**) or on the Internet at **socialsecurity.gov**.

Creditable Coverage and Late Enrollment Penalties

Creditable Coverage

If you or your dependents are eligible for Medicare and have Prescription Drug coverage through the Program, you may stay in the Program and choose not to enroll in the Medicare Prescription Drug plan. If the Prescription Drug coverage under the Program is at least as good as Medicare Part D Prescription Drug coverage (and therefore considered "creditable coverage"), then you and your dependents can continue to receive Prescription Drug Benefits under the Program and avoid higher Medicare Part D premiums if you or your dependents sign up for Medicare Part D Prescription Drug coverage later. If you are eligible for Medicare, you will be provided with an annual notice informing you whether your coverage is creditable or not.

Late Enrollment Penalties

If you or your dependents drop or lose your current Prescription Drug coverage under the Program and do not enroll in a Medicare Part D Prescription Drug plan within 63 consecutive days after your current Prescription Drug coverage under the Program ends, you may pay a higher Medicare Part D premium (a penalty) to join a Medicare Part D Prescription Drug plan later.

If you or your dependents go 63 consecutive days or longer without creditable Prescription Drug coverage under this Program (or any plan that offers creditable Prescription Drug coverage), your monthly Medicare Part D premium may increase by at least 1 percent of the Medicare Part D base beneficiary premium per month for every month that you are without creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19 percent higher than the Medicare Part D national base premium. You may have to pay this higher Medicare Part D premium (penalty) as long as you have Medicare Part D Prescription Drug coverage. In addition, you may have to wait until the next Medicare Part D annual enrollment period to enroll in a Medicare Part D Prescription Drug plan.

Qualified Status Changes Associated with Medicare

A gain or loss of Medicare Eligibility may affect your ability to change your Program coverage during the Plan Year.

To determine what your coverage options are due to a change in eligibility under Medicare:

- See the "Contributions" section for information on your ability to change your contribution election.
- See the "Change-in-Status Events" section for information on your ability to change your coverage election.

If you have further questions about a change in status associated with Medicare, please contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Additional Medicare Contact Information

For More Information About Medicare Part D and This Program

If you have questions about how the Program coordinates Prescription Drug coverage with Medicare Part D, you may contact your Prescription Drug Benefits Administrator at the toll-free number on your identification card.

For More Information About Your Options Under Medicare Part D Prescription Drug Coverage

More detailed information about Medicare Part D Prescription Drug plans is available in the "Medicare & You" handbook. If you or your dependent is eligible for Medicare, you will receive a copy of this handbook in the mail every year from Medicare. You also may be contacted directly by Medicare Part D Prescription Drug plans.

For more information about Medicare Part D Prescription Drug coverage:

- Visit Medicare on the Internet at **medicare.gov**.
- Call your State Health Insurance Assistance Program (refer to the "Helpful Resources & Tools" section of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call Medicare at **800-MEDICARE** (**800-633-4227**). TTY users should call **877-486-2048.**

WHEN COVERAGE ENDS

KEY POINTS

- *Coverage under the Program generally terminates on the last day of the month in which your employment with the Company ends.*
- *Coverage for an eligible Spouse/Partner or Child will end as of the last day of the month, when the Spouse/Partner or Child no longer meets the requirements to be eligible under the Program.*
- *Under certain circumstances, coverage will be continued for a disabled Former Employee and a Disabled Child(ren).*
- *You and your eligible Spouse/Partner and Child(ren) may be able to continue coverage under COBRA in certain circumstances. In some circumstances, continued coverage may be provided after your death for some period of time.*

For Employees

Coverage under the Program will stop on the earliest of the following:

- The last day of the month in which your employment with the Company stops.
- The last day of the month in which you stop being an Eligible Employee.
- Your company is no longer a Participating Company.
- The last day of a period for which contributions for the Cost of Coverage have been made in full, if the contributions for the next period are not made in full when due.
- The day the Program ends.

See the "Extension of Coverage – COBRA" and "Your Conversion Rights" sections for information about what rights you may have to continue coverage.

The remainder of this section describes certain other situations where continued coverage may be available for you and/or your covered dependents.

For Covered Spouse/Partner and Child(ren)

Coverage for your Spouse/Partner, and/or your Child(ren), stops when one of the following occurs:

- Your coverage stops.
- The last day of a period for which contributions for the Cost of Coverage have been made in full if the contributions for the next period are not made in full when due.

Coverage for a Spouse/Partner or Child will stop sooner if one of the following occurs:

- The individual becomes covered as an Employee of the Company under this Program.
- The individual is no longer eligible as defined in the section called "Eligible Dependents." (Coverage stops on the last day of the month in which the individual is no longer eligible.) Coverage ends for your Child(ren) at the end of the month in which they turn age 26.

See the "Extension of Coverage – COBRA," "Surviving Dependent Coverage" and "Your Conversion Rights" sections for information about what rights you or your dependents may have to continue coverage.

A mentally or physically incapacitated Child's medical benefit coverage under the Program will not stop due to age. It will continue as long as your dependent's coverage under the Program continues and the Child continues to meet the conditions described in the sections entitled "Eligible Dependents" and "Certification of Disabled Dependents."

Rescission of Coverage

A rescission of your coverage occurs if the coverage is cancelled retroactively except when the termination is for nonpayment. Your coverage can be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice or omission that constitutes fraud; or if you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

You will be provided with 30 calendar days advance notice before your coverage is rescinded. You have the right to request an internal Appeal of a rescission of your coverage. Once the internal Appeal process is exhausted, you may have the additional right to request an independent external review. If you appeal a rescission in coverage, coverage will be maintained pending a resolution of the Appeal to the extent required by law. See the "External Appeals Process for Certain Eligibility Claims" section for information.

If You Are Laid Off From Active Employment

If you terminate employment due to a force adjustment or layoff, continued Company contributions to your medical coverage may be available for a limited period (as long as you continue to pay any applicable contribution) in accordance with the layoff provisions of your Company's collective bargaining agreement. You should refer to your collective bargaining agreement to determine the layoff benefits and what options are available for extended coverage. You may also contact the Eligibility and Enrollment Vendor for assistance with questions.

If You Are Leaving the Company

If you leave the Company, you may be eligible for Post-Employment Benefits under this Program or a program for Eligible Former Employees for your job classification. The eligibility requirements for Post-Employment Benefits are set forth in the Summary Plan Description (SPD) for the medical program or programs applicable to your job classification.

- The tables below summarize the Post-Employment Benefits eligibility and contribution rules that generally apply to Eligible Employees under this Program at termination of employment. You should also review the applicable Program SPD for details including applicable definitions and any exceptions that may apply to your specific circumstances. In the event of a conflict between the tables below and applicable Program SPD, the applicable Program SPD will govern. The Company has reserved the right to amend or terminate all benefit programs and any changes will supersede the information herein.

Eligibility Rules

Eligibility Rules	
Eligible Former Employees	
You are an Eligible Former Employee if...	You (1) Are a former Bargained Employee of a Participating Company (2) Were a member of one of the covered bargaining units in a population group listed below as of your termination of employment (3) Meet the termination of employment date requirements under the Program for your covered bargaining unit; and (4) Meet the eligibility condition applicable to you under the Program specified below.
Population Groups	• AT&T East Core Contract - CWA District 1 who terminated employment on or after Jan. 1, 1990 • SNEIS - CWA District 1 who terminated employment on or after Jan. 1, 1990 and on or before May 8, 2012
You meet one of the following eligibility conditions...	• Rule of 75 • Modified Rule of 75 • Pension Based Eligibility • Eligible Former Disabled Employee • If you were hired/rehired or transferred on or after Aug. 9, 2009, you are not eligible for coverage once you are Medicare Eligible.
Dual Enrollment - Special Rule	
Dual Enrollment	While you may be eligible under more than one status (for example, as an Eligible Former Employee and a dependent in the Program), you are not allowed to be enrolled in this Program or any other medical program or plan sponsored by a member of the AT&T Controlled Group (with the exception of the AT&T Eligible Former Employee CarePlus - A Supplemental Benefit Program) at the same time. In addition, you and your Spouse/Partner cannot cover both your dependents at the same time. See the "Dual Enrollment" section for more information.

Contribution Rules - Company Self-Funded Option

<table>
<tr><th colspan="2">Service History</th><th>Contribution Rules</th></tr>
<tr><td rowspan="3">Eligible Former Employees</td><td>You terminated employment on or after Jan. 1, 1990, and on or before April 8, 2012</td><td>A monthly contribution calculated under the DDB Cap provision is required if all of the following apply:
• You are not Medicare Eligible
• You are enrolled in a Company Self-Funded Option (excluding the Company Self-Funded SelectMed Option)
• The DDB Cap is exceeded
A monthly contribution of $100 for Individual coverage and $210 for Family coverage is required if all of the following apply:
• You are Medicare Eligible
• You are enrolled in a Company Self-Funded Option (excluding the Company Self-Funded SelectMed Option)
A monthly contribution of $42 for Individual coverage and $84 for Family coverage is required if you are enrolled in the Company Self-Funded SelectMed Option
Note: If Family coverage is elected and certain members are Medicare Eligible while others are not (referred to as a split family), a combination of these provisions will apply.</td></tr>
<tr><td>Your Termination Date is after April 8, 2012, and
• You were hired or rehired on or before Aug. 8, 2009, or
• Your employment classification changed from Temporary or Term to Regular on or before Aug. 8, 2009</td><td>You pay the following monthly contribution
Jan. 1, 2014, through Dec. 31, 2014
Individual: $58
Family: $121
Jan. 1, 2015, through Dec. 31, 2015
Individual: $79
Family: $163
Jan. 1, 2016, through Dec. 31, 2016
Individual: $90
Family: $195</td></tr>
<tr><td>Your Termination Date is after April 8, 2012, and
• You were hired, rehired or transferred after Aug. 8, 2009, and on or before June 3, 2013; or
• Your employment classification changed from Temporary or Term to Regular after Aug. 8, 2009, and on or before June 3, 2013</td><td>The monthly contribution is 50% of the total Cost of Coverage.
Note: Former Employees who are Medicare Eligible are not eligible for coverage. See the "Eligibility and Participation" section for information.</td></tr>
</table>

Service History		Contribution Rules
	Your Termination Date is after April 8, 2012, and • You were hired, rehired or transferred after June 3, 2013; or • Your employment classification changed from Temporary or Term to Regular after June 3, 2013	The monthly contribution is 100% of the total Cost of Coverage. *Note: Former Employees who are Medicare Eligible are not eligible for coverage. See the "Eligibility and Participation" section for information.*

Contact the Eligibility and Enrollment Vendor to request a copy of the applicable SPD. See the “Contact Information” section for contact information. You also may be eligible to elect continuation coverage under COBRA in lieu of the Benefits available for Eligible Former Employees.

If Your Active Employment Ends by Reason of Disability

If you are disabled, you may be eligible to continue your (and your Eligible Dependents’) coverage under this Program or a program for Eligible Former Employees. See the section entitled “Eligible Former Disabled Employees” in the program SPD for Eligible Former Employees for a description of the eligibility requirements applicable to totally disabled former Employees.

If Your Active Employment Ends by Reason of Your Death

If you have a surviving Spouse/Partner and/or Child(ren) covered by the Program as of the date of your death, they will be eligible to elect continuation coverage under COBRA. See the “Extension of Coverage – COBRA,” “Surviving Dependent Coverage” and “Your Conversion Rights” sections for information about what rights you or your dependents may have to continue coverage.

In addition, your surviving dependents may be able to obtain continued coverage under the Program for a limited period on the same basis as during your active employment or may be able to continue coverage at their own expense for a period longer than the maximum COBRA coverage period.

EXTENSION OF COVERAGE - COBRA

KEY POINTS

- *COBRA continuation coverage is a temporary extension of group coverage that allows Program participants who have lost coverage due to a Qualifying Event to continue coverage for a period of time.*
- *If you experience a COBRA Qualifying Event, you must notify the Eligibility and Enrollment Vendor 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 65-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 Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* 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 and special enrollment rights.

You can find specific information describing the coverage to be continued under the Program elsewhere in this document and in the Plan document. For more information about your rights and obligations under the Program, you can get a copy of the Plan document by requesting it from the Plan Administrator as described in the "Your ERISA Rights" section.

COBRA-Qualifying Events: When Is COBRA Continuation Coverage Available?

Eligible Employee

If you are an Employee 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 Eligibility and Enrollment Vendor 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, AT&T will notify the Eligibility and Enrollment Vendor within 30 days of the Qualifying Event:

- The end of your employment.
- The reduction of your hours of employment.
- AT&T Inc.'s or your Participating Company's commencement of a Chapter 11 proceeding in bankruptcy.

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 Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor 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

COBRA Notice and Election Procedures

All COBRA notices must be provided to the Eligibility and Enrollment Vendor 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. (If you are unable to use a telephone because of deafness, the COBRA Administrator has TTY telephone service available.) See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

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 Eligibility and Enrollment Vendor 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 65 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 65-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.

When you consider whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. By continuing your coverage through COBRA, you may avoid that coverage gap. Second, if you do not get COBRA continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's/Partner's employer). Make sure you submit your request within 30 days after your group health coverage ends because of a Qualifying Event. You will also have the same special

enrollment right at the end of COBRA continuation coverage if you get continuation coverage for the maximum time available to you. Also, in certain circumstances, the Program provides Company Extended Coverage (CEC) and may share in the cost of that coverage as described in the “When Coverage Ends” section.

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 Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor. You must make your first payment for COBRA continuation coverage no later than 60 days after the date of your election. The amount of your required first payment will be stated on your initial bill. It will include the cost of COBRA continuation coverage from the date coverage begins through the end of the month following the month in which the bill is issued. Claims for payment of Benefits under the Program may not be processed and paid until you have elected COBRA continuation coverage and made the first payment. **Any Benefits paid during this period will be retroactively canceled if you do not elect COBRA or if coverage is canceled because you do not make timely payments.** Bills for subsequent coverage will be issued monthly.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. The maximum duration for COBRA continuation coverage is described in this section. COBRA continuation coverage can end before the end of the maximum coverage period for several reasons that are described in the “Termination of COBRA Coverage Before the End of the Maximum Coverage Period” section.

