Frontier Communications

Effective 01/01/2022

Anthem Silver Plan
For Pre 65 Retirees Not Eligible for Medicare

Summary Plan Description

This Summary Plan Description ("SPD") describes the medical benefits that are provided by the medical option listed on the front cover of this SPD to eligible retirees. The Frontier Retiree Medical Plan (the "Plan") includes many different medical options (each a "Medical Option"), each withseparate enrollment rules and separate and distinct medical benefits.

Eligible Retirees who are not eligible for the Medical Option described in this SPD, but rather are eligible for other Medical Options provided by the Plan (or who otherwise enroll in a different Medical Option provided by the Plan), will receive their own summary plan description that describes the Medical Option that applies to them. If you have questions as to which Medical Option is available to you, please contact the Plan Administrator.

The Plan is sponsored by Frontier Communications Company for the benefit of the eligible retirees of Frontier Communications Company and its divisions, subsidiaries and designated affiliates (referred to as the "Company").

This SPD is intended to provide a summary of the major provisions of the Plan, but is not intended to augment rights and benefits (or provide greater or additional rights and benefits) that are provided under the terms of the official plan documents. You can obtain a copy of the official plan documents from the Plan Administrator. Rights and benefits are described as clearly as possible with minimal use of technical words and phrases used in the official plan documents.

The Plan and the Medical Option described in this SPD is intended to be continued. However, the Company reserves the right at any time, and in its sole discretion (subject to any applicable collective bargaining agreement) to amend, modify, reduce, discontinue or terminate, in whole or in part, the Plan or any Medical Option thereunder or to increase the required contributions at any time. This may be done at any time, including after your retirement or termination of employment, and without prior notice.

Participation in the Plan and any Medical Option should not and may not be viewed as a contract or promise of continued coverage in the future. Keep in mind that coverage under this Medical Option ceases upon eligibility for Medicare.

Many words used in this SPD have special meanings. These words appear in capitals and are defined for you. Refer to the **Definitions** section for the best understanding of what is being stated.

Table of Contents

Health Schedule of Benefits Anthem Silver Plan (PPO)

BENEFIT PERIOD	Calendar Year
DEPENDENT AGE	Up to age 19, or up to age 23 if full-time students

	Network	**Non-Network**
***DEDUCTIBLE** **(Per Benefit Period)**		
Per person	$1,000	$2,000
Two person	$2,000	$4,000
Per family	$3,000	$6,000

* Note: When a Member incurs covered medical expenses during the last 3 months of a Benefit Period, which are applied against but do not satisfy that year's Deductible, those expenses may be carried over and applied against the Deductible(s) for the next Benefit Period, but not the Out of Pocket. If the Deductible is met, there is no carry-over credit given.

If you enroll in Single coverage, for you only, you must meet the individual deductible before benefits begin. If you enroll in two-person coverage or family coverage, the applicable deductible is treated as a combined amount for those enrolled. However, no individual will have to pay more than the individual deductible when receiving care before the plan pays benefits for that person. Additionally, no one enrolled member will contribute more than the individual deductible in meeting the applicable combined deductible.

OUT-OF-POCKET LIMIT **(Per Benefit Period – Excluding Deductible)**		
Per person	$5,000	N/A
Two person	$10,000	N/A
Per family	$15,000	N/A

Non-network out-of-pocket amounts apply to In-Network but In-Network out-of-pocket amounts do not apply to Non-Network

Deductible does not apply to preventive and Emergency room services.
The Out-of-Pocket Limit includes Coinsurance, except Prescription Drug, and does not include Deductible.

THE AMOUNTS REFLECTED FOR DEDUCTIBLE AND COINSURANCE ARE YOUR RESPONSIBILITY.

LIFETIME MAXIMUM	$1,000,000

	Network	Non-Network
PREVENTIVE CARE SERVICES		
Well Baby and Well Child exams including	No Coinsurance /No deductible	50% Coinsurance
Wellness (age 6 and older)	30% Coinsurance/No deductible	50% Coinsurance
Routine Physicals : **One exam per calendar year**	30 % Coinsurance /No deductible	
Hearing Tests related to a medical condition	30% Coinsurance	50% Coinsurance
Hearing Aid Up to $500 benefit every two calendar years	30% Coinsurance	50% Coinsurance
Routine gynecological exams (limited to 1 per Calendar Year)	30% Coinsurance/ No deductible	50% Coinsurance
Routine Mammograms (limited to 1 per Calendar Year)	30% Coinsurance/ No deductible	50% Coinsurance
Routine Pap Smears (limited to 1 per Calendar Year)	30% Coinsurance/ No deductible	50% Coinsurance
Routine PSA tests to screen for prostate cancer (limited to 1 per Calendar Year)	30 % Coinsurance/ No deductible	50% Coinsurance
PHYSICIAN OFFICE SERVICES	30% Coinsurance	50% Coinsurance
Diagnostic Lab & X-ray (includes non-routine mammography, pap smears and PSA tests)	30% Coinsurance	50% Coinsurance
Allergy Services		
Office Visits and Testing	30% Coinsurance	50% Coinsurance
Injections	30% Coinsurance	50% Coinsurance
OUTPATIENT FACILITY SERVICES **(For Surgical Procedure)**	30% Coinsurance	50% Coinsurance
Physical Medicine Therapies (Physical, Speech, Occupational Therapies and Chiropractic & Manipulation Services)	30% Coinsurance	50% Coinsurance
Acupuncture	30% coinsurance	50% Coinsurance

Maximums per Benefit Period	40 visits for Physical & Occupational Therapy combined Physician Office Services or Outpatient Facility Services. 20 visits for Speech Therapy whether Physician Office Services or Outpatient Facility Services 30 visits for Chiropractic & Manipulation Services whether Physician Office Services or Outpatient Facility Services	
OUTPATIENT SURGERY	30% Coinsurance	50% Coinsurance
HOME CARE SERVICES	30% Coinsurance	50% Coinsurance
Maximums per Benefit Period	100 visits	
INPATIENT SERVICES	30% Coinsurance	50% Coinsurance
Maximum per Benefit Period for Inpatient Services for Physical, Medicine & Rehabilitation	60 days	
SKILLED NURSING FACILITY SERVICES	30% Coinsurance	50% Coinsurance
MATERNITY SERVICES	30% Coinsurance	50% Coinsurance
DURABLE MEDICAL (rental up to the purchase price)	30% Coinsurance	50% Coinsurance
AMBULANCE SERVICES	30% Coinsurance	50% Coinsurance
TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) SERVICES up to a $1,000 lifetime maximum per person	30% Coinsurance	50% Coinsurance
MENTAL HEALTH/SUBSTANCE ABUSE (coinsurance apply towards out of pocket maximum)		
Inpatient Mental Health	30% Coinsurance	50% Coinsurance
Maximum per Benefit Period	30 days per calendar year, 90 days lifetime	
Inpatient Substance Abuse	30% Coinsurance	50% Coinsurance
Maximum per Benefit Period	30 days per calendar year and 60 days lifetime	
Outpatient Mental Health Services	30% Coinsurance	50% Coinsurance
Maximum per Benefit Period	30 visits for Outpatient Mental Health	

	Network	Non-Network
Outpatient Substance Abuse Services	30% Coinsurance	50% Coinsurance
Maximum per Benefit Period	30 visits for Outpatient Substance Abuse	
HUMAN ORGAN AND TISSUE TRANSPLANT		
Inpatient Services	30% Coinsurance	50% Coinsurance
HOSPICE SERVICES	30% Coinsurance	50% Coinsurance
EMERGENCY CARE	30% Coinsurance /No deductible	50% Coinsurance
URGENT CARE (in urgent care facility)	30% Coinsurance	50% Coinsurance

Definitions

Administrative Services Agreement – The agreement regarding services and Plan benefits between the Claim Administrator and the Company.

Authorized Services – A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance by Anthem to be paid at the Network level.

Benefit Period – The 12-month period of time that the Claim Administrator, on behalf of the Plan Sponsor, pays benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends when your coverage ends.

Benefit Period Maximum – The maximum dollar amount or visit limit the Plan allows for specific Covered Services during a Benefit Period.

Claim Administrator – An organization or entity that the Plan Sponsor contracts with to provide administrative and claims payment services and/or Covered Services under the Plan, currently Anthem Blue Cross and Blue Shield.

Coinsurance – A specific dollar amount or percentage of the Maximum Allowable Amount for which you are responsible for a Covered Service.

Contributions – The periodic charges which the Plan Sponsor may require the Covered Person pay to maintain coverage under the Plan.

Covered Person – A Member or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan Sponsor and for whom the required Contributions have been made. Covered Persons are sometimes referred to as "you."

Covered Services – Medically Necessary services supplies, or treatment as described in the Plan Benefits. To be considered Covered Services, services must be:

- within the scope of the license of the Provider performing the services;
- rendered while coverage under this Plan is in force;
- within the Maximum Allowable Amount;
- not specifically excluded or limited by this Plan.

A charge for a Covered Service is incurred on the date the service, supply, or treatment was provided to you.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. It is also care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas;
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Deductible – The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before the Claim Administrator, on behalf of the Plan Sponsor, starts to pay Covered Services each Benefit Period.

Dependent – A person of the Eligible Retiree's family who is eligible for coverage under the Plan as determined by the Plan Administrator as described in the Eligibility and Enrollment section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Effective Date – The date when a Covered Person's coverage begins under the Plan as determined by the Plan Administrator.

Eligible Retiree – An individual who satisfies the requirements set forth in the Eligibility and Enrollment Section and Schedule A.

Emergency - An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the

absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care – Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or stabilize an individual in an Emergency.

Experimental/Investigative - Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claim Administrator or the Claim Administrator's designee, on behalf of the Plan Sponsor, determines in its sole discretion to be Experimental/Investigative. The Claim Administrator, on behalf of the Plan Sponsor, will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claim Administrator, on behalf of the Plan Sponsor, determines that one of more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claim Administrator, on behalf of the Plan Sponsor. In determining whether a service is Experimental/Investigative, the Claim Administrator, on behalf of the Plan Sponsor, will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;

- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claim Administrator, on behalf of the Plan Sponsor, to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- documents of an IRB or other similar body performing substantially the same function; or

- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- medical records; or

- the opinions of consulting Providers and other experts in the field.

Identification Card – A card issued by the Claim Administrator, on behalf of the Plan Sponsor, that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you. Furnishing your Identification Card to someone who is not enrolled in the Plan constitutes fraud and your Plan coverage may be terminated.

Inpatient – A Covered Person who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Covered Person who is placed under observation for fewer than 24 hours.

Lifetime Maximum – The maximum dollar amount the Claim Administrator, on behalf of the Plan Sponsor, will pay for Covered Services during your lifetime while covered under this Plan.

Mail Order – A prescription drug program which offers you a convenient means of obtaining maintenance medications by mail if you take prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy mail order service which has entered into a reimbursement agreement with the Claim Administrator, and sent directly to your home.

Maximum Allowable Amount - The Maximum Allowable Amount is the lesser of:

- The Provider's usual charge for the service or supply; or
- The charge the Claims Administrator determines is appropriate based on the complexity of the service, the range of services provided and the cost of providing the same or a similar service or supply within the geographic area where the Provider is located.