COBRA Events	
Event	**Length of Coverage**
If you leave the Company (for reasons other than gross misconduct)	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you no longer meet the eligibility requirements	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you are on a military leave	Coverage for you and your dependents may last for up to 24 months
If you die	Coverage for your dependents may last for up to 36 months
If you and your Spouse divorce or become legally separated or Partner requirements are no longer met	Coverage for your Spouse, Partner and/or Eligible Dependent Child(ren) may last for up to 36 months**

COBRA Events	
Event	**Length of Coverage**
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*
**An 18-month continuation period may be extended. For more information, see the "18 Months (Extended Under Certain Circumstances)" section below.* ***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.*	

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 Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor no later than the 60th day after the later of the date of the second Qualifying Event or the date coverage would otherwise end, using the notification procedure specified in the "COBRA Notice and Election Procedures" section. **If the notice procedure is not followed or notice is not given within the required period, then there will be no extension of COBRA continuation coverage due to a second Qualifying Event**.

- **Medicare extension for Spouse/Partner and Child(ren)**. If a COBRA-Qualifying Event that is a termination of employment or a reduction of hours occurs within 18 months after the Employee becomes entitled to Medicare, then the maximum coverage period for the Spouse/Partner and eligible Child(ren) will end three years after the date the Employee became entitled to Medicare (but the covered Employee's maximum coverage period will remain 18 months).

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage for the Employee/Eligible Former Employee, Spouse/Partner and/or Child(ren) will automatically terminate when any one of the following six events occurs before the end of the maximum coverage period:

- The premium for the Qualified Beneficiary's COBRA continuation coverage is not paid in full within the allowable grace period.

- After electing COBRA continuation coverage, you (the Employee/Eligible Former Employee, Spouse/Partner or Child) become covered under another group health plan/program (as an Employee or otherwise) 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 special enrollment, 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 and HIPAA Special Enrollment Rights

If you elect COBRA, you will be given the same opportunity available to similarly situated Active Employees to change your coverage options or to add or eliminate coverage for dependents at Annual Enrollment. In addition, the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA continuation coverage certain rights to add coverage for Eligible Dependents if that person acquires a new dependent (through marriage, birth, adoption or placement for adoption) or if an Eligible Dependent declines coverage because of other coverage and later loses that coverage as a result of certain qualifying reasons. Except for certain Child(ren) described in the "Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period" section above, dependents who are enrolled in a special enrollment or Annual Enrollment do not become Qualified Beneficiaries. Their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under Qualified Medical Child Support Orders

If you have a Child that is receiving Benefits under the Program pursuant to a Qualified Medical Child Support Order received by the Eligibility and Enrollment Vendor during your (the Employee's/Eligible Former Employee's) period of employment with the Company, he or she is entitled to the same rights under COBRA as an eligible Child of yours, regardless of whether that Child would otherwise be considered eligible (other than on account of age).

When You Must Notify Us About Changes Affecting Your Coverage

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the **addresses of family members**. While you are an Active Employee, your address in the system of the Eligibility and Enrollment Vendor will be used to send COBRA notices. See the *Active Employee Address and Telephone Number Changes* table in the "Information Changes and Other Common Resources" section for information on how to keep your address current while you are an Active Employee. For former Employees, if your address changes, you must promptly report your address change. See the *Pension Service Center* table in the "Information Changes and Other Common Resources" section for information on whom to contact to report your address change. If

you are not eligible to receive a pension plan benefit, or have already received your entire pension plan benefit in a lump sum and are not eligible for an Eligible Former Employee death benefit from your pension plan, contact the Eligibility and Enrollment Vendor to update your home address. See the *Pension Service Center* table in the “Contact Information” section for contact information.

Also, for all participants, if your marital status changes or if a covered Child ceases to be eligible for coverage under the Program terms, you, your Spouse/Partner or Child must promptly notify the Eligibility and Enrollment Vendor to remove that person from your coverage. You also must provide the appropriate mailing address for mailing your Spouse’s/Partner’s or Child’s COBRA notice. Such notification is necessary to protect COBRA rights for your Spouse/Partner and Child(ren). In addition, you must notify us if a disabled Employee or family member is determined to no longer be disabled. Once your dependent is enrolled in COBRA, he or she must promptly report any address changes. See the “Information Changes and Other Common Resources” section for information on whom to contact to report your address change.

For More Information

Contact the Eligibility and Enrollment Vendor 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** (EBSA’s website).

Contact Information

For contact information for the COBRA Administrator, see the *Eligibility and Enrollment Vendor* table in the “Contact Information” section. For contact information for the Plan Administrator, see the *Other Plan Information* table in the “Plan Information” section.

Surviving Dependent Coverage

If you are enrolled in the Program as of your date of death, medical coverage for your enrolled dependents will continue through the end of the month and continued coverage under Company Extended Coverage (CEC) will be available after that, under the same terms that would have applied if you remained alive, subject to their continued eligibility and payment of required contributions. Company contributions toward the Cost of Coverage will be available for up to six months for your surviving Spouse/Partner and other dependents who are enrolled under CEC. See the “Surviving Dependents” subsection in the “Contribution” section for more information on surviving dependent contributions.

After eligibility for COBRA ends, unless COBRA coverage is lost due to nonpayment of required contributions or voluntary termination of coverage, your surviving Spouse/Partner may continue medical coverage for himself or herself and any dependent Child(ren) who were enrolled for medical coverage at the time of your death, provided they have remained eligible for CEC and paid all applicable premiums. Your surviving Spouse/Partner may continue medical coverage for your dependent Child(ren) until they no longer qualify as dependents under the Program or your surviving Spouse/Partner is no longer covered.

If your surviving Spouse/Partner decides to terminate Program coverage for any reason or is terminated from coverage because of not having paid the required contribution, he or she will not be permitted to re-enroll in medical coverage. If your surviving Spouse/Partner declines coverage under this extended option at the time it is offered, he or she will not be permitted to elect

medical coverage at a later date. Once enrolled in this extended option, your surviving Spouse/Partner may not enroll new dependents.

Surviving dependent CEC coverage will terminate for all covered survivors at the end of the month in which the surviving Spouse/Partner:

- Fails to make the required contributions.
- Drops the coverage on himself or herself.
- Dies.
- Marries; or forms a legally recognized partnership.

The following additional conditions apply to this extended coverage:

- Surviving dependent CEC is available if you die while on a leave of absence or short-term disability.
- Surviving dependent CEC is not available if you die while receiving severance payments.
- Surviving Spouses, LRPs or Child(ren) cannot add new dependents during this Company Extended Coverage (CEC) period.

> **IMPORTANT:** To report a death, call the Eligibility and Enrollment Vendor listed in the “Contact Information” section. Please have information regarding the deceased available when you call, such as name and Social Security number.

WHAT HAPPENS WHEN YOU LEAVE THE COMPANY

Active Program Coverage

Active Program coverage for you and your covered dependents continues through the end of the month in which your employment terminates. If eligible for Post-Employment Benefits, your Post-Employment Benefits will be subject to provisions that apply to Eligible Former Employees unless you elect COBRA continuation coverage under your active Program coverage. Information concerning your options as a former Employee will be provided by the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

Post-Employment Coverage

The Eligibility and Enrollment Vendor will send you information regarding Post-Employment Benefits and required monthly contributions. Contact the Eligibility and Enrollment Vendor if you do not receive this statement within two weeks of your employment Termination Date or if you would like to make any changes to your coverage. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for more information.

If you are eligible for Post-Employment Benefits, your coverage will begin on the first day of the month following your employment Termination Date, subject to the payment of any required contributions. For example, if you terminate employment on June 15, the effective date for Post-Employment Benefits is July 1. See the “When Coverage Ends” section for more information.

There is a separate SPD for your post-employment coverage Program benefits. You will receive a copy of your post-employment SPD either electronically or by mail. You can also access a copy of your SPD at the Eligibility and Enrollment Vendor's website.

Steps You Must Take to Ensure Coverage Continuation	
Within two weeks of your termination of employment	Look for information from the Eligibility and Enrollment Vendor.
Within 31 days of receipt of information from the Eligibility and Enrollment Vendor	Enroll for Post-Employment Benefits available to Eligible Former Employees, if applicable.
Within 31 days of enrollment for Post-Employment Benefits available to Eligible Former Employees	Submit payment for any required contributions.
Within 65 days of your active Program coverage end date or receipt of COBRA Enrollment Notice, whichever is later	Elect COBRA coverage, if applicable.
Within 45 days of receipt of a bill for COBRA coverage from the Eligibility and Enrollment Vendor	Submit payment for COBRA coverage.
Ongoing	• Submit payments to the Eligibility and Enrollment Vendor by the payment due date. • Promptly report your address change by calling the Pension Service Center. If you are not eligible to receive a pension plan benefit or have already received your entire pension plan benefit in a lump sum and are not eligible for a retiree death benefit from your pension plan, report your address change to the Eligibility and Enrollment Vendor. • Promptly report any Change-in-Status Events to the Eligibility and Enrollment Vendor. • See the "Contact Information" section for contact information.

Dependent Coverage

If you are eligible for Post-Employment Benefits, you may cover your Eligible Dependents who were enrolled in active Program coverage at the time you terminated employment, subject to dependent eligibility requirements and payment of any required contributions. If you acquire a new dependent after you terminate employment, contact the Eligibility and Enrollment Vendor to find out if your new dependent is eligible for coverage. The Eligibility and Enrollment Vendor will advise you of the steps you must take to enroll your new dependent, if eligible, and any additional cost you must pay for coverage of your new Eligible Dependent.

Annual Deductible Credit

If the medical option you were covered under as an Active Employee does not change when you terminate employment and begin your Post-Employment Benefits, you will receive credit for any amounts applied to your Annual Deductible as an Active Employee for the remainder of the

calendar year in which you retire. Your Annual Deductible will begin anew on Jan. 1 of the following year.

If the post-employment medical option you are covered under is different than the medical option you were covered under as an Active Employee, you will not receive any Annual Deductible credit. You will be subject to the full Annual Deductible amount that applies to your Post-Employment Benefits.

Enrollment in Medicare

Eligibility for Medicare may affect your Benefits under the Program. Once you or your covered dependent is Medicare Eligible or will become eligible soon, it is important to understand how the Program works with Medicare and to notify the Eligibility and Enrollment Vendor. See the "If You, Your Spouse or Your Dependent is Eligible for Medicare" section for details.

COBRA Coverage in Lieu of Post-Employment Benefits

Upon your termination of employment from the Company, you will receive a COBRA enrollment notice from the Eligibility and Enrollment Vendor. As an alternative to Post-Employment Benefits for Eligible Former Employees, you may choose to continue your active Program coverage by electing COBRA coverage, as provided by federal law. Eligibility for COBRA coverage does not affect your eligibility for Post-Employment Benefits for Eligible Former Employees. However, if you elect COBRA coverage, you may not commence your Post-Employment Benefits for Eligible Former Employees until such time as COBRA coverage ends. Once COBRA coverage ends, you may enroll in Post-Employment Benefits for Eligible Former Employees. See the "Extension of Coverage – COBRA" section for more information.

Extension of Benefits

When coverage ends, the Program generally pays no further Benefits, unless a Covered Person is in the Hospital at that time. In that case, the hospitalized individual will continue to receive Medical Benefits only for the current Hospital services and only for the specific condition being treated at the time coverage terminated. This extension of Medical Benefits is provided subject to all applicable provisions of the Program. After the extension, all Medical Benefits cease, unless you are eligible for post-employment or COBRA continuation coverage.

PLAN ADMINISTRATION

KEY POINTS

- *The Plan is administered by the Plan Administrator, who has full authority and discretion to administer, interpret and enforce the terms of the Plan, and who may delegate that authority and discretion to other entities or individuals. The Plan Sponsor has the right to amend or terminate the Plan at any time.*
- *You must exhaust your Claims and Appeals rights under the Program before bringing a court action for Benefits.*

- *There are time limits for filing an action for Benefits under the Program.*
- *It is very important that you keep the Plan informed of any changes in your mailing address, contact information and family status changes.*

Plan Administrator

The Plan Administrator is the named fiduciary of the Plan, including all component Programs, and has the power and duty to do all things necessary to carry out the terms of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, to resolve any ambiguity in the terms of the Plan, to make findings of fact, to determine the rights and status of you and others under the Plan, to decide and resolve disputes under the Plan and to delegate all or a part of this discretion to third parties. To the extent permitted by law, such interpretations, findings, determinations and decisions are final, conclusive and binding on all persons for all purposes of the Plan.

If the Plan Administrator fails to strictly enforce any provision of the Plan in a given instance, it will not be construed as a waiver of that provision in any later case. The Plan Administrator reserves the right to strictly enforce each and every Plan provision at any time without regard to its prior actions and decisions, the similarity of the circumstances or the number of occurrences.

The Plan Administrator has the authority and discretion to settle or compromise any Claim against the Plan based on the likelihood of a successful outcome as compared with the cost of contesting such Claim. The Plan Administrator also has the authority and discretion to pursue, relinquish or settle any Claim of the Plan against any person. No person may rely on the actions of the Plan Administrator regarding Claims by or against the Plan in connection with any subsequent matter.

Coverage under the Program will be determined solely according to the terms of the Program and the applicable facts. Only the duly authorized acts of the Plan Administrator are valid under the Program. You may not rely on any oral statement of any person regarding the Program and may not rely on any written statement of any person unless that person is authorized to provide the statement by the Plan Administrator and one of the following applies:

- The statement is an official decision of the Plan Administrator to an individual whose eligibility for enrollment, participation or payment of Benefits under the Program is in dispute.
- The statement constitutes a duly authorized interpretation of an ambiguous or doubtful term of the Program.
- The statement constitutes the issuance of a rule, regulation or policy under the Program and applies to all participants.
- The statement communicates an amendment to the Program and applies to all participants.