These amounts are determined and updated for market changes frequently by the Claims Administrator, and vary by your geographic location. These amounts are sometimes generally referred to as reasonable and customary amounts.

Medically Necessary or Medical Necessity – An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Claim Administrator, on behalf of the Plan Sponsor, to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this SPD.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Conditions (including Substance Abuse) – A condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the Chapter entitled "mental disorders".

- Mental Health is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.
- Substance Abuse is a condition brought about when an individual uses alcohol or other drugs in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) manual.

Network Provider – A Provider that has a provider agreement with the Claim Administrator regarding payment for Covered Services and certain administration functions for this Plan's benefits.

New FDA approved drug product or technology – The first release of the brand name product or technology upon the initial FDA new drug approval or other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA approved drug product or technology does not include:

- New formulations: A new dosage form or new formulation of an active ingredient already on the market;
- Already marketed drug product but new manufacturer: A product that duplicates another firm's already marketed drug product: same active ingredient, formulation or combination;
- Already marketed drug product, but a new use: A new use for a drug product already marketed by the same or a different firm; or
- Newly introduced generic medications (generic medications contain the same active ingredient as their counterpart brand name medications).

Outpatient – A Covered Person who receives services or supplies while not an Inpatient, except in the home.

Payment Maximum – The maximum amount of payment for Covered Services for the time period or other limit specified in the Schedule of Benefits. Payment means the amount actually paid by the Claim Administrator for services received from a Provider.

Plan Sponsor (We, us and our) – The legal entity contracting with the Claim Administrator for administration of group health care benefits, which is Frontier Communications Company.

Prescription Legend Drug – A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug and Cosmetic Act, is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain atleast one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug.

Prescription Order – A written request by a Physician for a drug or medication and each authorized refill for it.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Claim Administrator, on behalf of the Plan Sponsor, approves. This includes any licensed Provider rendering services which are required to be reimbursed by applicable state law. Providers include, but are not limited to, the following persons and facilities:

- **Alcoholism Treatment Facility –** A facility which provides detoxification and/or rehabilitation treatment for alcoholism.
- **Ambulatory Surgical Facility –** a facility which has an organized staff of Provider, which:
  - has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
  - provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  - does not provide Inpatient accommodations; and

- is not, other than incidentally, used as an office or clinic for the private practice of a Physician, or Professional Other Provider.

- **Birthing Center**
- **Chiropractor**
- **Certified Nurse Midwife (C.N.M.)**
- **Certified Registered Nurse Anesthetist (C.R.N.A.)**
- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- **Drug Abuse Treatment Facility –** A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency –** A facility which:
  - Provides skilled nursing and other services on a visiting basis in the Subscriber's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Facility –** A facility which provides in the home as Home Infusion Therapy for Total Parental Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy or IV pain management, a combination of:
  - Skilled nursing services,
  - Prescription drugs, and
  - Medical supplies and appliances
- **Hospice –** A facility Provider which provides medical, social, psychological, and spiritual care as palliative treatment for terminally ill patients in the home and/or as an Inpatient using an interdisciplinary team of professionals.
- **Hospital –** An institution which maintains an establishment for the medical or surgical care of bed patients for a continuous period longer than twenty-four hours and which:
  - is open to the general public twenty-four hours each day for emergency care; and
  - has a minimum of ten patient beds; and
  - has an average of two thousand patient days per annum; and
  - has on duty a two thousand patient per annum; and
  - has on duty a registered nurse twenty-four hours each day; and
  - is not primarily providing psychiatric, rehabilitative, drug or alcoholism treatment.
- **Laboratory (Clinical)**
- **Occupational Therapist**
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy –** An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network or a Non-Network Provider.
- **Physical Therapist**
- **Physician –** One of these professionals licensed under applicable State laws:
  - Doctor of Medicine (M.D.)
  - Doctor of Osteopathy (D.O.)
  - Podiatrist or Surgical Chiropodist (D.P.M. or D.S.C.)
  - Dental Surgeon (D.D.S.)
  - Chiropractor (D.C.)
  - Doctor of Optometry (O.D.)
- **Psychiatric Hospital –** A facility which, for compensation of its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Health Disorders. Such services are provided by or under the supervision of an

organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

- **Psychologist –** A licensed clinical psychologist. In states where there is no licensure law, the psychologist must be certified by the appropriate professional body.
- **Rehabilitation Hospital –** A facility which is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve same reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.
- **Respiratory Therapy**
- **Skilled Nursing Facility –** A facility which mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other thanincidentally, a place that provides:
  - minimal Custodial, ambulatory, or part-time care, or
  - treatment for Mental Health Disorders, Substance Abuse, pulmonary tuberculosis.

  The facility or program must be licensed, certified, or otherwise authorized pursuant to the laws of the state where located as a skilled nursing home and approved by the Claim Administrator to provide the Skilled Nursing services covered by this Plan.
- **Speech Therapist**

Skilled Care – Care which must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is available 24 hours per day and usually involves a treatment plan.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Eligibility and Enrollment

This section tells how to apply for coverage, how and when you become eligible for coverage under this Plan, who is considered a Dependent, and when your coverage starts. This section also explains how to handle changes in coverage level (from retiree only to Two Person or Family).

Eligible Retirees and Initial Enrollment

Coverage for an Eligible Retiree is effective on the date the individual becomes an Eligible Retiree, provided such Eligible Retiree has enrolled for coverage. You are classified as an Eligible Retiree if you satisfy the eligibility requirements in Schedule A of this SPD.

To enroll for coverage, Eligible Retirees are required to complete the required enrollment process by contacting Milliman, Inc at 1-866-333-2074 Option 2. You must enroll by the date established by the Plan Administrator for initial enrollment. An Eligible Retiree that enrolls is also referred to as the "Member." By enrolling for coverage, an Eligible Retiree is authorizing the Company to withhold the amount of the required Contribution from his or her monthly pension benefit payment. If the monthly pension benefit payment is not enough to cover the cost of this coverage, the Eligible Retiree must pay the difference each month, as required by the Plan Administrator. Failure to make these payments on a timely basis will result in a loss of coverage that cannot later be reinstated.

Once made, an election will continue in effect for future Plan Years until changed by the Eligible Retiree during an annual enrollment period or as otherwise permitted. Although typically elections will carryover into future years, the Plan Administrator may require an affirmative election for a future year.

If an Eligible Retiree does not enroll by the date established by the Plan Administrator upon initially becoming eligible, then that person cannot later enroll for coverage under the Plan. An Eligible Retiree must maintain continuous coverage in one of the Medical Options under the Plan; once an Eligible Retiree drops coverage (or coverage otherwise terminates for any reason, including for non-payment of premiums), that individual loses the right to resume coverage in the future, including during annual enrollment. If an Eligible Retiree drops coverage or fails to make the required contributions for coverage, his enrolled Dependents also will lose coverage.

You will receive an Identification Card, which shows your identification number. It is important for you to know which family members are eligible to apply for benefits under Family Coverage. You must specify which Dependents will be enrolled in the Plan. See the section below on Dependent Eligibility.

When you or an enrolled Dependent reaches age 65 or otherwise become eligible for Medicare (such as due to your total disability), you and your family must immediately notify the Company. Coverage under this Medical Option ceases upon eligibility for Medicare, even if you choose not to enroll in Medicare. No medical benefits are provided under this Medical Option following the date you become eligible for Medicare (regardless of enrollment in Medicare); however, your Dependents will continue to be covered as described below.

Special Enrollment for Dependents Not Covered Upon Initial Eligibility

Although not required by law, if you declined medical coverage for any of your Dependents because of other coverage, you may be able to enroll such Dependents for medical coverage under the Plan if (1) they were eligible for coverage when you first became eligible to enroll in this Medical Option, (2) your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards theother coverage), (3) you request enrollment within 31 days after your Dependents' other coverage ends(or after the employer stops contributing towards the other coverage), and (4) such individuals are eligible Dependents on the date of enrollment.

If you are an Eligible Retiree and have a new Dependent child as a result of birth, adoption, or placement for adoption, you will be permitted to enroll the newborn or newly adopted child within 31 days after the birth, adoption or placement for adoption in the appropriate Medical Option. New spouses or children of new spouses are not eligible to be covered under this Plan.

If you fail to properly add an eligible Dependent during this special enrollment period, you cannot enroll them until the following annual enrollment period, in which case coverage will be effective on the following January 1.

Remember that if you, the Eligible Retiree declines enrollment when you are first eligible, you will not later be permitted to enroll in the Plan, even if you lose other coverage, get married, or have or adopt a child.

Qualified Status Changes

If you are enrolled as an Eligible Retiree, you may change certain benefit choices during the year if the Plan Administrator determined you have experienced a qualified status change and you contact the Plan Administrator within 31 days of the event. Qualified status changes include the following:

- Divorce.
- Birth, adoption or placement for adoption.
- Death of a Dependent.
- Dependent becomes ineligible/eligible for coverage.
- Change of home address that affects eligibility.

Enrollment or changes in enrollment must be consistent with a qualified event as determined by the Plan Administrator.

Dependent Eligibility

An individual may be enrolled as a Dependent if the individual satisfies one of the following classifications as described in this section.

Spouse Coverage

Your legal spouse is eligible to be covered under the Plan if you were married to that individual at the time of your retirement from Frontier. If you do not enroll such spouse in the Plan when you first become an Eligible Retiree, the spouse remains eligible for coverage only if coverage was declined because the spouse had other medical coverage and such individual has not had a lapse in medical coverage for more than 31 days. Ex-spouses and spouses acquired after your retirement date are not eligible, even if court-ordered.

Surviving Spouse and Surviving Children

If you die, your eligible surviving spouse and eligible dependents on the date of your death will continue to be eligible for coverage after your death under this medical option as long as the required premiums are paid and satisfy any other applicable conditions of the Plan, such as the definition of a Dependent. If a surviving spouse remarries, the new spouse and any new children are not eligible for retiree medical coverage.

Domestic Partners

A domestic partner is not eligible for coverage under this Plan.

Children

Your unmarried children under age 19 are eligible to be covered under the Plan if they are primarily dependent upon you for financial support (or upon you and your former spouse, if you are divorced) and do not have coverage elsewhere through their own full-time employment. As described below, eligible children may be covered after reaching age 19 only if they are full-time students or are disabled as determined by the Plan Administrator. The term "children" includes:

- your biological and adopted children (and children placed for adoption)
- the following children who, on the date of your retirement with the Company and while enrolled in the Plan, live with you in a parent-child relationship for at least half of the year or who are primarily dependent upon you for financial support –
    - step-children,
    - your or your spouse's foster children, and
    - children for whom you or your spouse are the legal guardian.
- children named in a Qualified Medical Child Support Order (QMCSO) requiring you to provide health coverage, provided the Plan is required to provide such coverage

Grandchildren cannot be covered unless you or your spouse are their legal guardian or have legally adopted them.

Eligibility of Children of a Domestic Partner

The unmarried dependent children of your domestic partner are not eligible for coverage under the Plan.

Full–Time Students Eligibility

Unmarried children over age 19, who meet the above requirements, may be covered if they are:

- enrolled as full–time students in a qualifying school, college or university, and
- younger than age 23.

The Plan Administrator may request proof of full–time student status at any time once a child reaches age 19. Acceptable proof includes a letter from a qualifying school, college or university that a child is enrolled full-time, as defined by the school, college or university. It is your responsibility to report a change in your child's eligibility.

Disabled Children Eligibility

A physically or mentally disabled child, who meets the above requirements, is eligible for coverage even though he or she has reached age 19, if:

- your child is enrolled for coverage and disabled on the date coverage would usually end
- your child is your dependent for federal tax purposes
- your child was covered under the plan (or the Frontier Medical Plan for active employees) prior to the date the disability began, and
- the Plan Administrator determines that your child meets the definition of disabled as defined by the Plan for this purpose.

If you don't want your child's claim processing to be delayed, provide proof of your child's disability at least 120 days before the child's coverage usually would end. If your disabled child is already 19 or older when you are first eligible to enroll, you should submit evidence that you satisfy the above two rules of your child's disability to the Plan Administrator.

During initial and subsequent enrollment periods you may be required to provide additional information regarding your child's continuous disability. A copy of the Social Security Disability Award is an acceptable document.

Exclusions

Other persons who are not eligible as described above may not be covered by the Plan. If any individual is not classified by the Company as an Eligible Retiree or eligible Dependent, that person is not eligible under the Plan.

Proof of Dependent and Eligibility Status

You may be asked to provide proof of your eligible dependent children when you enroll. In addition, the Company reserves the right to audit at any time the status of your enrolled spouse and dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of your marriage and proof for your enrolled dependent children. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be disenrolled from the Plan, possibly retroactively. Providing the Company with false or misleading information regarding a spouse or dependent child, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria may constitute misrepresentation. If the Company determines that misrepresentation has occurred, the Company may also terminate or suspend the Member's Plan coverage, require repayment of the ineligible individual's prior claims, require payment of the total value of the ineligible individual's coverage or take other corrective action.

Changes in Coverage

You must apply to enroll your Dependents within 31 days of the date that person first becomes an eligible Dependent or that person cannot be added unless there is a qualified status change, special enrollment right or future annual enrollment period where coverage is permitted to be added.

Whenever an event occurs which ends eligibility for one of your Dependents such as a spouse losing eligibility due to divorce or annulment or a child reaching the age limit, you must promptly (but in no event later than 60 days after the relevant event) notify the Plan Administrator, or its designee. In

addition, the Plan Administrator, or its designee must be notified when a Covered Person becomes eligible for Medicare and when the address of any Covered Person changes. Family Coverage should be changed to Single Coverage when only the Eligible Retiree is eligible.

When your Coverage Starts

Coverage starts on the Effective Date, as determined by the Plan Administrator. This day may be different for Members and Dependents. You will receive information about the required premiums for coverage. Premiums are generally paid through pension deductions. If the premium is greater than your pension payment, you will instead be billed for the total premium due. If you fail to make a required payment, coverage will be terminated and cannot be reinstated.

Termination, Continuation, and Conversion

Termination of Coverage

Except when noted otherwise, coverage under the Plan ends upon the earliest of the following to occur:

- The date the Plan ends, or the coverage is discontinued or terminated
- The date you fail to make your required contributions
- The last day of the month you no longer meet the eligibility requirements
- The last day of the month in which you become eligible for Medicare
- The date you fail to cooperate with the Plan Administrator or Claim Administrator with respect to the administration of your benefits.

Coverage for your enrolled Dependents (including your spouse) ends at the same time that your coverage ends, except that your spouse and children will remain eligible in the event of your death or eligibility for Medicare. However, your enrolled Dependent's coverage will end:

- The last day of the month in which your enrolled Dependent no longer meets the eligibility requirements (such as upon divorce, cessation of full-time student status, age, eligibility for Medicare)
- The last day of the month for which the required premiums are not paid on a timely basis
- The last day of the month in which you remove the enrolled Dependent from coverage
- The date the enrolled Dependent fails to cooperate with the Plan Administrator or Claim Administrator with respect to the administration of benefits
- The date the Plan ends, or the coverage is discontinued or terminated

It is your responsibility to report a change in a spouse or dependent child's eligibility. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded. Your Plan coverage and your spouse/dependent child's Plan coverage may also be terminated or suspended for engaging in misrepresentation or fraud against the Plan, including filing or participating in filing a false, misleading or fraudulent claim for benefits, allowing your ID card to be used by an individual who is not enrolled in the Plan, providing false or misleading information regarding a spouse or dependent child, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria.

Continuation of Coverage (COBRA)

The Plan gives your Dependents the option to extend your medical coverage in certain instances when coverage under the Plan would otherwise end. This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

If one of the circumstances listed in the COBRA Continuation Coverage Chart causes your spouse or dependent child to lose medical coverage under this Plan, continuation coverage may be available. The length of COBRA continuation coverage available is outlined below.

It is the responsibility of you or your spouse or dependent child who would lose coverage to contact the COBRA Administrator at 1-866-211-6801 within 60 days of the event to request an application to continue participation due to a qualifying event such as divorce, legal separation, or your child losing eligibility for coverage.

You or your covered spouse or dependent child must pay the full group rate for continued coverage, plus 2% for administrative expenses.

If COBRA is elected, the coverage previously in effect will generally be continued. However, as the plan changes for Eligible Retirees not receiving COBRA, the same changes will apply to those covered through COBRA. You will be given the opportunity to make a new election during annual enrollment or when you have a qualifying status change.

You or your covered spouse or dependent child have 60 days from the COBRA continuation coverage election notice date to elect continued participation under COBRA. Once you make your election, you will have 45 days to pay the initial premium payment. COBRA continuation coverage will be effective the day after the qualifying event.

COBRA Continuation Coverage Chart

Circumstances	Maximum Continuation Period		
	Retiree	Spouse	Child
Retiree dies	N/A	N/A	N/A
Retiree and spouse divorce	N/A	36 months	36 months
Retiree becomes entitled to Medicare	N/A	N/A	N/A
Child no longer qualifies as dependent	N/A	N/A	36 months

In some cases, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If such a proceeding is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree, spouse and covered children may be entitled to COBRA. For more information, please contact the Plan Administrator.

COBRA continuation coverage will terminate before the end of the indicated time period if:

- After electing COBRA continuation coverage, you or your covered spouse or dependent child becomes covered under another group health care plan (provided the plan does not have pre-existing condition exclusions affecting the covered individuals)
- You or your covered spouse become entitled to Medicare after electing COBRA continuation coverage

- The first required premium is not paid within 45 days, or any subsequent premium is not paid within 30 days of the due date
- If all health plans are terminated by the Company

It is important to keep the Plan Administrator informed of any changes in address and/or marital status. It is also important to keep a copy, for your records, of any notices you send to the Plan Administrator.

How to Obtain Covered Services

Network Providers are the key to providing and coordinating your health care services.

Network Services and Benefits

If your care is rendered by a Network Provider benefits will be provided at the Network level. No benefits will be provided for items which are not a Covered Service even if performed by a Network Provider or as an Authorized Service. Claim Administrator have final authority to determine the Medical Necessity of the service or referral to be arranged.

Claim Administrator may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other Facility. This decision is made upon review of your condition and treatment.

If the type of Provider required is not included in the Network and/or not available within the reasonable distance, i.e. 30 miles of the member's geographical area, Anthem will authorize the use of an out-of-network provider. **You must call the precertification toll free number on the back of your ID card for authorization prior to services being rendered**. Network Providers are described below:

> **Network Providers** include Physicians, Hospitals, and other Providers who contract with the Claim Administrator to perform services for you.
>
> For services rendered by Network Providers:
> - you will not be required to file any claims for services you obtain directly from Network Providers. **Network Providers will seek compensation for Covered Services rendered from the Claim Administrator and not from you except for approved coinsurance, copayments and/or Deductibles**. You may be billed by your Network Provider(s) for any non-covered services you receive or where you have not acted in accordance with this SPD.

Non-Network Services

Services which are not obtained from a Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care. In addition, certain services are not covered unless obtained from a Network Provider; see your **Schedule of Benefits.**

For services rendered by a Non-Network Provider, you are responsible for:

- obtaining any Precertification which is required;
- filing claims; and

- higher cost sharing amounts, including amounts in excess of the Maximum Allowable Amount.

Not Liable For Provider Acts or Omissions

Neither the Plan, the Company, the Plan Administrator nor the Claim Administrator are responsible for the quality of medical care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan, the Company, the Plan Administrator or the Claim Administrator based on what a Provider does or does not do.

Health Care Management

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by assuring the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements which may be conducted either prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or to determine which services require Pre-certification, call the Pre-certification telephone number on the back of your Identification Card.

Members are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Member's Precertification request.

Your right to benefits for Covered Services provided under this Benefit Booklet is subject to certain policies, guidelines and limitations, including, but not limited to, the Administrator's Medical Policy.

A description of each Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

Medical Policy

The purpose of Medical Policy is to assist in the interpretation of Medical Necessity. However, the provisions of this SPD take precedence over Medical Policy. Medical technology is constantly changing and the Claim Administrator, on behalf of the Plan Sponsor, reserves the right to review and update Medical Policy periodically.

Precertification

NOTICE: Precertification or prior authorization does NOT guarantee coverage for or the payment of the service or procedure reviewed.

Precertification is a Health Care Management feature which requires that an approval be obtained from the Claim Administrator, on behalf of the Plan Sponsor, before incurring expenses for certain Covered Services. The Plan's procedures and timeframes for making decisions for Precertification requests differ depending on when the request is received and the type of service that is the subject of the Precertification request.

Urgent Review means a review for medical care or treatment that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. Applying the prudent layperson standard, the Claim Administrator, on behalf of the Plan Sponsor, may determine that an Urgent Review should be conducted. Concurrent Reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay will be determined. Medical Necessity includes a review of both the services and the setting. **For certain services you willbe required to use the Provider designated by the Claim Administrator's Health Care Management staff.** The care will be covered according to your benefits for the number of days approved unless the Claim Administrator's Concurrent Review determines that the number of days should berevised. If a request is denied, the Provider may request a reconsideration. The Claim Administrator's Physician reviewer will be available by telephone for the reconsideration within one business day of therequest. An expedited reconsideration may be requested when the Member's health requires an earlierdecision.

Generally, the ordering Provider, facility or attending Physician may call to request a Precertification review ("requesting provider"). The Claim Administrator, on behalf of the Plan Sponsor, will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on your behalf for a specific Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on the Plan's process for designating an authorized representative, call the **Precertification telephone number** on the back of your Identification Card.