Administration

The Plan Administrator has contracted with third parties for certain functions including, but not limited to, the processing of Benefits and 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.

Nondiscrimination in Benefits

The federal tax and other laws prohibit discrimination in favor of highly compensated participants or key Employees with regard to some of the Benefits offered under the Program. The Plan Administrator may restrict the amount of nontaxable Benefits provided to key Employees or highly compensated participants and their covered dependents so that these nondiscrimination requirements are satisfied.

Benefits provided under the Program will not discriminate in any of the following ways:

- On the basis of any health factor, including evidence of insurability.
- As to eligibility for Benefits on the basis of a health factor.
- On the basis of premiums or contributions for similarly situated individuals.

Amendment or Termination of the Plan or Program

AT&T Inc. 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 AT&T-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. In order to bring an action against the Plan for Benefits, you must bring the action no later than five years following the date your Claim was denied.

You Must Notify Us of Address Changes, Dependent Status Changes and Disability Status Changes

In order to protect your rights under the Program and those of your family members, it is vitally important that you keep the Plan Administrator informed of any changes in your mailing address and those of any covered family members who do not live with you. While you are an Active Employee, your address in the system of the Eligibility and Enrollment Vendor 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. See the *Active Employee Address and Telephone Number Changes* table in the "Information Changes and Other Common Resources" section for information on how to keep your address current while you are an Active Employee.

Also, for all participants, if your marital status changes, you must promptly report the change to the Eligibility and Enrollment Vendor. 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 Eligibility and Enrollment Vendor.

Where eligibility of a dependent is lost through divorce or other loss of eligibility, you, your Spouse/Partner or dependent must promptly notify the Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor 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 Administrator 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.
- **External Review Process.** The external review process is available for review of certain Adverse Benefit Determinations and Rescissions of Coverage. This process utilizes an Independent Review Organization (IRO). Information regarding the availability of the external review process and arrangements with IROs is provided in this table.
- **Collective Bargaining Procedures (if applicable).** Certain Programs contain provisions maintained pursuant to a collective bargaining agreement. The *Other Plan Information* table provides information on how to obtain copies of the collective bargaining agreement.

The text immediately after the table provides information regarding the arrangements by the Plan Administrator with various third parties to provide Services to the Plan, including Benefits Administration and eligibility and enrollment functions. Please see the applicable *Benefits Administrator* table in the "Contact Information" section for contact information for these third parties.

Other Plan Information	
Plan Name	AT&T Umbrella Benefit Plan No. 3
Program Name	AT&T East Bargained Employee Medical Program
Plan Number	603
Plan Sponsor/Employer Identification Number (EIN)	AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333** EIN 43-1301883
Plan Administrator	AT&T Services, Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**

Other Plan Information	
Name and Address of Employer	Affiliates of AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Type of Administration	Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with the Program as follows The Plan Administrator administers Claims and Appeals for Benefits under the Program 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 benefit. The Plan Administrator administers enrollment, eligibility, monthly contribution and COBRA under the Program provisions, including the determination of initial Claims for eligibility, on a contract basis with the Eligibility and Enrollment Vendor, see the "Contact Information" section for more information. The AT&T Eligibility and Enrollment Appeals Committee (EEAC) determines final Appeals from the denial of eligibility. The EEAC has full discretionary authority to interpret Plan provisions as they apply to eligibility for benefits. See the "Contact Information" section for the address to write to.
Agent for Service of Legal Process	Process in legal actions in which the Plan is a party should be served on the Plan at the following address CT Corporation 350 North St. Paul Street Dallas, TX 75201 **210-351-3333** Service of Legal Process may also be made upon a Trustee.
Type of Plan	The Plan is an employee health and welfare benefit plan.
Plan Year	Jan. 1 through Dec. 31
Trustee	AT&T Voluntary Employee Beneficiary Association Trust Frost National Bank 100 W. Houston Street San Antonio, TX 78299
Plan Funding and Contributions	Participating Companies and covered Employees share in the cost of providing coverage under the Program. Certain costs of the Program may be paid through a trust, established exclusively for purposes of providing Benefits through the Program. Program Benefits are not paid for by insurance, except for Benefits under a Fully-Insured Managed Care Option, when coverage under such option has been elected by the participant.

Other Plan Information	
External Review	The Benefits Administrator has engaged at least three Independent Review Organizations (IROs) for the purpose of providing external review of Adverse Benefit Determinations and final Adverse Benefit Determinations under the Program's External Review Process policy. External review is available with respect to Claims for Eligibility involving rescission of coverage and Claims for Benefits involving medical judgment. When you request external review under the Program's external review procedure, you will be provided with the name and contact information for the IRO which has been assigned to review your Claim. A copy of the Program's External Review Process policy will be provided to you by the Benefits Administrator upon request at no cost to you.
Plan Records	All Program records are kept on a calendar year basis beginning on Jan. 1 and ending on Dec. 31.
Collectively Bargained Plan	With respect to certain Eligible Employees, the 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.
Insurance	As an alternative to Program Benefits, participants in certain geographic areas may be permitted to enroll in and receive medical Benefits through a Fully-Insured Managed Care Option (such as an HMO). All questions regarding Benefits, including but not limited to, benefit levels, coverage, policies, benefit summaries, Claims determination and Claims Appeals will be provided to you by the Fully-Insured Managed Care Option administrator.

Type of Administration and Payment of Benefits

Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with the Program, as described below. Benefits under the Company Self-Funded Option(s) are paid by AT&T Participating Companies directly or through funds made available for this purpose through the trusts identified in the "Plan Funding" row in the *Other Plan Information* table above. The Benefits Administrators below do not insure Benefits provided under the Program.

Medical Benefits Administrator

The Plan Administrator administers Claims and Appeals for medical Benefits under the Company Self-Funded Option(s) on a contract basis with Blue Cross and Blue Shield of Illinois. The Plan Administrator has discretionary authority to interpret the provisions of the Company Self-Funded Option(s) and to determine entitlement to medical Benefits.

Mental Health/Substance Abuse (MH/SA) Benefits Administrator

The Plan Administrator administers Claims and Appeals for Mental Health/Substance Abuse (MH/SA) Benefits under the Company Self-Funded Option(s) on a contract basis with ValueOptions. The Plan Administrator has discretionary authority to interpret the provisions of the Company Self-Funded Option(s) and to determine entitlement to MH/SA Benefits.

Prescription Drug Benefits Administrator

The Plan Administrator administers Claims and Appeals for Prescription Drug Benefits under the Company Self-Funded Option(s) on a contract basis with CVS Caremark Inc. The Plan

Administrator has discretionary authority to interpret the provisions of the Company Self-Funded Option(s) and to determine entitlement to Prescription Drug Benefits.

Eligibility and Enrollment Vendor

The Plan Administrator administers enrollment, eligibility, monthly contributions and COBRA under the Program provisions, including the determination of initial Claims for Eligibility, on a contract basis with Aon Hewitt (AT&T Benefits Center). The AT&T Eligibility and Enrollment Appeals Committee (EEAC) determines final Appeals from the denial of a Claim for Eligibility. The EEAC has full discretionary authority to interpret the provisions of the Program and to determine eligibility for Program Benefits and monthly contribution amounts.

WHAT HAPPENS WHEN BENEFITS ADMINISTRATORS CHANGE

Certain administrative procedures and medical policies may change when a Benefits Administrator for the Company Self-Funded Option changes. If a new Benefits Administrator denies coverage for a Service that was determined to be eligible for coverage under the Company Self-Funded Option by the former Benefits Administrator, unless the decision by the prior Benefits Administrator is determined to have been a mistake, the Company Self-Funded Option will cover such Service for such Covered Person for a period of 12 months from the date the new Benefits Administrator assumed its responsibilities. However, this is the case only as long as the facts applicable to the Covered Person or relevant Program provisions have not materially changed since the prior Benefits Administrator made its determination. For purposes of this provision, *materially changed* means a change in the Service or supply, or terms of the Company Self-Funded Option such that the new Benefits Administrator determines, in its sole discretion, that as a result of the change, the Service would not be covered under the Company Self-Funded Option.

If you believe you have been denied coverage for a Service by a new Benefits Administrator that was approved by the prior Benefits Administrator and there has not been a material change as described above, contact the new Benefits Administrator and let them know that you may have a situation that is covered by this transition provision and ask them to please review your Claim accordingly.

RIGHT OF RECOVERY AND SUBROGATION

KEY POINTS

- *In this section, the term "you" includes your covered family members or dependents and also includes any trust or special needs trust established to receive monies recovered on account of your Injury.*
- *The Program will pay Benefits for you, but will have the right to recover those Benefit payments from the party who caused the Injury or from an insurance policy.*

- *You have an obligation to cooperate with the Program's exercise of its rights under this section.*
- *If the Program pays Benefits that should have been paid by another or pays excessive Benefits, the Program will have a right to recover the excess payment.*

This section applies if you or your covered family members are injured, suffer an Illness or are disabled as a result of the negligent or wrongful act or omission of another.

Summary of the Program's Right of Recovery

If you recover any amount for your Injury, Illness or disability by way of a settlement or a judgment in or out of a court of law, the Program must be reimbursed out of the recovery for the amounts paid by the Program, up to the full amount you have recovered, without any reduction for legal fees or costs and without regard to whether you have been made whole by the recovery. The Program's right of reimbursement shall have the status of an equitable lien against your recovery.

It is the intent of this Program that you should recover only one payment for any cost that is covered under the Program. If you suffer an Injury, Illness or disability for which another may be responsible or may have a financial or insurance obligation, the Program will be reimbursed from any recovery you may obtain, to the extent of the Benefits paid by the Program. For example, if you are injured by another person and obtain a recovery from the other person's insurance or from your own uninsured or underinsured motorist coverage, then you must reimburse the Program for the medical expenses the Program paid for that Injury.

Under this section, the term "recovery" means any and all sums of money and/or any promise to pay money in the future, received by you from the person who caused the Injury or Illness, or from any other source (such as your or their other insurance coverage, uninsured, underinsured, homeowners or umbrella insurance policies). Recovery includes payments no matter how characterized, including but not limited to sums paid or promised as compensation for actual medical expenses, pain and suffering, aggravation, wrongful death, loss of consortium, punitive or exemplary damages, attorneys' fees, costs, expenses or any other compensatory damages. "Recovery" may be obtained by way of judgment, settlement, arbitration, mediation or otherwise. The Program shall have an equitable lien on any recovery, and the Program's right to recovery shall not be reduced, even if you receive less in recovery than the full amount of damages claimed or suffered by you, unless the Program agrees to a reduction. The amount of money to be recovered by the Program shall not be reduced by any legal fees or costs that you incur in connection with obtaining a recovery unless the Program agrees to such reduction.

If you decline to pursue a recovery, the Program is "subrogated" to your rights and shall succeed to all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any Services and Benefits the Plan pays on your behalf relating to any Illness, Injury or disability caused by any third party. This means the Program can step into your shoes and possess your right to pursue a recovery to the extent of the Benefits paid (and to be paid) for the Injury. The Program has the option to bring suit against or otherwise make a claim to collect directly from the person or entity that may be responsible for the Injury or Illness, with or without your consent. If the Program exercises this option, you must cooperate in pursuing such recovery, including assisting the Program's attorneys in preparing or pursuing the case, including attendance at hearings, depositions and trial. In the event the Program obtains any recovery, the Program will apply the monies received first to the Program as reimbursement for Benefits, second to the Program or its attorneys for costs, expenses and attorneys' fees incurred in

connection with the recovery, and third, any remaining balances to you. The Plan Administrator, however, may, in its sole discretion, apportion the recovery in some other manner if it chooses to do so.

You are required to cooperate fully with the Program, the Benefits Administrator or their agents in the exercise of these rights of subrogation and recovery, including:

- You must sign all necessary forms requested by the Program or the Benefits Administrator, including, without limitation, an acknowledgement of the Program's rights to reimbursement or subrogation and an assignment of your Claims or causes of action against the other party.
- You must provide the Program or the Benefits Administrator with all reasonably necessary information as requested.
- You may not take any action after your Illness, Injury or disability that could prejudice the Program's rights as described in this section, or the Program's ability to obtain reimbursement or subrogation.
- You must promptly notify the Program of any recovery obtained from the responsible person or entity, or their or your insurer, whether by judgment, settlement, arbitration or otherwise.

Right of Recovery of Overpayments

The Program or the Benefits Administrator may pay Benefits that should have been paid by another plan or program, organization or person, or may pay Benefits in excess of what should have been paid under this Program. In such event, the Program may recover the excess amount from the other plan, organization or person, or from you, including by reducing future Benefits otherwise payable under this Program, if necessary.

ERISA RIGHTS OF PARTICIPANTS AND BENEFICIARIES

KEY POINTS

- *ERISA is a federal law that provides certain rights and protections to all participants.*
- *The persons who are responsible for the operation of the Plan have a duty to act prudently and in the interest of the Plan and their beneficiaries.*
- *No one may fire or discriminate against you for exercising your rights under ERISA.*

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants are entitled to:

- Receive information about your Plan and Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including collective

bargaining agreements, insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the EBSA.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies. Your written request must be directed to:

  AT&T Services, Inc.
  Attn: Plan Documents
  P.O. Box 132160
  Dallas, TX 75313-2160

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

- Continue group health plan coverage in certain situations.

  You may have the right to continue health care coverage for yourself, Spouse/Partner or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (see the “Extension of Coverage – COBRA” section). You, your Spouse/Partner or your covered dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan.

  If you had creditable coverage from another group health plan or health insurance issuer before you became a participant in this Plan, you should be provided a certificate of creditable coverage, free of charge, from the other plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under this Plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Benefits that is denied or ignored, in whole or in part, and you have exhausted all applicable administrative remedies under the Plan, you may file suit in state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance With Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER PROGRAM INFORMATION

KEY POINTS

- *This section describes various laws that may impact your right to Program Benefits.*
- *Some laws provide specific Program eligibility rights.*
- *Other laws provide specific Program coverage rights, such as coverage for mastectomy, childbirth and Mental Health/Substance Abuse Services.*
- *Certain laws protect the privacy and security of your protected health information.*

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that requires a group health benefits plan to provide parity between Mental Health/Substance Abuse (MH/SA) benefits and medical and surgical benefits.