It is your responsibility to ensure that Precertification has been obtained by your Network or Non-Network Provider. You must verify that your Provider obtains the required Precertification on your behalf or you must obtain the required Precertification yourself. If you do not obtain the required Precertification, you are responsible for all charges for services the Claim Administrator, on behalf of the Plan Sponsor, determines are not Medically Necessary and **a non-compliance penalty of $300**. **If you do not obtain the required Precertification, a Retrospective Review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services the Claim Administrator, on behalf of the** Plan Sponsor**, determines are not Medically Necessary.**

You are responsible for obtaining Precertification for the following services:

- Inpatient admissions to Hospitals and other covered facilities, except for emergency admissions and Maternity admissions which result in childbirth (including admissions of forty-eight (48) hours for normal delivery and ninety-six (96) hours for C-section delivery)
- Home Care Services
- UPPP Surgery
- Plastic/Reconstructive surgeries for
  - Blepharoplasty
  - Rhinoplasty
  - Hairplasty
  - Panniculectomy and Lipectomy/Diatasis Recti Repair
  - Insertion/Injection of prosthetic material collagen implants

- Chin implant/Mentoplasty/Osteoplasty mandible
- Diagnostic services for PET

You are responsible for obtaining Precertification for the following Durable Medical Equipment/Prosthetics:

- Wheelchairs (special size, motorized or powered and accessories)
- Hospital beds, rocking beds, and air beds
- Electronic or externally powered prosthetics
- Custom made orthotics and braces

For Emergency admissions and Maternity stays of 48 hours for vaginal delivery or 96 hours in the case of C-section delivery, Precertification is not required. However, you must notify the Claim Administrator, on behalf of the Plan Sponsor, of your admission within 24 hours or as soon as possible if your medical condition prevents you from notifying the Claim Administrator within 24 hours.

Precertification Procedures

Prospective Review means a review of a request for Precertification that is conducted prior to a Member's Hospital admission or course of treatment. For Prospective Reviews, a decision will be made and telephone notice of the decision will be provided to the requesting Provider, as soon as possible, taking into account the medical circumstances, but not later than two business days from the time the request is received by the Claim Administrator, on behalf of the Plan Sponsor. For Urgent reviews, telephone notice will be provided to the requesting Provider as soon as possible taking into account the medical urgency of the situation, but not later than one calendar day from the time the request is received by the Claim Administrator, on behalf of the Plan Sponsor.

If additional information is needed to certify benefits for services, the Claim Administrator, on behalf of the Plan Sponsor, will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request. For Urgent Reviews the Claim Administrator, on behalf of the Plan Sponsor, will notify the requesting Provider by telephone of the specific information necessary to complete the review within 24 hours after receipt of the request by the Claim Administrator.

The requested information must be provided to the Claim Administrator, on behalf of the Plan Sponsor, within 45 calendar days. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. For Urgent Reviews, the requested information must be provided within 48 hours after the Claim Administrator's request for specific information.
A decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, but not later than two business days (one calendar day for Urgent Reviews) after the Claim Administrator's receipt of the requested information.

If a response to the Claim Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Claim Administrator's possession and telephone notice of the decision will be provided to the requesting Provider not later than two business days (one calendar day for Urgent Reviews) after the expiration of the period to submit the requested information.

Written notice of Prospective Review decisions will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

Concurrent Review

Concurrent Review means a review of a request for Precertification that is conducted during a Member's Inpatient Hospital stay or course of treatment. As a result of Concurrent Review, additional benefits may be approved for care which exceeds the benefit(s) originally authorized by the Claim Administrator's Health Care Management staff, on behalf of the Plan Sponsor.

If a request for Concurrent Review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by the Claim Administrator, on behalf of the Plan Sponsor. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting Provider within one calendar day from the time the request is received by the Claim Administrator, on behalf of the Plan Sponsor.

For Concurrent Reviews that do not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the requesting Provider within one business day from the time the request is received by the Claim Administrator, on behalf of the Plan Sponsor.

If additional information is needed to certify benefits for services for a Concurrent Review that does not qualify for Urgent review, the Claim Administrator, on behalf of the Plan Sponsor, will notify the requesting Provider by telephone and will send written notice to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review within one business day after receipt of the request. You or your authorized representative and the requesting Provider have 45 calendar days from the date of the Claim Administrator's request to provide the information to the Claim Administrator, on behalf of the Plan Sponsor. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the requesting Provider within one business day from the time the requested information is received by the Claim Administrator, on behalf of the Plan Sponsor. If a response to the Claim Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Claim Administrator's possession and telephone notice of the decision will be provided to the requesting Provider not later than one business day after expiration of the period to submit the requested information.

Written notice of Concurrent Review decisions will be sent to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

The Claim Administrator, on behalf of the Plan Sponsor, will not reduce or terminate **a previously approved** on-going course of treatment until you or your authorized representative receive telephone notice of the Claim Administrator's decision and have an opportunity to appeal the decision and receive notice of the appeal decision**.**

Retrospective Review

Retrospective Review means a review of a request for Precertification that is conducted after health care services have been provided to a Member but prior to a claim being submitted. It does not include the

review of a claim. If Precertification is required and approval is not obtained prior to the service being rendered, the Claim Administrator, on behalf of the Plan Sponsor, will conduct a Retrospective Review.

For Retrospective Review, a decision will be made within 2 business days from the time the request is received by the Claim Administrator, on behalf of the Plan Sponsor.

If additional information is needed to certify benefits for services, the Claim Administrator, on behalf of the Plan sponsor, will notify you or your authorized representative and the requesting provider in writing of the specific information necessary to complete the review within 2 business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from the date of the Claim Administrator's request to provide the information to the Claim Administrator, on behalf of the Plan Sponsor. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day.

A decision will be made within 2 business days from the time the requested information is received bythe Claim Administrator, on behalf of the Plan Sponsor. If a response to the Claim Administrator'srequest for specific information is not received or is not complete, a decision will be made based upon the information in the Claim Administrator's possession not later than 2 business days after expiration of the period to submit the requested information.

Written notice of Retrospective Review decisions will be provided to you or your authorized representative and the Provider(s) within 2 business days from the time the request is received by the Claim Administrator, on behalf of the Plan Sponsor.

If additional information is requested for a Retrospective Review, written notice of the decision will be provided within 2 business days of receiving the requested information or 2 business days of the expiration of the time period for submitting the information, whichever occurs first.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to assure that your care is provided in the most appropriate and cost effective care setting. This feature allows the Claim Administrator, on behalf of the Plan Sponsor, to customize your benefits by approving otherwise non-covered services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Claim Administrator's Health Care Management staff, on behalf of the Plan Sponsor. In managing your care, the Claim Administrator, on behalf of the Plan Sponsor, has the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

Covered Services

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Network Provider to be covered at the Network level, except for Emergency Care. All services which are not received from a Network Provider or as an Authorized Service will be considered a Non-Network Service.** All Covered Services are subject to the exclusions listed in the **Exclusions** section. All Covered Services must be

Medically Necessary and not Experimental/Investigative. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider, as an Authorized Service, or from a Non-Network Provider.

Preventive Care Services

Preventive Care Services mean care which is rendered by a Network Provider to prevent future health problems for a Covered Person who does not exhibit any current symptoms. See your **Schedule of Benefits** for any limitations. Preventive Care Services include:

Routine Exams and Immunizations

- Routine exams (e.g., pelvic exams) covered one per year. Some exams such as those required by a child's school are covered only when approved by a Network Provider.

- Non-routine exams are covered as determined by your physician, subject to medical necessity.

- Immunizations (including those required for school), flu shots, injections for overseas travel.

Routine/Preventive Diagnostic Services

- One routine screening mammogram is covered per female per calendar year.
- One routine cytologic screening (pap test).
- One routine prostate specific antigen (PSA) is covered per calendar year, regardless of age.
- One routine ultrasound per pregnancy.
- Other routine Diagnostic Services as determined appropriate for your age or sex when performed on an asymptomatic patient as preventive care.

Physician Office Services

Office Services include care in a Physician's office that is not related to Maternity and Mental Health/Substance Abuse Services, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Substance Abuse Services** for services covered by the Plan. For Emergency Accident and Emergency Medical Care refer to **Emergency and Urgent Care** in this section.

Office visits for medical care and consultations to examine, diagnose, and treat an injury or illness performed in the Physician's office. Office visits include injections such as allergy injections. When an allergy injection or allergy serum is the only charge from a Physician's office, the Coinsurance still applies.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

Therapy Services for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

Outpatient Facility Services

Outpatient Facility Services include **both facility and professional charges** for Surgical Services, Diagnostic Services, and Therapy Services when rendered as an Outpatient at a Hospital or other Provider. Outpatient Facility Services do not include care that is related to Maternity or Mental Health/Substance Abuse Services, except as otherwise specified (refer to the specific sections for more detail on coverage).

For Emergency Accident Care and Emergency Medical Care refer to the **Emergency and Urgent Care Services.**

Home Care Services

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment which the Claim Administrator, on behalf of the Plan Sponsor, has authorized through Precertification prior to the date treatment starts. Covered Services include the following only when such items were included in the authorization provided:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Nutritional Guidance
- Home Health Aide Services
- Diagnostic Services
- Therapy Services (visit limits specified in the Schedule of Benefits do not apply when rendered in the home)
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)

Home infusion therapy – Home infusion therapy is covered and includes a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes services and supplies for Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, IV pain management and IV home chemotherapy.

Home infusion services are covered only if received from a Home Infusion Facility.

Inpatient Services

Inpatient Services include:

- charges from a Hospital, Skilled Nursing Facility or other Provider for Room, Board and General Nursing Services;
- Ancillary Services; and,
- professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- a room with two or more beds;

- a private room. The private room allowance is the Provider's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available.
- a room in a special care unit approved by the Claim Administrator, on behalf of the Plan Sponsor. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- operating, delivery, and treatment rooms and equipment;
- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other facility Provider;
- medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services;
- Therapy Services.

Professional Services

- **Medical care visits –** One visit per day by any other Physician.
- **Intensive medical care –** Constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care –** Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation –** A personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.
- **Surgery and Anesthesia –** Professional services for surgery and the administration of general anesthesia.
- **Newborn exam –** The first Inpatient visit to examine a newborn. A Network Provider should be selected from the directory to perform this exam, normally a pediatrician. See **Preventive Care Services** for information regarding Outpatient routine benefits available for children after discharge.

Coinsurance Waiver

When a Covered Person is transferred from one Hospital or facility Provider to another Hospital or facility Provider on the same day, any Coinsurance stated in dollars per admission in the **Schedule of Benefits** is waived for the second admission. Coinsurance stated as a percentage are not waived.

Maternity Services

Maternity Services include Inpatient Services, Outpatient Facility Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn.

If Maternity Services are not covered because the mother is not a covered member, hospital charges for ordinary routine nursery care for a well newborn are not covered.

If a newborn infant requires additional definitive treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement, then the infant should be considered as a Covered Person in its own right, and benefits authorized are the same as for basic Hospital care. The claim should be billed separately from the mother's charges.

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will, at a minimum, be 48 hours for a vaginal delivery and 96 hours for a C-section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending Physician or the nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child and the mother agrees, provided the following are met:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
  - the antepartum, intrapartum, and postpartum course of the mother and infant;
  - the gestational stage, birth weight, and clinical condition of the infant;
  - the demonstrated ability of the mother to care for the infant after discharge; and
  - the availability of postdischarge follow-up to verify the condition of the infant after discharge.
- At-home post-delivery follow-up care visits are covered for you at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:
  - parent education;
  - physical assessments;
  - assessment of the home support system;
  - assistance and training in breast or bottle feeding; and
  - performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At the mother's discretion, this visit may occur at the Physician's office.

Diagnostic Services

Coverage for Diagnostic Services when provided as part of Preventive Care Services, Physician Office Services, Inpatient Services, Outpatient Facility Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services;
- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;
- Ultrasound services;
- Allergy tests; and
- Hearing tests (unless related to an examination for prescribing or fitting of a hearing aid).