Wherever the Program provides MH/SA Services, coverage will generally be provided to the same extent as medical and surgical Services. This means the Program:

- May not apply more restrictive financial or treatment limitations on Benefits for MH/SA Services when compared to Benefits for medical and surgical Services.

- May not apply more restrictive annual or lifetime maximum dollar limits on MH/SA Services than are applied to medical and surgical Services.
- Must cover Non-Network Benefits for MH/SA Services to the same extent as Non-Network Benefits for medical and surgical Services.

However, the Program may apply cost-containment methods as long as those methods are consistent with parity requirements under federal law. Common cost-containment methods for MH/SA Services may include the following:

- Cost sharing: Co-payments, Coinsurance and Annual Deductibles
- Limitations on the number of office visits or inpatient/outpatient days
- The terms and conditions of the amount, duration or scope of Benefits

Federal guidelines for MH/SA Services as required under the MHPAEA are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to MHPAEA or MH/SA Services, please see the applicable *Benefits Administrator* table in the "Contact Information" section for contact information.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), as amended, is a federal law intended to extend health care benefits and coverage to most Americans by 2014.

The PPACA, sometimes referred to as Health Care Reform or the Affordable Care Act (ACA), imposes new mandates on both insurers and employers who provide group health benefits to their employees and their dependents. These mandates have been gradually phased in since 2010, will continue to evolve through 2018 and include the following:

- Coverage of adult children up to age 26
- Coverage of certain preventive health services
- External review of adverse Claim for Eligibility determinations relating to rescission and Claims for Benefits involving medical judgment
- Enhanced benefits communication materials
- Regulation of annual limits on essential benefits and prohibition of pre-existing condition requirements for certain participants
- Provision of certain coverage to participants in clinical trials
- A prohibition on the use of health factors, medical condition or history, Claim experience, genetic information, disability or evidence of insurability in eligibility rules

Federal guidelines for certain health care benefits and coverage as required under the PPACA are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to PPACA or mandated health care benefits and coverage, please see the applicable *Benefits Administrator* table in the “Contact Information” section for contact information.

Qualified Medical Child Support Orders

The Program extends Benefits to an Employee's noncustodial Child, as required by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court or agency order that does both of the following:

- Meets all applicable legal requirements for qualification.
- Creates, recognizes or assigns to a Child of an Employee (alternative recipient) the right to receive health benefit coverage under the Program.

An alternative recipient is any Child of a participant who is recognized by a medical child support order as having a right to enrollment under a participant’s program for group health benefits.

A medical child support order has to satisfy certain specific conditions to be qualified. The Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor.

If the Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor 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 *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

Your Conversion Rights

Conversion to an individual coverage policy may be available to you and your Eligible Dependents whose coverage under the Program ends. Coverage under the Program ends when either of the following occurs:

- Your coverage ends due to a termination of employment.
- Your coverage under the Program ends at the end of the maximum COBRA continuation coverage period of 18 or 36 months, as applicable to your specific situation.

You and your Eligible Dependent(s) must have been enrolled in the Program for a minimum of three months to be eligible for conversion coverage.

There are important differences between conversion coverage and coverage under the Program including the cost, coverage and benefits offered under a conversion policy. Conversion coverage

is subject to the terms and conditions in effect at the time you apply. Premium Rates are often the same as individual policy rates and often significantly greater than group policy rates.

There is no physical examination requirement for conversion coverage.

You must apply for and pay the premium amount for conversion coverage within 31 days of the end of your coverage under the Program. If you fail to meet the 31-day deadline, you may lose your right to conversion coverage. Please note: you are responsible for any conversion fee associated with your conversion coverage.

Conversion coverage may not be available in all states. If conversion coverage is not available to you and your Eligible Dependents, you may be eligible for state-sponsored “risk pool” coverage.

To determine the availability of conversion coverage under the Program, contact your medical Benefits Administrator. See the *Benefits Administrator* table in the “Contact Information” section for contact information.

IMPORTANT NOTICES ABOUT YOUR BENEFITS

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) is a federal law prohibiting discrimination against an Employee, dependent or Spouse on the basis of an individual’s genetic information. Genetic information is defined as information about an individual’s genetics based on genetic tests of an individual’s family members or information about the manifestation of a disease or disorder within an individual’s family. Genetic information includes any request for or receipt of genetic services (including genetic testing, counseling or education), or participation in clinical research that includes such services, by the individual or family member.

Federal guidelines related to GINA are constantly evolving, however, the Program is making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to the use of your genetic information or GINA, please see the *Benefits Administrator* table in the “Contact Information” section for contact information.

Women’s Health and Cancer Rights Act of 1998 (WHCRA)

An individual who is receiving mastectomy-related Benefits under this Program and who elects breast reconstruction in connection with the mastectomy will receive coverage for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to give a symmetrical appearance, any needed prostheses and coverage for treatment of physical complications of all stages of the mastectomy, including lymphedema. This coverage is subject to any Annual Deductible, Co-payment or Coinsurance percentage levels applicable to other medical and surgical Benefits provided under the Program.

If you have any questions with respect to WHCRA or mastectomy-related Benefits, please see the *Benefits Administrator* table in the “Contact Information” section for contact information.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage under the Program, but are unable to afford the premiums, some states have premium-assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that participates in CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are **not** currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **877-KIDS NOW (877-543-7669)** or **insurekidsnow.gov** to find out how to apply.
- If you qualify, you can ask the state if it has a Medicaid or CHIP program that might help you pay the contributions for health coverage under the Program.
- If you or your dependents are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Program is required to permit you and your dependents to enroll in the Program — as long as you and your dependents are eligible, but not already enrolled in the Program. This is called a "special enrollment" opportunity in the Program, but you must request coverage within 60 days of being determined eligible for premium assistance.

Alternatively, if you and your dependents are eligible, but not enrolled in the Program, and you lose your eligibility for premium assistance under Medicaid or CHIP, you are entitled to a "special enrollment" opportunity in the Program, but you must request coverage within 60 days of losing eligibility for premium assistance.

Federal guidelines related to premium assistance are constantly evolving, however, the Program is making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to premium assistance, please see the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

For information on which states have a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration dol.gov/ebsa **866-444-EBSA (866-444-3272)**	U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services cms.hhs.gov **877-267-2323 (choose option 4), ext. 61565**

Notice of HIPAA Privacy Rights

The privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) went into effect April 14, 2003, and require that we send you updated notices regarding the privacy of your health information. You have received a summary of those rights from the Plan. If you are an Active Employee, you may also view or print a copy of this notice through the Benefits section of **OneStop** (from work). If you are a former Employee or an Active Employee, you may view or print a copy of this notice through the AT&T secure Internet site at **access.att.com** (from home). See the "Information Changes and Other Common Resources" section for information.

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.

You have the right to inspect and copy, request amendment or correction, restrict the use or disclosure and request an accounting of the uses and disclosures of your PHI. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose PHI will be used or maintained by the Plan.

You may request a free copy of this information at any time upon request by contacting the Benefits Administrator as identified in the "Contact Information" section.

You may also view or print a copy of this Notice through the Benefits section of **OneStop** (from work) or the AT&T secure Internet site at **access.att.com** (from home).

Newborns' and Mothers' Health Protection Act

To the extent this Program provides Benefits for Hospital lengths of stay in connection with childbirth, the Program will cover the minimum length of stay required for deliveries (i.e., a 48-hour Hospital stay after a vaginal delivery or a 96-hour stay following a delivery by Cesarean section). The mother's or newborn's attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by federal law. No Provider authorization is required from the Program or any Benefits Administrator for prescribing a length of stay less than 48 or 96 hours. This coverage is subject to any applicable Annual Deductible, Co-payment or Coinsurance percentage levels.

Federal guidelines for minimum Hospital stays related to childbirth as required under Newborns' and Mothers' Health Protection Act (NMHPA) are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to NMHPA or Hospital stays related to childbirth, please see the *Benefits Administrator* table in the "Contact Information" section for contact information.

CONTACT INFORMATION

Contact Information	
Benefits Administrator	
Name	Blue Cross and Blue Shield of Illinois
Type	Medical
Services Provided	Medical Benefits Administration
Benefits Administrator Contact Numbers	
Contact Numbers Information	To reach a Customer Service Professional
Domestic Telephone Number	**800-621-7336** (Service Center) **800-621-0965** (For medical services requiring Notification or Preauthorization) **800-299-0274** (NurseLine)
Benefits Administrator Hours of Operation	
Hours of Operation	**Service Center:** The customer service center is available Monday through Friday 7 a.m. to 7 p.m. Central time. For medical services requiring Notification or Preauthorization, the customer service center is available Monday through Friday from 8 a.m. to 5 p.m. Central time. **Interactive voice response (IVR) system:** During off hours, the IVR is available Monday through Friday from 6 a.m. to 11:30 p.m. Central time and on Saturday from 6 a.m. to 3 p.m. Central time. **NurseLine:** The NurseLine is available 24 hours a day, seven days a week.
Benefits Administrator Website	
Website Access Information	Public Site is available for general information. **IMPORTANT:** Registration is required to use the member portal BlueAccess for Members.
Website	**bcbsil.com/att**
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	Blue Cross and Blue Shield of Illinois 3405 Liberty Drive Springfield, IL 62704
Claims	
Claims Regular	Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680-4112

Contact Information	
Claims Overnight	Blue Cross and Blue Shield of Illinois 3405 Liberty Drive Springfield, IL 62704
Appeals	
Appeals Regular	Blue Cross and Blue Shield of Illinois Attn: Appeals Coordinator 3405 Liberty Drive Springfield, IL 62704
Appeals Overnight	Blue Cross and Blue Shield of Illinois Attn: Appeals Coordinator 3405 Liberty Drive Springfield, IL 62704
Benefits Administrator Email	
Email Information	Blue Access for Member (BAM) Portal offers "I need to contact Customer Service" email option to submit inquiries
Benefits Administrator Fax Number	
Domestic	**217-698-2883**

Contact Information	
Benefits Administrator	
Name	CVS Caremark
Type	Prescription Drugs
Services Provided	Prescription Drug Administrator
Benefits Administrator Contact Numbers	
Contact Numbers Information	To reach a service associate or access the interactive voice response (IVR) system
Domestic Telephone Number	**800-378-8851**
Hearing Impaired Telephone Number	**800-231-4403**
Benefits Administrator Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7 a.m. to 11 p.m. and Saturday from 7 a.m. to 5 p.m. Central time, except some holidays. **Interactive voice response (IVR) system:** The IVR is available 24 hours a day, seven days a week.

Contact Information	
Benefits Administrator Website	
Website Access Information	**IMPORTANT:** To access the member website, you must be a registered user and will need your username and password. If you're not registered, select Not Registered and follow the instructions listed. The group code is ATTRX. To access the IVR or to speak to a service associate, you will need the CVS Caremark ID or Social Security number of the primary member.
Website	**caremark.com**
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	CVS Caremark Inc. Attn: Research Team P.O. Box 6590 Lee's Summit, MO 64064-6590
Claims	
Claims Information	Claim forms and/or mail-service order forms are available via the website or by phone.
Claims Regular	CVS Caremark Inc. Attn: Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196
Appeals	
Appeals Regular	CVS Caremark Inc. Appeals Department/AT&T MC109 P.O. Box 52084 Phoenix, AZ 85072-2084
Benefits Administrator Fax Number	
Domestic	**866-689-3092**

Contact Information	
Benefits Administrator	
Name	ValueOptions
Type	Mental Health/Substance Abuse (MH/SA)
Services Provided	Mental Health/Substance Abuse (MH/SA) Benefits Administration
Benefits Administrator Contact Numbers	
Contact Numbers Information	To reach a Care Manager

Contact Information	
Domestic Telephone Number	**800-554-6701**
Benefits Administrator Hours of Operation	
Hours of Operation	**Interactive voice response (IVR) system:** The IVR is available 24 hours a day, seven days a week.
Benefits Administrator Website	
Website Access Information	**valueoptions.com/members/Members.htm**
Website	**achievesolutions.net/att**
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	ValueOptions P.O. Box 1860 Latham, NY 12110
Claims	
Claims Regular	ValueOptions P.O. Box 1920 Latham, NY 12110
Appeals	
Appeals Regular	**Appeals Regular (Administrative Appeals)** ValueOptions (AT&T Appeals) P.O. Box 1860 Latham, NY 12110 **Clinical (Medical Necessity) Appeals** ValueOptions (AT&T Appeals) P.O. Box 1860 Latham, NY 12110
Benefits Administrator Fax Number	
Domestic	**877-826-8584**

Contact Information	
Vendor	
Name	AT&T Benefits Center
Type	Eligibility and Enrollment Vendor
Services Provided	Responsible for eligibility, enrollment, contributions, billing and COBRA processing
Vendor Contact Numbers	
Domestic Telephone Number	**877-722-0020**

Contact Information	
International Telephone Number	**847-883-0866**
Vendor Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7 a.m. to 7 p.m. Central time **Interactive voice response (IVR) system:** An IVR is available 24 hours a day (except Sunday from 1 a.m. to noon Central time and periodically during the week for one hour between midnight and 5 a.m. for maintenance and updates).
Vendor Website	
Website Access Information	To access the website, you will need your AT&T Benefits Center user ID and password. To access the AT&T Benefits Center via the telephone, you will need to provide the last four digits of your Social Security number, your date of birth and your AT&T Benefits Center password.
Website	**resources.hewitt.com/att**
Vendor Mailing Address	
General Mailing Address	
Mailing Address Information	AT&T Benefits Center 4 Overlook Point P.O. Box 1474 Lincolnshire, IL 60069-1474
Claims	
Claims Regular	AT&T Benefits Center Benefits Determination Review Team P.O. Box 1407 Lincolnshire, IL 60069-1407
Appeals	
Appeals Regular	AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 1407 Lincolnshire, IL 60069-1407
Vendor Fax Number	
Domestic	**847-883-8217** for general information **847-554-1397** for Claims and Appeals only

Contact Information	
Benefits Administrator	
Name	Fidelity Service Center
Type	Pension Service Center

Contact Information	
Services Provided	Term of Employment (also known as Net Credited Service), Death and Survivor Benefits Administration
Benefits Administrator Contact Numbers	
Contact Numbers Information	Applies to all Employees and Eligible Former Employees
Domestic Telephone Number	**800-416-2363**
International Telephone Number	Dial your country's toll-free AT&T Direct Access Number, then enter **800-416-2363.**
Hearing Impaired Telephone Number	**888-343-0860**
Benefits Administrator Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7:30 a.m. to 11 p.m. Central time. **Interactive voice response (IVR) system:** The IVR is available 24 hours a day, seven days a week.
Benefits Administrator Website	
Website Access Information	**IMPORTANT:** Call the Fidelity Service Center to report the death of an Employee, an Eligible Former Employee and/or an Eligible Dependent. You do not need a Fidelity Service Center PIN or Social Security number/customer ID to report a death.
Website	**netbenefits.com/att**
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	Fidelity Service Center P.O. Box 770003 Cincinnati, OH 45277-0065

INFORMATION CHANGES AND OTHER COMMON RESOURCES

It's important to keep your work and home addresses current because the majority of your Benefits, payroll or similar information is sent to them. In addition, your home address determines the Fully-Insured Managed Care Options available in your area. In certain cases your home ZIP code is used to determine your level of coverage. Please include any room, cubicle, apartment or suite number that will help make mail routing more efficient. Keep in mind that your home address could affect certain Benefits such as whether you reside in a Network Area or what Fully-Insured Managed Care Options are available.

Active Employee Address and Telephone Number Changes
For Employees with access to the Employee intranet: **Home and work address updates:** • Go to the OneStop website (**onestop.web.att.com**) and select eLink (eCORP) under Tools & Resources. • Enter your AT&T user ID and password for the AT&T Global Logon. (If you do not know your password, please follow the instructions on the screen.) • Once logged on, click OK. • On the eCORP home page, click on "Employee Services." *Note: Please be sure the far right-hand scroll bar is all the way to the top.* • Select Personal Information. • Select Maintain Addresses and Telephone Numbers. • To update your home address, select "Edit" at the bottom of the Permanent Residence box, make any necessary changes and click Save. • To update your work address, select "Edit" at the bottom of the Cubicle/Office box, make any necessary changes and click Save. **For Employees without access to the Employee intranet:** Contact your supervisor or eLink assistant.

Eligible Former Employee Home Address Changes
Call the Fidelity Service Center to change your address. **Telephone numbers and dialing instructions:** **800-416-2363** **888-343-0860** (hearing-impaired) Dial your country's toll-free AT&T Direct Access Number and then enter **800-416-2363** (international) **Hours of operation:** Monday through Friday from 7:30 a.m. to 11 p.m. Central Time You will need to establish a user name and password, if you haven't already, and you will need it when you call to speak to a service associate. IMPORTANT: These instructions are for recipients of long-term disability benefits, Employees on a leave of absence (LOA), as well as COBRA participants, alternate payees and survivors who have a pension benefit (including a retiree death benefit) or savings plan benefit that has yet to be paid to you. If you are not eligible to receive a pension or savings plan benefit or have already received your entire pension and savings plan benefits in a lump sum and are not eligible for a retiree death benefit from your pension plan, call the AT&T Benefits Center at **877-722-0020** to update your home address.

AT&T Benefits Intranet and Internet Access
Your Health Matters section of OneStop (Active Employees only) Go to the Your Health Matters section of **OneStop** at **onestop.web.att.com**.
Your Health Matters section of access.att.com (Active Employees from home) Go to the Your Health Matters section of **access.att.com** (AT&T's secure Internet site) for Benefits information at home.
Your Benefits section of access.att.com (Eligible Former Employees from home) Go to the Your Benefits section of **access.att.com** (AT&T's secure Internet site) for Benefits information at home.

DEFINITIONS

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

Actively at Work. A time when an Employee is actually working for the Company on a regular basis at the Employee's customary place of employment, receiving short-term disability benefits under a Company-sponsored disability plan, or is on a leave of absence (LOA) that provides for continued coverage, but only for the period of continued coverage while on the LOA.

Admission. The period of time between an entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the patient leaves or is discharged from the Hospital or Skilled Nursing Facility.

Adverse Benefit Determination. A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a Program Benefit, including any such denial, reduction, termination of, or failure to provide or make a payment that is based on a determination of a Covered Person's eligibility to participate in the Program.

Allowable Amount or Allowable Charge. The dollar amount which is the basis on which Benefits for Eligible Expenses are calculated as determined by the applicable Benefits Administrator for a Covered Health Service. The Program will not pay Benefits toward any amount above the Allowable Charge for a Covered Health Service. See the "Allowable Charges for Eligible Expenses" section for additional information.

Alternate Care. Care provided under the terms of an Alternate Care Plan developed by the Benefits Administrator in lieu of or to avoid a potentially more costly alternative. Alternate Care does not extend or create coverage for Services that are otherwise specifically excluded. See the "Alternate Care" subsection of the "What Is Covered" section for additional information.

Alternate Care Plan. A Course of Treatment developed by a Benefits Administrator that meets the definition of Alternate Care. See the "What Is Covered" section for more information.

Alternative Facility. A health care facility that is not a Hospital and that provides Covered Health Services on an outpatient basis, as permitted by law. The facility must be duly licensed by the appropriate state and local authority to provide such Services.

Ambulance Services. A transportation vehicle (air or ground) designed and equipped to be capable of transporting individuals with Emergency Medical Conditions. The vehicle must comply with state or local laws governing the licensing and certification of an emergency medical transportation vehicle.

Annual Deductible. The amount of money you must first pay out of pocket each calendar year for Covered Health Services before the Program begins to pay Benefits that are subject to a Deductible. See the "Cost Sharing" subsection of the "Medical Benefits" and "Prescription Drug Coverage" sections for information.

Annual Enrollment. The period specified by the Company during which Eligible Employees, Eligible Former Employees and COBRA participants may make changes to their coverage (including coverage options and enrolled dependents) under the Program. See the "Annual Enrollment" section for additional information.

Annual Maximum. The maximum dollar amount the Program will reimburse in a calendar year for certain nonessential health Benefits.

Annual Out-of-Pocket Maximum. The maximum amount of the Allowable Charges for Eligible Expenses that you will pay out of pocket for Covered Health Services each calendar year that account toward the applicable Annual Out-of-Pocket Maximum. See the "Cost Sharing" subsection of the "Medical Benefits" and "Prescription Drug Coverage" sections for information.

Appeal. A written request for the review of an Adverse Benefit Determination or a denial of a Claim for Eligibility under the formal process outlined in the Program for a Claim for Eligibility or Claim for Benefits, as applicable. See the "Claims Procedure" section for more information.

Applicable Premium Rate. The premium charged for a specified level of coverage such as "Individual" or "Family" for coverage under a Fully-Insured Managed Care Option.

AT&T Controlled Group. AT&T Controlled Group includes any of the following:

- Corporation that is a member of a 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.
- Organization (whether or not incorporated) that is a member of an affiliated service group (as defined by section 414(m) of the Code) that includes the Company.
- Other entity required to be aggregated with the Company and treated as a single employer under section 414(o) of the Code.

AT&T Controlled Group Member. Each entity in the AT&T Controlled Group.

AT&T Inc. AT&T Inc. or its successor. Sometimes referred to as "Company".

Bargained Employee. Either: (1) an Employee whose job title and classification is included in a collective bargaining agreement between a Participating Company and a union, or (2) an Employee whose job title and classification have been excluded from a collective bargaining agreement represented by the union, but for whom the Company provides the same Benefits provided to Employees included in a collective bargaining agreement between the union and the Participating Company.

Benefit Maximum. See the" Benefits at a Glance" and "What Is Covered" sections for Benefit information, including any Benefit Maximums and other Benefit limitations.

Benefits. Payments for Covered Health Services that are available under the Program. The availability of Benefits is subject to the terms, conditions, limitations and exclusions of the Program.

Benefits Administrator. Any third party, insurance company or other organization or individual to which the Company or the Plan Administrator has delegated the duty to process and/or review Claims for Benefits under the Program.

Brand-Name Drug. Medication sold by a pharmaceutical company under a trademark-protected name. Brand-name medications can only be produced and sold by the company that holds the patent for the drug.

Calculation Year. The calendar year immediately preceding the Plan Year the Program Premium Equivalent Rate will be in effect.

Change-in-Status Event. Certain life events such as marriage, birth of a Child, loss of benefits under another employer's medical plan, or going on an LOA that under the terms of the Program trigger the ability to change your enrollment under the Program. See the "Enrollment and Changes to Your Coverage" section for information.

Child(ren). See the "Eligible Dependents" section for the definition of Child(ren).

Claim. A Claim for Benefits or a Claim for Eligibility.

Claim for Benefits. A request for Benefits from the Plan that is made by the claimant or their representative in accordance with the Plan's established procedures for filing a Claim for Benefits and includes both Pre-Service and Post-Service Claims.

Claim for Eligibility. A written request for eligibility or enrollment sent to the address specified by the Eligibility and Enrollment Vendor following a denial of enrollment that has not been resolved informally.

Claims Administrator. See the definition of Benefits Administrator.

COBRA. The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) as enacted April 7, 1986, and as subsequently amended from time to time. Any reference to COBRA shall be deemed to include any applicable regulations and rulings. See the "Extension of Coverage – COBRA" section for information.

Code. The Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings.

Coinsurance. The percentage of the Allowable Charge that you pay for Covered Health Services. Other cost-sharing requirements may apply. See the "Cost Sharing" subsection for more information.

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

Company. AT&T Inc. and its subsidiaries 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.

Company Self-Funded Option. A coverage option under the Program, the Benefits under which are not funded through insurance.

Complications of Pregnancy. Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not complications of pregnancy.

Congenital Anomaly. A condition or conditions that is present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits (COB). The method of determining which health plan pays a plan participant's Claims first (primary), which pays second (secondary) and, in some cases, which pays third (tertiary), when the participant has coverage under more than one health plan. See the "Coordination of Benefits" section and the "If You Have Other Group Health Insurance" subsection of the "If You, Your Spouse or Your Dependent is Eligible for Medicare" section for more information.

Co-pay (Co-payment). The specific fixed dollar amount (for example $15) you pay for certain Covered Health Services under the Program. See the "Benefits at a Glance" subsection of the "What Is Covered" and/or "Prescription Drug Coverage" sections for cost-sharing information.

Cost-effective. In connection with Durable Medical Equipment and prosthetic devices, the least expensive equipment that performs the necessary function.

Cost of Coverage. The total cost to the Plan to provide Benefits under the Program. With respect to the Fully-Insured Managed Care Option, the Cost of Coverage is the Applicable Premium Rate. With respect to the Company Self-Funded Options, it is the Company Self-Funded Premium Equivalent Rate. See these specific definitions for more information.

Counseling. A therapeutic clinical process based on face-to-face interaction between a Covered Person and/or a Covered Person's family and a Practitioner and/or other persons with similar clinical conditions for the purpose of identifying the Covered Person's problems and needs, setting goals and interventions, resolving problems and promoting new behaviors.

Course of Treatment. The continuous treatment of a person for a condition.

Coverage Plan. See the "Coordination of Benefits" section.

Covered Health Services. Services, supplies (including Durable Medical Equipment) and Prescription Drugs provided for the purpose of preventing, diagnosing or treating an Illness or Injury, Mental Illness, substance abuse or their symptoms that are determined by the Benefits Administrator to be Medically Necessary and included in the "What Is Covered" section and not excluded under the "Exclusions and Limitations" section. To be considered a Covered Health Service, it must be provided:

- When the Program is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this SPD; and
- Only when the person who receives Services is a Covered Person and meets all eligibility requirements specified in the Program.

Covered Person. Either the Eligible Employee, Eligible Former Employee or an Eligible Dependent if, and only if, the individual is enrolled under the Program. References to "you" and "your" throughout this SPD, except with to respect to eligibility and enrollment, are references to a Covered Person. See the "Eligibility and Participation" section for eligibility provisions.

Custodial Care. Services that:

- Are non-health related Services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating).
- Are health-related Services that do not seek to cure or that are provided during periods when the medical condition of the patient who requires the Service is not changing.
- Do not require continued administration by trained medical personnel to be delivered safely and effectively.

Daily Charge. The charges for Room and Board from a facility such as a Hospital.

Designated Network Provider. A Provider, including a facility, chosen by the medical Benefits Administrator as a preferred Provider for certain specialized Services. These may include, for example, organ transplants, cancer treatment, congenital heart disease, kidney treatment and neonatal care. See the "What Is Covered" section for more information on Designated Network Providers and limitations available under the Program.

Diabetic Supplies. Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin diabetes prescribed by a Prescriber. Examples of equipment and supplies include lancets, test strips (blood or urine), insulin syringes and glucometers for all categories of diabetes listed.

Diagnostic Services. Professional Services rendered for the diagnosis of your symptoms and that are directed toward evaluation or progress of a condition, disease or Injury.

Disabled Child(ren). Your Child who is over the age of 26 and meets the requirements to be eligible for Program coverage due to disability. See the "Eligible Dependents" section for more information.

Domestic Partner. Your partner of the same gender:

- Who resides in the same household as you;
- Who is at least 18 years old, mentally competent to enter into a valid contract, unrelated to you and not legally married to anyone;
- With whom you have a close and committed personal relationship and there is no other such relationship with any other person; and
- With whom you share responsibility for each other's welfare and financial obligations.

Dual Enrollment. See the "Dual Enrollment" section for more information.