See your **Schedule of Benefits** for benefit limitations.

Surgical Services

Coverage for Surgical Services when provided as part of Physician Office Services, Inpatient Services, or Outpatient Facility Services is limited to the following:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by us.

The surgical fee includes normal post-operative care.

Services for reconstructive surgery following mastectomies are covered by the Plan and include coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Therapy Services

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Facility Services, or Home Care Services is limited to the following:

Physical Medicine Therapies

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. The **Schedule of Benefits** include certain limits.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following disease, injury, or loss of a body part.
- **Speech therapy** for the correction of a speech impairment resulting from disease, surgery, or injury. Speech therapy does not include language training for educational, psychological or developmental speech delays.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, and vocational therapies (such as hobbies, arts, and crafts).
- **Manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an

office visit will be counted toward any maximum for Spinal Manipulation Services as specified in the **Schedule of Benefits.**
- **Chiropractic Care** for the treatment of a condition not covered for maintenance care.

Other therapy services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

See your **Schedule of Benefits** for benefit limitations.

Physical Medicine and Rehabilitation Services

Coverage for Inpatient Services for a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker and a psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical Medicine and Rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Medical Supplies, Equipment, and Appliances

The supplies, equipment and appliances described below are covered under this benefit.

- **Medical and surgical supplies –** Syringes, needles, oxygen, surgical dressings, splints and other similar items furnished and billed by a Network provider, which serve a medical purpose. Covered Services do not include items usually stocked in the home for general use like band aids, thermometers, and petroleum jelly.

- **Durable medical equipment –** The rental (or, at our option, the purchase) of durable medical equipment prescribed by a Physician or Professional Other Provider. Rental costs must not be more than the purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use. Repair of medical equipment is covered. Non-covered items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, or articles of clothing.

- **Prosthetic appliances –** Purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

  - replace all or part of a missing body organ and its adjoining tissues;
  - replace all or part of the function of a permanently useless or malfunctioning body organ.

Benefits for prosthetic appliances include:

- the first lens(es) following cataract surgery.
- the first breast prostheses and the first two surgical brassieres following a mastectomy.
- the first wig following cancer treatment.

Non-covered items include but are not limited to dental prosthesis, eyeglasses or contact lenses or their fitting except as provided above.

- **Orthotic devices –** A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part.

  Non-covered items include but are not limited to orthopedic shoes and arch supports.

Ambulance Services

Local transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- from your home, scene of accident or medical emergency to a Hospital;
- between Hospitals;
- between Hospital and Skilled Nursing Facility;
- from a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a covered benefit only when Medically Necessary, except:

- When ordered by a Plan Sponsor, school, fire, or public safety official and the Covered Person is not in a position to refuse.
- When a Covered Person is required by the Claim Administrator, on behalf of the Plan Sponsor, to move from a Non-Network provider to a Network Provider.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

Temporomandibular Joint Disorder

The Plan will pay up to $1,000 during your lifetime for splint therapy or surgical treatment for disorder or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), Craniomandibular Joint Disorders, including the complex of muscles, nerves and other tissues related to those joints.

This does not include dental work, such as, but not limited to orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or equilibrations, whether done for dental or medical reasons.

Mental Health/Substance Abuse Services

Inpatient Services for Acute Care, Outpatient Facility Services, and Physician Office Services for the treatment of Mental Health Disorders or Substance Abuse are covered for the diagnosis, crisis intervention and short-term treatment of Mental Health Disorders or for detoxification and/or rehabilitation of Substance Abuse. Benefits are limited as specified in the **Schedule of Benefits.**

- **Inpatient services**

  Inpatient Services to treat Mental Health Disorders or Substance Abuse, and:

  - **Individual psychotherapy;**
  - **Group psychotherapy;**
  - **Psychological testing;**
  - **Family counseling –** Counseling with family members to assist in your diagnosis and treatment; and
  - **Convulsive therapy –** Convulsive therapy includes electroshock treatment or convulsive drug therapy.

- **Partial hospitalization services**

  The services covered for Inpatient Services are also covered for partial hospitalization. Partial hospitalization may be substituted for Inpatient benefits at two days for each available Inpatient day.

- **Outpatient services**

  The services covered for Inpatient Services are also covered for Outpatient (except Room, Board, and General Nursing Service).

The following diagnosis are covered under mental health services:

- Developmental delays;
- Autistic disease;
- Learning disabilities;
- Hyperkinetic Syndromes;
- Mental retardation.

Services rendered by Residential Facilities are not covered under the plan.

Tissue and Human Organ Transplant Services

Precertification must be obtained for benefits to be provided for Tissue and Human Organ Transplant Services and services must be obtained from the Provider designated by the approval. Contact the Claim Administrator as soon as your Physician suggests that your condition may require a tissue or human organ transplant.

If you received a human organ or tissue transplant prior to becoming a Covered Person, follow-up care will be covered and is subject to the same requirements which apply when the transplant is received while covered under this Plan.

When the recipient is a Covered Person, the donor's expenses will be considered expenses of the recipient.

Tissue Transplants

Benefits are payable for Inpatient Services, Outpatient Facility Services and Physician Office Services for tissue transplants and all related charges which are described as Covered Services. Tissue transplants include certain bone marrow transplants and cornea transplants. Covered Services also include the Maximum Allowable Amount for the acquisition, preparation, transportation and storage of the tissue to be transplanted.

Benefits are payable for bone marrow and other tissue transplants which the Claim Administrator does not consider to be Experimental/Investigative.

When the Claim Administrator considers a bone marrow or other tissue transplant to be Experimental/ Investigative, the transplant and all Covered Services performed in relation to the transplant (e.g., chemotherapy) are excluded, whether rendered prior or subsequent to the actual transplant.

Contact the Claim Administrator to determine your benefits if you are advised that you require a tissue transplant.

Human Organ Transplants

Benefits are payable for Inpatient Services, Outpatient Facility Services and Physician Office Services for human organ transplants and all related charges which are described as Covered Services for a human organ transplant that the Claim Administrator does not consider to be Experimental/Investigative. Covered Services also include the Maximum Allowable Amount for the acquisition, preparation, transportation and storage of the human organ to be transplanted.

When the Claim Administrator considers a human organ transplant to be Experimental/Investigative, the transplant and all Covered Services performed in relation to the transplant (e.g. anti-rejection drugs) are excluded, whether rendered prior to subsequent to the actual transplant. If a covered human organ transplant is done in conjunction with an Experimental/Investigative transplant, then the Claim Administrator will determine the portion of the charges, which relate to the covered human organ transplant and allow only those charges.

Hospice Care Services

Hospice care may be provided in the home or Hospice Facility for medical, social and psychological services used as palliative treatment for patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician (refer to schedule of benefits).

Covered Services include the following only when such items were authorized by your Network Provider:

- Skilled Nursing Services (by an R.N. or L.P.N.);
- Diagnostic Services;
- Physical, speech and inhalation therapies;
- Medical supplies, equipment and appliances;
- Counseling services (except bereavement counseling);
- Inpatient confinement at a Hospice; and
- Prescription Drugs obtained from the Hospice.

Accident Related Dental Services

Outpatient Facility services and Physician Office services, Emergency Care services and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face. Injury as a result of chewing or biting is not considered an accidental injury.

The only other dental expenses that are Covered Services are charges for Outpatient Facility Services when the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient. Extraction of impacted wisdom teeth is not covered.

Emergency Care and Urgent Care

Emergency Care

Medically Necessary emergency care under this Plan includes Emergency Accident Care and Emergency Medical Care rendered at a Network Hospital. Services which the Plan determines to meet the definition of Emergency Care will always be covered.

Emergency Accident Care means the initial visit for evaluation and treatment of an accidental traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to result in serious physical impairment or loss of life.

Emergency Medical Care means the initial visit for evaluation and treatment of a serious potentially life-threatening condition manifested by severe symptoms occurring suddenly and unexpectedly which could result in serious physical impairment or loss of life if not treated immediately. Emergencies include, but are not limited to, heart attacks, strokes, poisoning, loss of consciousness or respiration, and convulsions.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, your treatment will always be considered an Emergency. **For inpatient admissions for Emergency Care, in order to obtain authorization for a specific length of stay, you must contact the Claim Administrator within 24 hours of your admission or as soon as possible if your medical condition prevents you from notifying the Claim Administrator within 24 hours. Contacting the Claim Administrator for authorization will assure that you know the number of days considered Medically Necessary for your diagnosis. Thus, you can avoid having to pay charges for any excessive Inpatient days which the Claim Administrator does not consider Medically Necessary.**

Urgent Care

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care but which is not life threatening and does not require use of an emergency room at a hospital. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Urgent Care is covered when obtained at an Urgent Care Center or a Physician's office. Refer to your **Schedule of Benefits** for limitations. Urgent Care treatment received in an emergency room is not covered.

Often an urgent rather than an emergency medical problem exists. Services which the Claim Administrator, on behalf of the Plan Sponsor, determines to meet the definition of Urgent Care will be paid based on the Provider who performed the service.

If you experience an accidental injury or a medical problem, the Claim Administrator will determine based on the prudent layperson standard, whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes based on your diagnosis and symptoms.

See your Schedule of Benefits for benefit limitations.

Prescription Drug Benefits

Benefit Period	Calendar Year
Deductible Per Person	**$150**

This deductible is in addition to the medical deductible.

Coinsurance

Per prescription	$12.00 Generic Preferred retail $35.00 Brand Preferred Brand retail $55.00 Brand Non-Preferred Brand retail $75.00 Other Drugs retail $30.00 Generic Preferred obtained through the mail service program. $87.50 Brand Preferred obtained through the mail service program $137.50 Brand Non-Preferred obtained through the mail service program. $187.50 Other Drugs obtained through the mail order program
Days Supply	30-day supply for drugs obtained through a Pharmacy other than a mail service Pharmacy. 90-day supply for drugs obtained through the mail service program.

Definitions

Brand Name Drug - The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. Brand name drugs consist of formulary and non-formulary. Drugs falling under the formulary tier are selected for their effectiveness, utilization and cost. Formulary drugs are always under review and subject to update. Brand name drugs that don't fall under the formulary tier, will fall under non-formulary tier. To find out what drugs are on the formulary go to www.Express Scripts.com, click on "Learn about Formularies" and enter the name of the drug or treatment category. Express Scripts (or other applicable Claims Administrator) solely determines the formulary drug listing and the Company has no authority or discretion over which drugs are included in the formulary drug listing. The formulary drug listings are subject to change at any time.

Generic Drugs - Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

Generic vs. brand-name medications
Brand-name medications are marketed under a trademark-protected name and are often available from only one manufacturer. Generic medications contain the same active ingredients as the original brand and must meet the same strict Federal regulations as their brand-name counterparts for quality, strength, and purity. Generic medications typically cost less than brands.

Your prescription benefit plan includes a formulary. The formulary is comprised of generic medications, preferred ("formulary") brand medications, and non-preferred ("non-formulary") medications. You will pay the lowest co-payment for generic medications, a mid-level co-payment for preferred/formulary brand medications, and the highest co-payment for non-preferred/non-formulary medications

Other Drugs – The Other Drugs category includes all anti-fungal drugs, Acne drugs and may include newly introduced drugs that are generally designed to improve the quality of life by remedying unpleasant conditions but are not medically necessary.