Durable Medical Equipment (DME). Medical equipment that:

- Is ordered by a Physician.
- Can withstand repeated use.
- Is not disposable.

- Is used to serve a medical purpose for treatment of an Illness, Injury or their symptoms.
- Is generally not useful to a person in the absence of an Illness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligibility and Enrollment Appeals Committee (EEAC). The committee appointed by the Company to make the final determination on eligibility and enrollment Appeals.

Eligibility and Enrollment Vendor. The Eligibility and Enrollment Vendor, referred to as the AT&T Benefits Center, is the third-party vendor that the Plan Administrator has delegated responsibility under the Program for initial eligibility determinations, enrollment administration, Cost of Coverage information, billing, COBRA administration and Change-in-Status Event administration.

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

Eligible Employee. An Employee of an AT&T Participating Company who satisfies the conditions for eligibility to participate in the Program set forth in the "Eligibility and Participation" section.

Eligible Expenses. The expenses for Covered Health Services that are eligible for consideration for payment of Benefits under the Program. Benefits paid under the Program are based on the Allowable Amount of Eligible Expenses determined by the Benefits Administrator.

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" section.

Emergency Facility. The emergency department of a Hospital, an acute care facility, or any other medical facility capable of providing Emergency Services, or treatment to Stabilize a patient with an Emergency Medical Condition.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to (i) place the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) result in the serious impairment to bodily functions; or (iii) lead to serious failure of any bodily organ or part to function properly.

Emergency Services. With respect to an Emergency Medical Condition, Emergency Services include:

- A medical screening examination that is within the capability of the emergency department of a Hospital, including related Services routinely available to the emergency department to evaluate the condition, and
- Further medical examination and treatment that is within the capabilities of the staff and facilities available at the Hospital, as are required to Stabilize the patient.

Employee. Any individual, other than a leased employee or Nonresident Alien Employed Outside the United States, who is carried on the payroll records of a Participating Company as a common law employee and who receives a regular and stated compensation, other than a pension or retainer, from that Participating Company, in exchange for services rendered to that AT&T 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;
- The term "Employee" does not include any individual:
  - Who is rendering services to an AT&T 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 AT&T Controlled Group and is providing services to an AT&T Participating Company; or
  - Who is treated by an agency, leasing organization or any other such company that is outside of the AT&T Controlled Group as an employee of such agency, leasing organization or other such company while rendering services to an AT&T Participating Company, even if such individual is later determined (by judicial action or otherwise) to have been a common-law employee of an AT&T 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 AT&T Participating Company that constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code). Notwithstanding the preceding sentence, any individual who is classified by an AT&T Participating Company as a global manager will not be considered a Nonresident Alien Employed Outside the United States.

Employer. The AT&T Controlled Group Member that issues your paycheck/that pays you.

ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time. Any reference to any section of ERISA shall be deemed to include any applicable regulations and rulings.

Essential Health Benefits. Health benefits determined pursuant to the Patient Protection and Affordable Care Act to be “Essential”. Generally Services under the following categories are considered to be Essential Health Benefits under the Patient Protection and Affordable Care Act: Ambulatory patient Services; Emergency Services, hospitalization; maternity and newborn care, mental health and substance abuse Services; Prescription Drugs; rehabilitative and habilitative Services and devices; laboratory Services; preventive and wellness Services and chronic disease management; and pediatric Services, including oral and vision care.

Evidence-based Medical Guidelines. Guidelines the United States Task Force on Preventive Care provides with respect to determination of covered Preventive Care Services under the Patient Protection and Affordable Care Act.

Expense Incurred. The actual billed cost for a Service or procedure; except when the Provider has contracted directly or indirectly or negotiated with the Benefits Administrator for a different amount.

Experimental or Investigational Services. Any procedures, drugs, devices, Services and/or supplies that (1) are provided or performed in special settings for research purposes or under a controlled environment and are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

Explanation of Benefits (EOB). A statement you receive after a Benefits Administrator has processed your Claim for Benefits. The EOB shows the expenses submitted for payment, the Allowable Charge for Eligible Expenses, the amount of Benefits payable and any amounts you must pay.

Extended Care Facility. An institution, other than a Hospital, that is accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by Medicare and is licensed to provide medical Services in a state. To be covered under the Program, the Extended Care Facility must provide direct medical treatment, have a professional nursing staff and operate under the supervision of a Physician. In addition, the facility must not be primarily a place for rest, the aged, Custodial Care or for the treatment of a mental health or substance abuse condition. An Extended Care Facility may operate under other names, such as a Skilled Nursing Facility, convalescent facility, intermediate care facility, subacute care facility or rehabilitation facility.

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

FDA. The U.S. Food and Drug Administration (FDA). A federal regulatory agency that collects and analyzes data about medications to determine if they are safe for manufacture and sale to consumers.

Fill. The dispensing of a prescription medication.

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

Fully-Insured Managed Care Option. An option that provides benefits under an insured arrangement and not through a Company Self-Funded arrangement.

Generic Drug. A drug that is equivalent to a Brand-Name Drug in that it uses the same active ingredients as a Brand-Name Drug and works the same way in the body. Generic Drugs are developed when the patent of a brand-name medicine expires permitting other drug manufacturers to make and sell the same medicine. This medicine is sold under its chemical or "generic" name. Generic equivalent drugs use the same active ingredients as Brand-Name Drugs and work the same way in the body. The FDA requires that Generic Drugs must be as high quality, strong, pure and stable as brand-name medicines.

Health Care Network (HCN). The group of Providers of health care Services that have an agreement in effect with the medical Benefits Administrator or an affiliate (directly or through one or more other organizations) who have agreed to participate in the HCN that the Benefits Administrator makes available for use by the Program. The term Health Care Network was previously referred to as the Point-of-Service Network.

Health Care Network (HCN) Coverage. The coverage option available under the Program that generally provides a different level of Benefits for Services performed by Network and Non-Network Providers. See the definition of Health Care Network (HCN).

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

Home Health Care. Treatment prescribed in writing by a Physician for the care of a Covered Person's Injury or Illness in the person's home.

Home Health Care Agency. A public or private agency that specializes in giving nursing and other therapeutic Services in the Covered Person’s home, including skilled nursing care, therapist, home visits, nutrition therapy and medical supplies prescribed by a Physician. An approved Home Health Care Agency must be licensed by a state department or agency having authority over home health care agencies.

Home Health Care Plan. A plan of Home Health Care treatment established and approved in writing by a Physician. The Physician must certify that Services of the patient receiving Home Health Care is Medically Necessary.

Hospice. An organization licensed according to state laws to provide care to terminally ill patients. A Hospice may be either an agency that performs Services in a patient’s home or a hospice facility the patient is admitted.

Hospice Care Program. A Hospice Care Program is:

- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families.
- A program that provides palliative and supportive medical, nursing and other health Services through home or inpatient care during the Illness.
- A program for persons who have a terminal Illness and for the families of those persons.

Hospital. A facility that is:

- Licensed as a general acute care hospital by the state in which it is located, accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and Medicare-certified.
- Provides 24-hour nursing Services by registered nurses (RNs) on duty or on call.
- Provides Services under the supervision of a staff of one or more Physicians to diagnose and treat ill or injured patients hospitalized for surgical, medical, or MH/SA conditions. A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Illness. A disorder of the body or mind, and pregnancy. Pregnancy shall include normal delivery, cesarean section, miscarriage, abortion, or any complications resulting from Pregnancy.

Injury. Bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms.

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.

Mail Order Prescription Drug Service. The purchase of Prescription Drugs using the Prescription Drug Benefits Administrator's mail order processing program according to the terms of the Program.

Maintenance Drug. A drug that is generally prescribed for chronic or long-term medical conditions, including but not limited to, diabetes or high cholesterol. The designation of a Maintenance Drug is determined by your Prescription Drug Benefits Administrator.

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

Medical Benefits. Amounts paid for:

- The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
- Amounts paid for transportation primarily for and essential to medical care referred to in the first bullet.

Medical Necessity. See the definition of Medically Necessary.

Medically Necessary. See the "Medically Necessary" section for a definition and details regarding how the Benefits Administrator determines Medically Necessary Covered Health Services, including examples of what is Medically Necessary and what is not considered Medically Necessary.

Medicare. The insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq., and as later amended.

Medicare Advantage. Coverage under Medicare Part C.

Medicare Allowable (MA). The amount Medicare will consider eligible for determining Medicare benefits.

Medicare Eligible. When you are eligible for Medicare as your primary coverage over the Program if you were to enroll in Medicare. See the "If You, Your Spouse or Your Dependent Are Eligible for Medicare" section for information.

Medicare Part D. The Part D (Voluntary Prescription Drug Benefit) of the insurance program established by Title XVIII of the United States Social Security Act, as amended, 42 U.S.C. Sections 1394, et seq.

Mental Health Services. Outpatient and inpatient Services to diagnose and treat mental disorders listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association (Manual); however the fact that a condition is listed in the Manual does not mean that treatment for the condition is a Covered Health Service under the Program.

Mental Illness. A condition that meets either of the following two requirements:

- It is classified as a mental illness in the latest edition of the International Classification of Disease of the United States Department of Health and Human Services; or
- It is a condition generally accepted by the health care professionals in the United States as one that requires psychiatric treatment and responds to such treatment.

MH/SA. The abbreviation for Mental Health/Substance Abuse.

MHPAEA. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Negotiated Rate. The agreed-upon payment for a Covered Health Service between the applicable Benefits Administrator and the Provider.

Network. The group of Providers of health care Services that have an agreement in effect with the applicable Benefits Administrator or an affiliate (directly or through one or more other organizations) which the Benefits Administrator makes available for use by the Program.

Network Area. The area determined by the medical Benefits Administrator to meet the requirements for availability of Network Providers. See the "How Network Areas are Determined" section for more information.

Network Benefits. Benefits for Covered Health Services that are provided by a Network Provider. See the "Network Benefits" subsection in the "Network Coverage" section for medical and MH/SA information.

Network Provider. A Provider who has contracted to participate in the applicable Benefits Administrator's Network available under the Program. Also referred to as In-Network Provider or preferred Provider.

Network Retail Cost. The cost to the Program of a Prescription Drug, including the Co-payment, if the medication was purchased by a Covered Person, using the Covered Person's Prescription Drug card, at a Network Retail Pharmacy.

Network Retail Pharmacy. A Retail Pharmacy that is in the Prescription Drug Benefits Administrator's Network of participating Retail Pharmacies and has a participating agreement in effect with your Prescription Drug Benefits Administrator.

Non-Network Provider. A Provider who has not contracted to participate in the applicable Benefits Administrator's Network available under the Program.

Non-Network Benefits. Benefits for Covered Health Services that are provided by a Non-Network Provider. See the "Non-Network Coverage" section for a description of Non-Network Benefits provided under the Program.

Non-Network Retail Pharmacy. A Retail Pharmacy that is not in the Prescription Drug Benefits Administrator's Network of participating retail Pharmacies available under the Program.

Non-Preferred Brand Drug. A Brand-Name Drug that is not on or has an alternative on the Prescription Drug Benefits Administrator's Preferred Drug Benefit Guide. There may or may not be a Generic Drug equivalent.

Notification. A written or oral notice provided by you, your Provider or your representative to the applicable Benefits Administrator using the procedure specified by the Benefits Administrator. See the "Notification and Preauthorization Requirements" section for information and a list of Covered Health Services that require Notification.

Nurse-Midwife. A person certified to practice as a Nurse-Midwife, who is licensed as a registered nurse by a board of nursing and has completed a state-approved program for the preparation of Nurse-Midwives.

Occupational Therapy. Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include Educational training or Services designed and adapted to develop a physical function.

Out-of-Pocket Maximum. See the definition of Annual Out-of-Pocket Maximum.

Outpatient Care. Health Services provided to a Covered Person who is not admitted to a facility as an inpatient (overnight). These Services may be provided in a variety of settings, including a Physician's office, clinic, the patient's home or Hospital outpatient department. Outpatient Care is often Hospital treatment that does not necessitate an overnight stay (for example, one-day surgicenters).

Outside Network Area or ONA. The geographic area outside of the Network Area for the Program. See the "Outside Network Area (ONA) Coverage" section for information.

Participating Company. Any AT&T Company that has elected to participate in the Program subject to approval by the Plan Sponsor.

Partner. Your Legally Recognized Partner (LRP) or, if eligible and enrolled in the Program, your Domestic Partner. See the definitions of Legally Recognized Partner and Domestic Partner for information.

Pharmacist. A person licensed to dispense Prescription Drugs under the laws of the state in which he or she practices.

Pharmacy. An establishment licensed by the state it is located in to dispense Prescription Drugs prescribed by an authorized licensed provider.

Physical Therapy. The treatment of a disease, Injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include Educational training or Services designed and adapted to develop a physical.

Physician. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) licensed to practice medicine in all its branches, prescribe and dispense all drugs and perform all surgery under applicable laws of the place where treatment is rendered.

Plan. The AT&T Umbrella Benefit Plan No. 3.

Plan Administrator. AT&T Services, Inc.

Plan Year. The calendar year beginning Jan. 1 and ending Dec. 31.

Post-Employment Benefits. Program coverage (excluding COBRA) made available to a former Employee who meets eligibility requirements for continued Program coverage after the Employee terminates employment. See the "What Happens When You Leave The Company" section for information.

PPACA. The Patient Protection and Affordable Care Act, as amended, including any applicable regulations and rulings. See the "Patient Protection and Affordable Care Act" section for information.

Practitioner. An individual who meets all of the following:

- The Practitioner is one of the following:
  - Podiatrist
  - Chiropractor
  - Psychologist or clinical psychologist with Ph.D. degree
  - Dentist
  - Optometrist
  - Nurse-Midwife
- The Practitioner is qualified and duly licensed or certified to practice in the state in which care is provided
- Operating within the scope of that Practitioner's license
- In addition, if the individual meets the above, a Practitioner may include an individual from the following list, but only when, in addition to meeting the above requirements of this definition, the patient has been referred to the Practitioner by a Physician or by the Benefits Administrator:
  - Registered physical therapist
  - Clinical social worker with master's degree (MSW)
  - Marriage, family and child counselor
  - Substance Abuse counselor
  - Speech pathologist
  - Audiologist
  - Occupational therapist
  - Dispensing optician
  - Nurse practitioner
  - Physician assistant
- An individual who holds a Master of Science in Nursing, a clinical nurse specialist or an individual certified in psychology and credentialed by the Benefits Administrator, but only when the patient has been referred to the Practitioner by the Benefits Administrator.

Preauthorization. Written or oral approval of a Covered Health Service received from the applicable Benefits Administrator before the Covered Health Service is delivered. See the "Notification and Preauthorization Requirements" section for information and a list of Covered Health Services requiring Preauthorization.

Preferred Brand Drug. A Brand-Name Drug that is included on the Prescription Drug Program Benefits Administrator's Preferred Drug Benefit Guide.

Preferred Drug Benefit Guide. A guide that identifies the U.S. Food and Drug Administration-approved drugs that the Prescription Drug Benefits Administrator's panel of doctors and pharmacists has determined to be as safe and effective and generally more cost-effective than Non-Preferred Brand Drugs. The Preferred Drug Benefit Guide is generally revised on a quarterly basis and may change throughout the Plan Year.

Preferred Provider Organization (PPO). The group of Providers of health care Services that have an agreement in effect with the medical Benefits Administrator or an affiliate (directory or through one or more other organizations) who have agreed to participate in the PPO Network which the Benefits Administrator makes available for use by the Program.

Pregnancy. The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body, usually, but not always in the uterus, and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Pregnancy Care. All of the following:

- Prenatal care
- Postnatal care
- Childbirth
- Any complications associated with Pregnancy

Premium Equivalent Rate. The projected average cost of a Company Self-Funded Option for a specified level of coverage, such as "Individual" or "Family."

Premium Rate. See the definition of Applicable Premium Rate.

Prescriber. A health care Practitioner licensed or authorized by law to issue an order for a Prescription Drug.

Prescription Drug. A drug or medicine approved by the United States Food and Drug Administration for general use by the public, requiring a prescription by a licensed Pharmacist or Physician.

Prescription Drug Benefit. Payments for outpatient Prescription Drugs that are available under the Program.

Preventive Care Drugs. Medications that are required under the Patient Protection and Affordable Care Act (PPACA) and associated regulations and guidance to be covered as preventive care as determined by the Prescription Drug Benefits Administrator. See the "Preventive Care Drugs" section for more information.

Preventive Care Services. Services that are determined by the Benefits Administrator to provide preventive care and are identified as preventive care in the Benefits Administrator's preventive care policy, including at a minimum Services required to be covered as preventive care under the Patient Protection and Affordable Care Act (PPACA) and associated regulations and guidance. See the "Preventive Care Services" section for more information.

Primary Subscriber. An Active Employee, Eligible Former Employee, or surviving Spouse/Partner/dependent who is eligible and enrolled for coverage. A Primary Subscriber is not an Active Employee, Eligible Former Employee, or surviving Spouse/Partner/dependent who is covered as a dependent on another Active Employee's, Eligible Former Employee's, or surviving Spouse/Partner/dependent's coverage.

Prior Authorization. A process by which the Benefits Administrator reviews requests for Covered Health Services before the Service is provided.

Program. The component part of the Plan providing Benefits for Covered Health Services to enrolled eligible individuals under the specified terms and conditions. See the "Using this Summary Plan Description" section for information.

Prospective Enrollment. The ability to drop or add coverage outside of Annual Enrollment or a Change-in-Status Event. See the "Prospective Enrollment" section for information.

Provider. Any health care institution or Physician or Practitioner licensed to render health care Services and practicing within the scope of that license.

Qualified Beneficiary. A Covered Person losing coverage under the Program who is eligible to elect COBRA continuation coverage. See the "Extension of Coverage – COBRA" section for more information.

Qualified Medical Child Support Order (QMCSO). See the "Qualified Medical Child Support Order" section for a definition and requirements.

Qualifying Event. An event such as loss of your job, reduction of your hours, death of a covered Employee or former Employee, divorce, or loss of eligibility as a Dependent, that results in the loss of coverage under the Program and gives rise to a right to elect COBRA continuation coverage. See the "Extension of Coverage – COBRA" section for more information.

Reasonable and Customary (R&C). The amount of charges that the Program will consider eligible for Allowable Charges, based on information obtained by the Benefits Administrator. The Benefits Administrator has the discretion to determine R&C based on several factors including the geographic area, prevailing rates, the Provider's experience, credentials, and expertise, and specific circumstances regarding the Services provided. See the "Allowable Charges for Eligible Expenses" section for more information.

Registered Domestic Partner (RDP). Any individual with whom an Employee or Eligible Former Employee has entered into a domestic partnership that has been registered with a governmental body pursuant to state or local law authorizing such registration and such relationship has not terminated. You may be asked to provide a copy of the domestic partner registration and other evidence that you continue to meet the requirements of the applicable registry and that the registered domestic partnership has not ended. See the "Dependent Eligibility Verification" section for information for dependent enrollment and verification of dependent eligibility.

Regular Employee. An individual who is classified as a Regular Employee by a Participating Company.

Retail Pharmacy. A place where Prescription Drugs are dispensed and provided to the Covered Person at point of sale.

Retail Prescription Drug Service. A Service administered by the Prescription Drug Benefits Administrator that provides up to a 30-day supply and is used for short-term, immediate-use medications.

Semi-private Room. A room with two or more beds.

Service or Services. Any of the following: medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices (including Durable Medical Equipment) and Prescription Drugs.

Skilled Nursing Facility. An institution licensed under state and local laws and regulations to operate as a Skilled Nursing Facility. Services include room and board in semi-private accommodations. Nursing Services must be supported by an approved treatment plan that leads to rehabilitation and an increased ability to function.

Specialty Pharmacy. A Pharmacy designated by the Prescription Drug Benefits Administrator for filling prescriptions for Specialty Prescription Drugs and providing associated Pharmacy management Services.

Specialty Prescription Drug Service. A Service administered by the Prescription Drug Benefits Administrator that provides Specialty Prescription Drugs.

Specialty Prescription Drugs. Drugs used in the management of certain chronic diseases, are often injectable or infused, treat complex and typically less common conditions, require complex Pharmacy management and frequently require coordination of Services.

Speech Therapist. An individual licensed to evaluate and treat speech impairments.

Speech Therapy. The treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and that is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include Educational training or Services designed and adapted to develop a physical function unless otherwise specifically provided for under the Program.

Spinal Treatment. The detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to distortion, misalignment or subluxation of or in the vertebral column.

Spouse. The person to whom you are legally married, including through Common Law Marriage.

Stabilize. (A) The term “stabilized” refers to: (i) with respect to an Emergency Medical Condition other than a pregnant woman having contractions, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, (ii) with respect to a pregnant woman having contractions, that the woman has delivered (including the placenta). (B) The term “to stabilize” refers to medical treatment of the condition as may be necessary to assure that the individual’s condition is stabilized.

Substance Abuse Services. Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Summary Plan Description (SPD). Each of the Program descriptions that are required by Section 102 of ERISA that provide a summary of the medical and prescription drug Benefits under the Program.

Temporary Employee. An individual who is classified as a “Temporary Employee” by a Participating Company.

Term Employee. An individual who is classified as a “Term 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 AT&T Controlled Group, as determined in accordance with the pension benefit plan the Employee participates in as of termination of employment.

Termination Date. The day immediately following an Employee’s last day on active payroll.

Unproven Service. Services that are not consistent with conclusions of prevailing medical research that demonstrate that the health Service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared with each other and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared with a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.) Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Illness or condition (one that is likely to cause death within one year of the request for treatment), the Benefits Administrator may, in its discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Illness or condition. For this to take place, the Benefits Administrator must determine that the procedure or treatment is promising, but unproven, and that the Service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Claim. Claim for treatment where a delay could seriously jeopardize the life or health of the patient or the ability to regain maximum function. Such a Claim is also one involving a condition that would, in the opinion of a Physician, Provider or Practitioner with knowledge of the condition subject the patient to severe pain that cannot be adequately managed without the care or treatment that is related to the Claim.

Urgent Care Facility. A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Illness, Injury, or the onset of acute or severe symptoms.

APPENDIX A: PARTICIPATING COMPANIES AND FORMER PARTICIPATING COMPANIES

Participating Companies

This appendix lists the Companies that participate in the Program and provides general information about groups of Employees and Eligible Former Employees that may be eligible to participate. Within this table, you will see various combinations of Company name, Employee groups and bargaining units, if applicable. If you are a Management or Nonmanagement Nonunion Employee, an "N/A" will be in the bargaining unit column. In addition, the Company acronym for this combination of Company name, Employee group and bargaining unit is listed in the first column.

This appendix is intended to provide information regarding Participating Companies and the Employee groups eligible to participate in the Program, not an individual's eligibility. Do not use this appendix to determine if you personally are eligible to participate in the Program. See the "Eligibility and Participation" section for specific information on eligibility.

	Participating Company Name and Acronym	**Employee Group**	**Bargaining Unit**
Population Abbreviation			
SBCSI - CWA District 1	AT&T Services, Inc. SBCSI	Bargained	AT&T East Core Contract - CWA District 1
SNET - CWA District 1	The Southern New England Telephone Company SNET	Bargained	AT&T East Core Contract - CWA District 1
TCORP - CWA District 1 (SNEDG)	AT&T Corp. TCORP	Bargained	AT&T East Core Contract - CWA District 1 (SNEDG)

APPENDIX B: 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. Marriage will generally trigger a HIPAA special enrollment right in addition to your right to a change in enrollment.

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

Change in Legal Marital or Partnership Status	Changes Permitted	Notes
Marriage or Partnership	AD, AS, C, DD, E, W	E, AD, AS: For newly eligible Spouse/Partner and any dependent Child(ren) of Employee or new Spouse/Partner. DD, W: Only if coverage is effective under new Spouse/Partner’s medical plan.
Death of Spouse/Partner*	AD, C, DD, DS, E	E, AD: Only if you lose coverage under your Spouse/Partner’s medical plan. DD: Only if other dependent loses coverage under your Spouse/Partner’s medical plan.
Divorce, Legal Separation, Legal Annulment or Dissolution of Partnership	AD, C, DD, DS, E	E, AD: Only if you or your dependent loses coverage under your Spouse/Partner’s medical plan. DD: Only if dependent loses coverage under your Spouse/Partner’s medical plan.

Change in Number of Dependents or Dependent Eligibility

You may change your enrollment if your dependent experiences a gain or loss of dependent status including birth, adoption, placement for adoption and death. Gaining a dependent will also trigger HIPAA special enrollment rights in addition to a change in enrollment.

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

**If a Dependent Dies*

If your dependent dies, you must notify the Fidelity Service Center at 800-416-2363. Although you are not required to notify the Fidelity Service Center within a specified period of time after the death of your dependent, please contact the Center as soon as possible to initiate the appropriate changes to your Program coverage.

Dependent Satisfies or Ceases to Satisfy Dependent Eligibility Requirements

In addition to birth and adoption, there are other Change-in-Status Events that may affect your dependent's eligibility under the Program and permit you to enroll the dependent. This applies to both your Spouse and Child dependents. There are many events which affect a dependent's eligibility under the Program including circumstances where a dependent:

- Reaches the maximum age for adult dependent Child coverage under the Program.
- Loses eligibility as a Spouse or dependent Child under the terms of the Program.
- Becomes your legal dependent.
- Becomes your certified disabled dependent Child.

Change in Dependent Status	Changes Permitted	Notes
Gain of Dependent Status	AD, AS, C, E, W	E, AD, AS: For the dependent only. W: Only if there is a gain of coverage under another health plan.
Loss of Dependent Status	DD, DS	May only drop coverage for the newly ineligible dependent.

Change in Employee's Employment Status

You may change your enrollment if you experience a change in employment that affects your eligibility under the Program including: termination of employment, commencement of employment, strike or lockout, commencement of an unpaid LOA, termination of an unpaid LOA, change in worksite that constitutes a change in employment status.

> IMPORTANT:
>
> (1) A change in employment status generally does not apply unless Benefit eligibility under the Program is affected as a result of the event.
>
> (2) A change in financial circumstance (for example, a pay reduction) is not considered a change in employment status unless it affects eligibility under the Program.

Change in Employee Employment Status	Changes Permitted	Notes
Gain of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	AD, AS, E	Only if eligibility for medical coverage option is gained.

Change in Employee Employment Status	Changes Permitted	Notes
Loss of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	W	
Employee Commences Strike or Lockout Resulting in a Change in Benefit Eligibility	W	Participants must lose eligibility and coverage.
Employee Returns From Strike or Lockout Resulting in a Change in Benefit Eligibility	AD, AS, E, W	
Employee Rehires Within 30 Days of Termination	Reinstate prior enrollment	No change permitted unless there is another permissible status change within that 30 day period.
Employee Rehires After 30 Days Following Termination	AD, AS, E	You may enroll and make new enrollment choices.

Change in Spouse's or Dependent's Employment Status

You may change your enrollment if your Spouse/Partner or dependent experiences a gain or loss of eligibility for medical coverage under another employer's plan as a result of a change in their employment status. Your change in enrollment for that individual under the Program must correspond with their specific Change-in-Status Event.

For example, if your dependent loses eligibility under his employer's medical plan due to a reduction of hours, you could change your enrollment to add him to your Program coverage. However, you could not change your election to drop all coverage under the Program.