Mandatory Generic Drug Policy

If a Brand Name Drug, which has no Generic Drug equivalent is dispensed, the Member will pay the applicable brand co-pay. However, if a Brand Name Drug which has a Generic equivalent is dispensed, the Member will pay the applicable brand co-pay plus the difference between the cost of the Brand Name Drug and its Generic Drug equivalent.

Quantity Limit Requirement

Your pharmacy benefit includes a Quantity Limit requirement for certain drugs.

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

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

Step Therapy Program

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

Mandatory Mail Order

You are entitled to receive up to three 30-day fills of prescriptions for any maintenance medication at your retail pharmacy. Maintenance medications are drugs taken on an ongoing basis like cholesterol-lowering drugs, heart medications and blood pressure medications. Some medical conditions that typically require maintenance medications are: thyroid conditions, high cholesterol and high blood pressure. After the original prescription and 2 refills have been obtained, any future fills of that maintenance medication will only be allowed through Express Scripts mail order service.

Covered Prescription Drugs

Covered Services include only:

- Prescription Legend Drugs;
- Oral contraceptive drugs and diaphragms are covered when obtained through an eligible Pharmacy;
- Injectable insulin (although insulin is not a Prescription Legend Drug) and syringes prescribed for the administration of insulin when included on the same prescription as the insulin.

Covered Services are referred to as Drugs in this section. Charges for the administration of any drug or for syringes are not covered, except as otherwise specified.

Not Covered under Prescription Drug Benefits

Items not covered under the prescription drug benefit include the following:

- Erectile Dysfunction drugs are not covered under the Plan;
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except injectable insulin;
- For prescriptions for any items which are available in the same strength without a prescription;
- For off label use of any prescription medication, except as otherwise required by state law;
- Drugs used for treatment of obesity, including any drug which is primarily for weight loss;
- Charges for the administration of any drug;
- Drugs consumed at the time when and at the place where the Prescription Order is issued, including but not limited to samples provided by a Physician;
- Medicine that can be purchased over–the–counter;
- Illegal drugs and medicines that may not be prescribed within the scope of the doctor's license;
- Drugs for cosmetic purposes (except where specifically allowed by this SPD);

- Nutritional and diet supplements;
- Ostomy bags and supplies;
- Immunization agents and vaccines;
- Biological and blood or blood plasma products;
- Prescriptions for more than a 30-day supply at retail pharmacies at any one time, and a 90-day supply from mail order at any one time, and any other quantity limitation applied by the Claims Administrator for a particular drug or drug class;
- Prescriptions that can be reimbursed under any workers' compensation law or government program;
- Refill orders submitted too early (i.e., before 25% or less of the previous supply is remaining);
- Prescriptions ordered later than one year from the date the doctor wrote the prescription (or earlier if required by applicable law);
- Prescriptions ordered for a quantity greater than the doctor prescribed;
- Prescription drugs which are experimental/Investigational;
- Prescription drugs which are not Medically Necessary;
- Prescriptions which must be shipped outside the U.S. or to Puerto Rico are not covered under the mail order program;
- Prescriptions purchased before coverage is in effect or after termination of coverage;
- Prescription drugs available due to service in the armed forces of any government;
- Prescriptions that are determined to be fraudulent, duplicative or that exceed dispensing protocols;
- Prescriptions related to sex transformation or male or female sexual or erectile dysfunctions (except for Viagra) or inadequacies, regardless of origin or cause; and
- Prescriptions for treatment of obesity, including any drug which is primarily for weight loss.

New prescription drugs become available every year—and uses for existing prescription drugs often change. The Claims Administrator will review these drugs to determine whether or not they will be covered. The Plan and Claims Administrators have the sole authority to determine which drugs are Covered Services. The mail order benefit may exclude coverage for any drug that cannot be dispensed in accordance with customary dispensing protocols.

Payment of Benefits

The amount of benefits paid is based upon whether you go to a Network Pharmacy or a Mail Order Program and whether you obtain a Generic or a Brand Name Prescription Legend Drug.

Coinsurance for Prescription Orders (or Drugs) are based on the Maximum Allowable Amount at the applicable point of sale. Any discounts, rebates or other funds received by the Claim Administrator and/or the Plan from drug manufacturers or similar vendors are excluded from the calculation of the Maximum Allowable Amount.

The amounts for which you are responsible are shown in the **Schedule of Benefits.** No payment will be made for any Covered Service unless the charge exceeds any applicable Deductible and/or Coinsurance for which you are responsible.

How to Obtain Prescription Drug Benefits

Network Pharmacy – Present your Prescription Drug Order and your Identification Card at a Network Pharmacy. The Pharmacy will file the claim for you. You will be charged for applicable Deductible and/or Coinsurance amounts.

Mail Order – Complete the Order and the Patient Profile form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Order service. Your Physician may also phone in the prescription to the Mail Order Pharmacy. You will need to submit the applicable Deductible and/or Coinsurance amount to the Mail Order service when you request a prescription or refill.

Specialty Medications

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

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

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

Specialty Pharmacy Copay Assistance

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

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

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

The plan is partnering with Express-Scripts' (ESI) "SaveOnSP", a specialty pharmacy copayment assistance program to manage this Program. For a current list of the specialty medications included in the Program logon to www.saveonsp.com/frontier; the site will be available effective 1/1/2020, when the program goes live. To enroll in the Program, call SaveonSP at 1-800-683-1074.

Participants who are currently taking any of the specialty medications that are part of the Program will also receive a letter from SaveOnSP explaining the Program and how to enroll. If you are newly prescribed any of the specialty medications that are part of the Program, you will be contacted when you first attempt to fill the prescription and given instructions on how to sign up for the Program.

While it is your choice whether to participate in the Program, if you do not participate in the Program, you will have to pay a higher SaveOnSP copay, up to the full retail cost of the applicable prescription drug. Further, because the applicable drug is not covered by the plan, any cost you would pay would not be credited to your deductible and out-of-pocket maximum.

Exclusions

This section indicates items which are excluded and are not considered Covered Services, but is in no way a limitation upon, or a complete listing of, such items which are not considered to be Covered Services. Medical expenses, services and supplies that are not Covered Services and are not covered by this Plan including the following:

- Services and supplies which the Claim Administrator determines are not Medically Necessary;
- Services and supplies not received from a Provider, acting within the scope of his or her license;
- Services and supplies which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Claim Administrator;
- Medical expenses for a condition resulting from active participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;
- Medical expenses relating to active participation in an act of war whether declared or undeclared;
- Services and supplies for court ordered testing or care unless Medically Necessary and authorized by the Claim Administrator;
- Medical expenses for which you have no legal obligation to pay in the absence of this or like coverage;
- Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Services or supplies received from a member of your immediate family (parent, child, spouse, sister, brother, or self);
- Expenses for completion of claim forms or charges for medical records or reports unless otherwise required by law;
- Expenses for missed or cancelled appointments, unless required prior notice was provided;

- Expenses for mileage costs or other travel expenses, except as authorized by the Plan Sponsor;
- Expenses for which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a Covered Person had applied for Part A and/or Part B, except, as specified elsewhere in this Plan Benefits description;
- Expenses in excess of the Maximum Allowable Amount or in excess of your Lifetime Maximum;
- Expenses incurred prior to the effective date of your coverage or after coverage terminates;
- Expenses for treatment and care connected with or incidental to treatment that is primarily intended to improve your appearance. However, benefits are provided for care and treatment intended to restore bodily function or correct a deformity resulting from disease, accidental injury, birth defects, or previous therapeutic process, only if the original procedure would have been a Covered Service under this Plan;
- Expenses for services which are performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition which is resolved or stable;
- Expenses for Custodial Care, domiciliary or convalescent care;
- Expenses for foot care only to improve comfort or appearance, including but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery) calluses, toenails, except for removal of nail roots;
- Expenses for dental treatment except as specified elsewhere in this SPD;
- Expenses related to weight loss or treatment of obesity, except for surgical treatment of morbid obesity up to a $20,000 lifetime maximum;
- Expenses for sex transformation surgery and related services, or the reversal thereof;
- Expenses for marital or personal growth counseling or personal growth;
- Expenses for eyeglasses or contact lenses. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery or for soft contact lenses due to a medical condition;
- Expenses for services or supplies primarily for educational, vocational, or training purposes (except diabetic education);
- Expenses for or related to developmental delays, learning disabilities, hyperkinetic syndromes, attention deficit disorder, or mental retardation (except for Prescription Drugs for treatment of these conditions, if Prescription Drugs are an eligible benefit);
- Expenses for personal hygiene and convenience items;
- Expenses for care received in an emergency room which is not Emergency Care;
- Expenses related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;
- Expenses at a health spa or similar facility;
- Expenses for anesthesia for non-covered services;
- Expenses for self-help training and other forms of non-medical self-care;
- Expenses for private duty nursing services except when provided through your Home Care Services benefit;
- Expenses for stand-by charges of a Physician;
- Expenses related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing;
- Expenses for research studies or screening examinations except as specified elsewhere in this Plan Benefits description;
- Expenses for physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or other purposes;
- Expenses for extraction of impacted wisdom teeth;

- Services rendered by Residential Facility for the treatment of Mental Illness and/or Substance abuse;
- Services or supplies available due to service in the armed forces of any government and any expenses incurred while serving in the armed forces of any government;
- Any expenses related to an occupational injury or illness;
- Any services or supplies available under a governmental plan (except a plan established by a government for its own civilian employees and their dependents);
- Charges for the reversal of sterilization procedures;
- Charges for or related to the fertility treatment or pregnancy of a surrogate mother;
- Autopsies; and
- Expenses related to missed appointments or storage of your health care information or data.