Change in Spouse/Partner or Dependent's Employment Status	Changes Permitted	Notes
Gain of Employment	DD, DS, W	Enrollment changes under the Program are only permitted for you, your Spouse/Partner or dependent who gain coverage under another employer's medical plan.
Loss of Employment Spouse	AD, AS, C, E	AD, AS, E: Only with respect to you, your Spouse/Partner or dependent who lose coverage under another employer's medical plan.
Change in Work Schedule that Triggers a Loss of Eligibility Under their Employer's Medical Plan	AD, AS, C, E	AD, AS, E: Only with respect to the individual who lost coverage under another employer's plan.
Change in Work Schedule that Triggers a Gain of Eligibility under their Employer's Medical Plan	DD, DS, W, C	Only with respect to the individual who gains coverage under another employer's plan.
Spouse/Partner or Dependent Commences a Strike or Lockout	AD, AS, C*, E	*Only if there is a loss in coverage consistent with the event.
Spouse/Partner or Dependent Returns from a Strike or Lockout	C*, DD, DS, W	*Only if there is a loss in coverage consistent with the event.

Change in Residence

If you experience a change of residence that affects eligibility under the Program, you are permitted to make an enrollment change. For example, you may change your option enrollment if, as a result of a move, you are no longer eligible for the medical benefit option under the Program.

Change in Residence	Changes Permitted	Notes
Relocation Triggers Gain in Eligibility	AD, AS, E	
Relocation Triggers Gain in Medical Benefit Option Availability	AD, AS, E, C	Only if eligibility for coverage option is gained.
Relocation Triggers Loss in Eligibility	C, W, DD, DS	
Relocation Triggers a Loss of Medical Benefit Option Availability	C, W, DD, DS	Only if eligibility for coverage option is lost.

Change in Benefit Coverage Under Another Employer's Plan

You may change your enrollment to add or drop medical coverage for you, your Spouse/Partner or dependent if any of you gain or lose coverage under another employer's medical plan.

Change in Benefit Coverage	Changes Permitted	Notes
Gain of Medical Coverage under Another Employer's Plan	DD, DS, C, W	
Loss of Medical Coverage under Another Employer's Medical Plan	AD, AS, C, E	AD, AS: Only with respect to the Spouse/Partner or dependent who lost coverage under another employer's medical plan.
Spouse/Partner or Dependent's Annual Enrollment Does Not Correspond with the Program's Annual Enrollment Period	AD, AS, C*, DD, DS, E, W **Only if there is a loss of coverage*	AD, AS, DD, DS, E, W: Changes are permitted that reflect corresponding changes in non-AT&T Spouse/Partner or dependent's medical plan.
You Gain Eligibility Under Another Employer's Medical Benefit Plan(s)	DD, DS, W	If Employee, Spouse/Partner and/or dependent coverage under other employer's medical plan is effective.
You Lose Eligibility Under Another Employer's Medical Benefit Plan(s)	AD, AS, C, E	

Loss of Coverage Under a Government or Educational Institution

You may change your enrollment if you experience a loss of group health coverage sponsored by an educational or governmental institution (for example: student health coverage provided by a university, coverage due to military service or certain Indian tribal programs, etc.).

> **IMPORTANT:** There is no change in enrollment permitted for a gain of coverage from a government or educational institution. However, there are special rules for a gain or loss of Medicaid or state sponsored Children's Health Insurance Program (CHIP) coverage. See the "Change in Medicaid and CHIP Coverage" section below.

Loss of Educational or Governmental Institutional Coverage	Changes Permitted	Notes
Your Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, C, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.
Spouse/Partner or Dependent's Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, C, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance

You may change your enrollment if you experience a gain or loss of Medicaid coverage or premium assistance provided under a state sponsored CHIP program.

*Note: This Change-in-Status Event permits an extended enrollment period of **60 days** from the date of the event.*

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance	Changes Permitted	Notes
Your Gain of Medicaid Coverage or CHIP Premium Assistance	W, C, E, AD, AS	
Your Spouse/Partner or Dependent's Gain of Medicaid Coverage or CHIP Premium Assistance	DD, DS, C, W	
Your Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, C, E, W, DD, DS	
Your Spouse/Partner or Dependent's Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, C, E, W, DD, DS	

Change in Cost

You may change your enrollment if you experience a significant increase or decrease in your portion of the cost of your medical option under the Program during a period of coverage.

You may also change your enrollment if your Spouse/Partner or dependent experiences a significant increase or decrease in the cost of another employer's medical plan.

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

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

The Eligibility and Enrollment Vendor generally will notify you of increases or decreases in the cost of medical coverage.

If there is an insignificant increase or decrease in the cost of your current medical option, the Eligibility and Enrollment Vendor may automatically adjust your enrollment contributions to reflect the minor change in cost and you will not be permitted to change your medical coverage.

Change in Cost	Changes Permitted	Notes
Significant Increase in Cost of Your Medical Benefit Option	AS, AD, C*, DD, DS, E, W **Only if Company contributions cease*	May change enrollment to match cost increase OR W and AD, AS, E: Another medical benefit option providing similar coverage OR W, DD, DS: If no other medical benefit option provides similar coverage
Significant Decrease in Cost of Your Medical Benefit Option	AS, AD, DD, DS, E, W	May change enrollment to match the cost decrease OR W, DD, DS: Current option and AD, AS, E: Drop other medical benefit option and add the medical benefit option with decreased cost
Increase in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, C*, E	**Only if Company contributions cease*
Decrease in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	
You, your Spouse/Partner or Dependent Experience a Complete Loss of Medical Plan Subsidy from Another Employer	C, E, AD, AS	

Change in Coverage Under Another Employer's Plan

You may make an enrollment change if you experience a change under another employer's plan (including a plan of your Spouse's or Dependent's employer) if the enrollment change is on account of and corresponds with the change and the other plan permits its participants to make an enrollment change.

Change in Enrollment Under Another Employer's Plan	Changes Permitted	Notes
Increase in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	If coverage under other employer's plan is effective.
Decrease in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, C*, E	AD, AS, E: If coverage under another employer's plan is decreased or dropped. *Only if Company contributions cease*

Addition or Significant Improvement of Benefit Plan Option

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

If a medical option is added or significantly improves, eligible individuals who have not enrolled in the Program may enroll.

If an addition or significant improvement is made under your Spouse/Partner or dependent's medical plan, you may change your enrollment under the Program consistent with those changes.

Addition or Significant Improvement of Benefit Plan Option	Changes Permitted	Notes
Addition or Significant Improvement of a Program Medical Benefit Option	AD, AS, DD, DS, E, W	DD, DS, W then AD, AS, E: May drop current medical benefit option and elect the new or significantly improved medical benefit option. AD, AS: If previously enrolled in a medical benefit option, you may elect the new or significantly improved medical benefit option.
Addition or Significant Improvement of Medical Benefit Option to Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	Only if coverage under another employer's plan is effective.

Significant Curtailment of Coverage (With or Without Loss of Coverage)

You may change your enrollment if you experience a significant curtailment of coverage under the Program during a period of coverage. In this case, you may change your enrollment for an existing medical benefit option even if there is no loss of coverage. An enrollment may be changed to a different medical benefit option or, in some cases, drop coverage if no similar coverage option is available under the Program.

Coverage is "significantly curtailed" only if there is an overall reduction in coverage provided under the Program that reduces coverage generally.

Significant Curtailment of Coverage	Changes Permitted	Notes
Significant Curtailment or Termination of Coverage With or Without a Loss of Coverage	C, DD, DS, W	
Significant Curtailment or Termination of Spouse/Partner or Dependent Coverage under Another Employer's Medical Benefit Plan	AD, AS, C, E	You may only change your election if there is a loss of coverage and no similar coverage is available under another employer's plan.

Medicare or Medicaid

If you, your Spouse/Partner, or dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Program. Similarly, if you, your Spouse/Partner or your dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to enroll or increase that person's coverage under the Program.

Change Due to Medicare or Medicaid	Changes Permitted	Notes
You Gain Medicare or Medicaid Coverage	C, W	
You Lose Medicare or Medicaid Coverage	AD, AS, C, E	
Spouse/Partner Gains Medicare or Medicaid Coverage	DD, DS	If Spouse/Partner or dependent enrolls in Medicare or Medicaid coverage.
Spouse/Partner Loses Medicare or Medicaid Coverage	C, E, AD, AS	AD, AS, E: If Spouse/Partner or dependent loses Medicare or Medicaid coverage.

Leave of Absence (LOA)

You may change your enrollment if you, your Spouse/Partner or dependent begin or return from an LOA.

Common LOAs that trigger the right to a change in enrollment are: federal Family and Medical Leave Act (FMLA), state family and medical leave, federal military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), unpaid personal leave, etc.

Change Due to LOA	Changes Permitted	Notes
You begin an LOA	DD, DS, W	Whether paid or unpaid whether FMLA or non-FMLA.
You return from an LOA	AD, AS, E	Whether paid or unpaid whether FMLA or non-FMLA.
Spouse/Partner or Dependent Begin an Unpaid LOA (including a FMLA leave) Resulting in a Loss of Eligibility under Another Employer's Medical benefit plan	AD, AS, C, E	AD, AS, E: Only with respect to Employee, Spouse/Partner who lost coverage under another employer's plan.

Change Due to LOA	Changes Permitted	Notes
Spouse/Partner or Dependent Returns from an Unpaid LOA (including a FMLA leave) Resulting in a Gain of Eligibility Under Another Employer's Medical Benefit Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gains coverage under another employer's plan.
Spouse/Partner or Dependent Starts an Unpaid LOA (Non-FMLA) Without a Change in Eligibility under Another Employer's Plan	AD, AS, E	Only with respect to you, your Spouse/Partner who loses coverage under another employer's plan.
Spouse/Partner or Dependent Returns from an Unpaid LOA (Non-FMLA) Without Change in Eligibility Under Another Employer's Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gain you, your Spouse/Partner's coverage under another employer's plan.

Judgments, Orders and Decrees

If a judgment, court order or judicial decree resulting from a divorce, legal separation, annulment or change in legal custody requires medical coverage for your Spouse/Partner or dependent, you (or in some cases, the Program) may make a change to your enrollment to meet the legal obligation. While the judgment order or decree will cause you to be able to make the change in enrollment, it will not cause a Spouse or dependent to be eligible for coverage.

In addition, coverage may be dropped for the dependent if another person (e.g. your former Spouse) is required to cover the dependent.

Note: This enrollment change does not apply to voluntary changes in responsibility for medical coverage of a dependent between ex-Spouses.

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

Change in COBRA Continuation Coverage

Change in COBRA Continuation Coverage	Changes Permitted	Notes
Mid-Year Expiration of Maximum Coverage Period of COBRA Continuation Coverage Under Another Employer's Group Health Plan	AD, AS *Only if there is a loss in coverage consistent with the event.	You must exhaust the maximum COBRA coverage period available to you in order to make this change in enrollment. In general, you will not be permitted to make this change if your COBRA continuation coverage is terminated by you or your COBRA continuation coverage Provider before the maximum period of coverage.

Status Change Codes:

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

APPENDIX C: SPECIAL MEDICAL BENEFITS ADMINISTRATOR OFFERING

The medical Benefits Administrator offers a special program that may help reduce your out-of-pocket costs. This program is unique to the medical Benefits Administrator and a similar program may or may not be available through different Benefits Administrators. The Organ and Tissue Transplant Services Program offers you access to facility Services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures.

This section includes detailed information about the Organ and Tissue Transplant Services Program. Coverage and offerings through this Program depend on your particular situation at the time you utilize the Program. If you have questions with respect to how the Program works, see the medical *Benefits Administrator* table in the "Contact Information" section for contact information.

Organ and Tissue Transplant Services

IMPORTANT: Please read this section in its entirety. Requirements for Preauthorization and coverage for recipients and donors are explained as they relate to the covered transplants. Failure to follow guidelines explained in this section may cause a delay or denial of coverage. If you have questions concerning coverage under this Program, contact the medical Benefits Administrator at the telephone number on your ID card.

Benefits are available for the following transplants:

- Bone Marrow
- Cornea*
- Heart**
- Heart/lung**
- Heart Valve
- Kidney
- Lung**
- Liver**
- Muscular-skeletal
- Pancreas**
- Pancreas/kidney**
- Parathyroid

**Benefits are also available for cornea transplants. You are not required to notify the medical Benefits Administrator of a cornea transplant nor is the cornea transplant required to be performed at a Designated Network Provider.*

***Inpatient and Outpatient Facility Services (including evaluation for transplant, organ procurement and donor searches) for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplantation procedures must be ordered by a Provider and communicated to the medical Benefits Administrator by telephone before your transplant surgery has been scheduled. This will ensure that the Hospital you plan to use for your transplant surgery is approved by the medical Benefits Administrator as a location with an approved Organ and Tissue Transplant Services Program.* Note: *No Benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a medical Benefits Administrator's approved Organ and Tissue Transplant Services Program.*

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the medical Benefits Administrator to be a proven procedure for the involved diagnoses. Benefits related to the above transplants will be provided for:

- Inpatient and Outpatient Covered Health Services related to the transplant surgery;
- Evaluation, preparation and delivery of the donor organ;
- Removal of the organ from the donor; and
- Transportation of the donor organ to the location of the transplant surgery. *Note: Benefits will be limited to the transportation of the donor organ in the United States or Canada.*

Coverage for Donor and Recipient Services

Benefits are available to the donor and the recipient as follows:

- If both the donor and recipient have coverage, each will have their benefits paid by their own program.
- If you are the recipient of the transplant and the donor for the transplant has no coverage from any other source, the Benefits described in this SPD will be provided to both you and the donor. In this case, payments made for the donor will be charged against your Benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the Benefits described in this SPD will be provided for you. However, no Benefits will be provided for the recipient.

Transportation and Lodging

The medical Benefits Administrator will provide a $50 per day/per person Benefit, as well as travel and lodging arrangements, for the patient and a companion (two companions if the patient is a dependent Child under the age of 26) if your place of residency is more than 50 miles from the Hospital where the transplant will be performed.

In addition to the other exclusions included in the "Exclusions and Limitations" section transportation and lodging Benefits are not provided for the following:

- Cardiac rehabilitation Services (when not provided to the transplant recipient immediately following transplant surgery and discharge from the Hospital).
- Travel time and related expenses required by the Provider.
- Drugs that do not have approval from the Food and Drug Administration.

- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified.
- Meals.