Exclusions

This section indicates items which are excluded and are not considered Covered Services, but is in no way a limitation upon, or a complete listing of, such items which are not considered to be Covered Services. Medical expenses, services and supplies that are not Covered Services and are not covered by this Plan including the following:

- Services and supplies which the Claim Administrator determines are not Medically Necessary;
- Services and supplies not received from a Provider, acting within the scope of his or her license;
- Services and supplies which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Claim Administrator;
- Medical expenses for a condition resulting from active participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;
- Medical expenses relating to active participation in an act of war whether declared or undeclared;
- Services and supplies for court ordered testing or care unless Medically Necessary and authorized by the Claim Administrator;
- Medical expenses for which you have no legal obligation to pay in the absence of this or like coverage;
- Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
- Services or supplies received from a member of your immediate family (parent, child, spouse, sister, brother, or self);
- Expenses for completion of claim forms or charges for medical records or reports unless otherwise required by law;
- Expenses for missed or cancelled appointments, unless required prior notice was provided;
- Expenses for mileage costs or other travel expenses, except as authorized by the Plan Sponsor;
- Expenses for which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a Covered Person had applied for Part A and/or Part B;
- Expenses in excess of the Maximum Allowable Amount or in excess of your Lifetime Maximum;
- Expenses incurred prior to the effective date of your coverage or after coverage terminates;
- Expenses for treatment and care connected with or incidental to treatment that is primarily intended to improve your appearance. However, benefits are provided for care and treatment intended to restore bodily function or correct a deformity resulting from disease, accidental injury, birth

defects, or previous therapeutic process, only if the original procedure would have been a Covered Service under this Plan;

- Expenses for services which are performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition which is resolved or stable;
- Expenses for Custodial Care, domiciliary or convalescent care;
- Expenses for foot care only to improve comfort or appearance, including but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery) calluses, toenails, except for removal of nail roots;
- Expenses for dental treatment except as specified elsewhere in this SPD;
- Expenses related to weight loss or treatment of obesity, except for surgical treatment of morbid obesity;
- Expenses for sex transformation surgery and related services, or the reversal thereof;
- Expenses for marital or personal growth counseling or personal growth;
- Expenses for eyeglasses or contact lenses. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery or for soft contact lenses due to a medical condition;
- Expenses for services or supplies primarily for educational, vocational, or training purposes (except diabetic education);
- Expenses for or related to developmental delays, learning disabilities, hyperkinetic syndromes, attention deficit disorder, or mental retardation (except for Prescription Drugs for treatment of these conditions, if Prescription Drugs are an eligible benefit);
- Expenses for personal hygiene and convenience items;
- Expenses for care received in an emergency room which is not Emergency Care;
- Expenses related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;
- Expenses at a health spa or similar facility;
- Expenses for anesthesia for non-covered services;
- Expenses for self-help training and other forms of non-medical self-care;
- Expenses for private duty nursing services except when provided through your Home Care Services benefit;
- Expenses for stand-by charges of a Physician;
- Expenses related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing;
- Expenses for research studies or screening examinations except as specified elsewhere in this Plan Benefits description;
- Expenses for physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or other purposes;
- Expenses for extraction of impacted wisdom teeth;
- Services rendered by Residential Facility for the treatment of Mental Illness and/or Substance abuse;
- Services or supplies available due to service in the armed forces of any government and any expenses incurred while serving in the armed forces of any government;
- Any expenses related to an occupational injury or illness;
- Any services or supplies available under a governmental plan (except a plan established by a government for its own civilian employees and their dependents);
- Charges for the reversal of sterilization procedures;
- Charges for or related to the fertility treatment or pregnancy of a surrogate mother;

- Autopsies; and
- Expenses related to missed appointments or storage of your health care information or data.

Claims Payment

When your care is rendered by a Network Provider, the Network Provider will file the claim on your behalf.

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement sent by the Claims Administrator, on behalf of the Plan Sponsor, to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any).
- General information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

You must file a claim for benefits and all supporting documentation within the earlier of the time specified on the applicable claim form or one year after the service was rendered or the supply was provided.

How Benefits Are Paid

The Plan shares the cost of your medical expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before the Plan begins to pay its share of the balance. Some services are subject to a Copayment, others may be subject to both a Deductible and Copayment.

Network Providers will seek compensation from the Plan for Covered Services. When using a Network Provider you are only responsible for Copayments, Deductibles, and non-covered charges. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. If you receive Covered Services from a Non-Network Provider, you are responsible for the full amount billed by a Provider. In some cases, a Non-Network Provider may file a claim for you, or you may be required to file a claim yourself.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the Schedule of Benefits to see what amount you are required to pay for each service.

Covered Person's Cooperation

Each Covered Person shall complete and submit to the Claim Administrator, on behalf of the Plan Sponsor, such consents, releases, assignments and other documents as may be requested by the Claim Administrator, on behalf of the Plan Sponsor, in order to obtain or assure reimbursement under Worker's Compensation or any other governmental program. Any Covered Person who fails to cooperate will be responsible for any charge for services.

Payment of Benefits

You authorize the Claim Administrator, on behalf of the Plan Sponsor, to make payments directly to Providers giving Covered Services for which the Claim Administrator, on behalf of the Plan Sponsor, provides benefits under this Plan. .

Provider Reimbursement

Benefits shown in the Plan Benefits or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with the Claim Administrator.

Providers who have a reimbursement agreement with the Claim Administrator have agreed to accept the Claim Administrator's Maximum Allowable Amount allowance as payment in full.

Providers who do not have a reimbursement agreement with the Claim Administrator will normally bill you for amounts the Administrator considers to exceed its Maximum Allowable Amount in addition to any Deductibles and/or Coinsurances.

Regardless of whether the Provider has a reimbursement agreement with the claim Administrator, your payment obligations for Deductibles and/or Coinsurance are always determined using the Maximum Allowable Amount.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network and Non-Network Providers. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider.

Lifetime Maximum Benefits

The Lifetime Maximum is the most the Plan will pay for an individual during his/her lifetime. The maximum lifetime medical benefits is listed in the Schedule of Benefits. Lifetime Maximums carry over if you change from one Medical Option to another Medical Option under the Plan. In addition, your expenses incurred as an active employee or Dependent of an active employee carryover and apply to the Lifetime Maximum as a retiree or a Dependent of a retiree.

Expenses related to prescription drugs and mental health benefits count towards your Lifetime Maximum.

General Provisions

Form or Content of this Plan Benefits Description

No agent or employee of the Claim Administrator is authorized to change the form or content of this Plan. Such changes can be made only through an endorsement authorized by an officer of the Plan Sponsor.

Disagreement With Recommended Treatment

Each Covered Person enrolls in the Plan with the understanding that the Physician or other Provider is responsible for determining the treatment appropriate for his/her care. You may, for personal or religious reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all

Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Plan is delayed or rendered impractical, the Claim Administrator shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, Network Providers shall render health care services provided under this Plan insofar as practical, and according to their best judgment; but Network Providers and the Claim Administrator shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As a Claim Administrator of your employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the customer service number on the back of your Identification Card.

Right to Recovery

In certain situations, the Company has the right to recover payments it has made to you or on your behalf.

- If an overpayment of benefits is made, the overpayment may be recovered either directly from you or out of future benefit payments.
- If you (or a Dependent) are legally entitled to recover all or part of the cost of a covered service or supply from another plan or insurer, the Company is entitled to reimbursement from the settlement for the benefits it has provided.
- If you (or a Dependent) should recover any charges for covered expenses from a third party (for example, as the result of a lawsuit) the benefit payable from the Plan will be reduced to reflect the amount you will recover. If benefits have already been paid, you will have to reimburse the Company.

Qualified Medical Child Support Orders

A "Qualified Medical Child Support Order" (QMCSO) is a medical child support order creating or recognizing your child's right to receive coverage under a medical, dental and/or vision plan established and maintained by the Plan Administrator. Orders that need to be qualified should be sent to:

Frontier Communications
Attn: Plan Administrator
3 High Ridge Park
Stamford, CT 06905-1337

Payments for coverage required by QMCSO's will generally be deducted from your pay. You may obtain a free copy of the procedures governing the qualification of QMSCO's by contacting the Plan Administrator.

Double Coverage

Retirees who have medical coverage through the Company cannot cover another employee (spouse) of the Company on their medical plan if the spouse employee also has medical coverage through the Company.

If you or a member of your family is covered by another health plan, there may be some duplication of benefit coverage between this Plan and the other health plan. For this purpose, "health plan" includes any group or individual health insurance plan, policy or contract, another employer's medical plan, and the medical care component of any long-term care plan or policy.

This section applies only to medical expenses and not prescription drug expenses.

Health Plan Rules

The primary plan pays benefits first, up to that plan's limits. The secondary plan will not pay benefits until the primary plan pays a portion or denies a claim. The total benefits paid from both plans cannot be greater than the benefits under the richer plan. The following are the regular rules for health plans. Special rules are discussed below with respect to other coordination situations. Coverage under this plan is primary for Eligible Retirees, unless they are covered as an employee by another plan.

- **Any other health plan covering an individual as an employee is the primary plan for that person.** For example, if your spouse is covered by a health plan offered by his or her employer, then that plan will be primary for your spouse.
- **If your child is covered by this Plan and your spouse's health plan as a dependent, then the birthday rule determines which is primary.** Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is your child's primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If your spouse's plan does not have the birthday rule, then the father's plan is primary. If none of these situations apply to you, please contact the Plan Administrator.
- **If parents are divorced or separated and a court decree establishes financial responsibility for medical care of a child,** then the health plan of the parent assigned that responsibility will be that child's primary plan. In the absence of a court decree and when not remarried, the health plan of the parent with custody will pay benefits before the health plan of the other parent. If the parent with custody has remarried and the stepparent's health plan also covers the child, the health plan of the parent with custody will pay first, the health plan of the stepparent will pay next, and the health plan of the parent without custody will pay last.

There are two other rules to keep in mind regarding double coverage. First, when an individual has coverage from two employers - one a current employer, the other, a previous employer - the current employer's health plan is primary. Second, when the preceding rules do not resolve which health plan is primary, the health plan covering the individual the longest is primary. When a health plan does not have a coordination of benefits provision, the rules in this provision are not applicable and the other plan'scoverage is automatically considered primary.

Special Rules

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

How Coordination Works

When the Plan is primary, your Medical Option pays benefits as if it were the only plan. After your Medical Option pays its benefits, or denies a claim, you may file a claim for any unpaid amounts with the secondary plan.

Here is how your Medical Option coordinates benefits when it pays secondary to any health plan, policy or contract (*e.g.,* automobile insurance):

- Your Medical Option determines the benefit that would be paid if it were the only plan. This includes applying the appropriate benefit levels and all other benefit limitations.
- The amount of benefit paid by the primary plan, policy or contract (*e.g.,* automobile insurance) is subtracted from any benefit that would be paid by your Medical Option. This means that when your Medical Option is secondary, it will only pay the difference, if any, between its usual benefit and the benefit paid by the primary plan, policy or contract.

Therefore, coverage under this Plan, and another plan may not result in your receiving 100% reimbursement for your health care expenses.

Medicare

This Plan is intended for retirees and dependents who are not entitled to Medicare. No benefits are payable under this Medical Option for any individual eligible for Medicare.

This Plan will assume you have enrolled for Medicare Part A and Part B, even if you in fact have not enrolled. Therefore, you should enroll in Part A and Part B as soon as you are eligible.

Reimbursing the Plan

If you or one of your Dependents suffers a loss or injury caused by the actions or omissions of a third

party, that third party may be responsible for paying your medical and prescription drug expenses. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you or your dependents due to you or your Dependent's accident, injury or illness, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, workers' compensation coverage and anyfirst-party insurance coverage. However, a party does not include any individual or supplementaryinsurance policy or coverage classified as an individual cancer, individual specific disease or individualhospital indemnity policy (e.g., individual policies sold by AFLAC). For purposes of any applicablecoordination of benefits rules, a third party shall pay primary and the Plan shall pay secondary.

For example, if you are injured in a car accident, the person who caused the accident (and the person's insurer) are the "third parties" and may be responsible for paying for your injury–related expenses. You and your Dependent will be required to provide the Plan or its agents information concerning any claim or lawsuit you or your Dependents may have against a third party for injury caused by that party. You or your Dependent must also provide the Plan or its agents any documents or information relevant to the protection of the Plan's rights of reimbursement. You may be asked to sign a repayment agreement as a condition for receiving benefits under the Plan. If the agreement is not signed or you fail to cooperate with the Claims Administrator, you will lose your benefits related to the accident/injury/illness. If you do not cooperate, the Claims Administrator may terminate your injury-related benefits from and after a certain date even if your injury-related benefits were approved before that date.

If you decide to sue the person who caused the accident/injury/illness, you must inform the Company. If you receive any type of payment, reimbursement or legal recovery from the third party or an insurer, you are obligated to reimburse the Plan for any expenses that the Plan paid (and will pay in the future) for the accident/injury/illness and for any related legal and collection costs the Plan incurred. Any amounts recovered in excess of the foregoing shall be paid to you, but any excess portion shall be first applied to reduce the liability of the Plan for future payments of benefits with respect to the accident/injury/illness that is the subject of the right of reimbursement. The Plan may initiate legal action against you or your Dependent (or anyone else holding the proceeds, such as a legal representative or trust) to collect the payment, reimbursement or legal recovery, and may take any other actions allowed by applicable law to protect the Plan's right of reimbursement.

In the above example, if the Plan paid for the medical expenses you incurred as a result of the accident, and you later received money from the person who caused the accident or such person's insurer, you must pay back the Plan from the money paid by the person who caused the accident or such person's insurer.

Your obligation to reimburse the Plan exists for any legal recovery that relates to an accident, injury or illness for which the Plan paid benefits (including any amounts used to pay your legal fees), even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for medical expenses. In addition, the right of full and unreduced reimbursement shall also apply even if the rights of the Plan are separated and treated as not resolved in the judgment, settlement, verdict or insurance proceeds (but in this case the Plan's rights shall be assigned to you to the extent reimbursement is actually received out of the recovery). The Plan's right to receive any payment, reimbursement, or recovery discussed in this section supersedes and has priority over you and your Dependent's right to receive any payment, reimbursement and recovery.

In order to recover any reimbursement, payment, overpayment or excess payment to which the Plan has a right of reimbursement as provided above, you and your Dependents, as a condition of receiving benefits under the Plan, grant to the Plan the following rights:

- A first priority equitable lien against the proceeds of any settlement, verdict, insurance proceeds or other amounts received by you or your Dependents from or on behalf of any third party that may be responsible for an illness, injury or condition for which the Plan incurred expenses. The amount of the lien is equal to the amount of prior and future benefits paid by the Plan.
- The right to impose a constructive trust on the proceeds from any settlement, verdict, insurance or other amounts awarded, transferred or paid by or on behalf of a third party to you or your Dependents and any other person or entity holding the proceeds, including a legal representative or trust.
- The right to bring any legal action or proceeding to enforce the above rights in any court of competent jurisdiction as the Plan may elect, and upon receiving benefits under the Plan you and your Dependents hereby submit to each jurisdiction regardless of your current or future residence.

Third party proceeds held directly or indirectly by you are intangible assets of the plan and are held by you in a constructive trust for the benefit of the plan. Any participant or dependent who directly or indirectly holds or exercises any control over third party proceeds is an ERISA fiduciary with respect to the third party proceeds and must hold the third party proceeds for the exclusive benefit of the plan. A legal representative is an ERISA fiduciary solely with respect to his or her direct or indirect control of third party proceeds and not with respect to his or her legal representation of you. No disbursement of third party proceeds or other recovery funds from any insurance coverage or other source shall be made until the plan's right of reimbursement interest is fully satisfied.

The plan's right of reimbursement shall apply without regard to any equitable defenses that a third party, participant and/or dependent asserts or may be entitled to assert, including any defense of unjust enrichment. ERISA preempts any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plan's right of reimbursement. Neither the make whole doctrine nor the common fund doctrine apply to the plan.

For purposes of this section, "you" and "your" includes your spouse/partner/dependents, your agent and any agent of the foregoing, your attorney and any attorney of the foregoing and your estate and any estate of the forgoing.

Right of Subrogation

When another party is legally responsible or agrees to compensate you or your Dependent for an accident, illness or injury for which the Plan has paid benefits, the Plan has the same rights ("right of subrogation") that you and your Dependent have against the party. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you or your Dependents due to you or your Dependent's injury, illness or condition, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, workers' compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., individual policies sold by AFLAC).

The Plan expressly rejects and overrides any default rule that the Plan does not have a right of subrogation until you or your Dependent have been fully compensated. If you or your Dependent enters into litigation or settlement with another party, the Plan's right of subrogation will still apply.

You and your Dependent will need to provide the Plan or its agents with any relevant information, assistance and documents that help the Plan obtain its subrogation rights. Also, you could be required to sign and deliver to the Plan or its agents documents to secure the Plan's subrogation rights, and you and your Dependent will be required to obtain the consent of the Plan or its agents before releasing any party from liability for payment. If you fail to cooperate with the Claims Administrator, you will lose yourbenefits related to the accident/injury/illness. If you do not cooperate, the Claims Administrator mayterminate your injury-related benefits from and after a certain date even if your injury-related benefitswere approved before that date.

Claim and Appeal Procedures

Background

There are separate procedures for claiming benefits under the Plan and there are separate procedures for making eligibility or any non-benefit claim relating to the Plan. Any formal claim for benefits and related appeals should be filed with the Claim Administrator under the procedures set forth below. Any formal claim for eligibility and related appeals (as well as any other non-benefit claim and appeal) should be filed with the Plan Administrator. These procedures are discussed in separate sections below.

Usually, benefits are paid in the ordinary course using the forms and procedures described in this SPD. However, occasionally you may wish to file a formal claim.

The Plan Administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it shall be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Plan Administrator or Claim Administrator decides in its discretion that the applicant is entitled to them. The Plan Administrator has periodically exercised its authority to delegate discretionary authority in contracts, letters and plan documents, to the various claims administrators under the Plan, and to their predecessors and successors.

Claims for Benefits

The Claim Administrator's customer service representatives are specially trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- your coverage and benefit levels, including Copayment amounts;
- specific claims or services you have received;
- doctors or Hospitals in the Network;
- referral processes or authorizations; and/or
- Provider directories.

A complaint procedure has been established to provide fair, reasonable, and timely review of complaints that you may have concerning the Plan. The Claim Administrator invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by medical Providers in the claim Administrator's Networks.

The Complaint Procedure

If you have a complaint, problem, or claim concerning benefits or services, please contact the Claim Administrator. Please refer to your Identification Card for the Claim Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claim Administrator of its procedures and contracts. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. If your complaint involves issues of Covered Services, you may be asked to sign a medical records release form so the Claim Administrator can request medical records for its review.

Benefit Claim Denial

If your claim for benefits is denied in whole or in part, you will receive a written notification of thedenial as described more fully below. This claim denial notice will include: specific reasons why the claim was denied; specific references to applicable provisions of the Plan document or other relevant records or papers on which the denial is based, and information regarding where you may review them;an explanation of how to appeal for reconsideration of the claim administrator's decision, including your right to submit written comments and have them considered, your right to review, upon request and free of charge, relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim; and a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary. You will receive notice from the Claims Administrator about your claim according to the type of claim you have filed.

- **Urgent Care Claims.** You will receive notice, in writing or by telephone, facsimile or other electronic method, within 72 hours of a claim for benefits where medical care is necessary to avoid serious jeopardy to your life or health, or to regain maximum function (or as determined by yourtreating physician).
- **Pre-Service Claims.** You will receive written notice within 15 days for a non-urgent claim for medical benefits where precertification is required before care is provided; unless an extension of time is required to review your claim, in which case you will be notified in writing of the need for an extension of up to 15 additional days.
- **Post-Service Claims.** You will receive written notice within 30 days for a non-urgent claim for medical benefits where precertification was not required and care has already been provided; unless an extension of time is required to review your claim, in which case you will be notified in writing of the need for an extension of up to 15 additional days.
- **Concurrent Care Claims.** If your request to extend a course of treatment is an Urgent Care Claim, you will receive written notice within 24 hours provided the request is received at least 24 hours prior to the end of the approved treatment. If a request to extend approved treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be processed according to the above time frame for an Urgent Care Claim. If the ongoing course of treatment is not an Urgent Care Claim, a request to extend the treatment will be considered a new claim and processed according to the Pre-Service Claim or Post-Service Claim procedures, whichever is applicable. However, you will be notified of any reduction or termination of the course of treatment sufficiently in advance so as to permit a full appeal before the termination or reduction takes effect.

The Claims Administrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide your claim. If an extension is required because there is

insufficient information to review your claim, you will receive a notice explaining the unresolved issues that prevent a decision on the claim and a listing of the additional information needed to resolve those issues. You will be given 45 days (48 hours in the case of an urgent care claim) from the receipt of that notice to provide the additional information to the Claims Administrator. During the time that a request for information from you is outstanding, the running of the time period in which the claims administrator must decide your claim is suspended.

Appeals of Denied Benefit Claims

Please note the Claims Administrator is the claims fiduciary for purposes of determining benefit claims. Appeals for denied benefit claims should be sent directly to your Claim Administrator's attention.

If your claim has been denied in whole or in part, you may appeal the denial by submitting a written request for review to the Claims Administrator within 180 days of the date that you receive the claim denial notice, or else you will lose your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your administrative appeal rights, which is generally a prerequisite to bringing suit.

Your right to appeal a denied claim includes the opportunity for you or your legal representative to:

- State the reasons why you feel your claim should not have been denied;
- Submit written comments, documents, additional facts and other information supporting your claim;
- Ask additional questions;
- Request to receive reasonable access (free of charge) to copies of all documents, records, and other information relevant to your claim; and
- Ask for a review that takes into account all comments, documents, records, and other information you have timely submitted, whether or not it was submitted or considered in the initial determination of your claim.

If your appeal is denied in whole or in part, you will receive written notification of the decision as described below. Such written notification will contain the following information: the specific reasons for the partial or complete denial of your claim; reference to the specific plan provisions on which the benefit determination was based; a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and a statement of your right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 as amended.

In addition, you also have the right to receive a copy of any internal rule, guideline, protocol or other similar criterion relied upon in the claim determination, if any, or a statement of your right to receive a copy of such internal rule, guideline, protocol, or other similar criterion, upon request and free of charge, and if your appeal was denied based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement of your right to receive such explanation upon request.

You will receive notification of the Claims Administrator's decision on appeal according to the type of claim you have filed.

- **Urgent Care Claims.** You will receive notice, in writing or by telephone, facsimile or other electronic method, within 72 hours of a claim for benefits where medical care is necessary to avoid serious jeopardy to your life or health, or to regain maximum function (or as determined by

yourtreating physician).

- **Pre-Service Claims.** You will receive written notice within 30 days for a non-urgent claim for medical benefits where precertification is required before care is provided.

- **Post-Service Claims.** You will receive written notice within 60 days for a non-urgent claim for medical benefits where precertification was not required and care has already been provided.

- **Concurrent Care Claims.** You will receive written notice within the time frame for an Urgent Care Claim, Pre-Service Claim or Post-Service Claim, whichever is applicable. However, you will be notified of the determination on appeal before a reduction or termination of a course of treatment takes effect.

The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Claims Administrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. The identity of a medical expert consulted in connectionwith your appeal will be provided.

In addition, the Claims Administrator may have two levels of appeal, and if more than one level applies to you, you will be notified how to file an appeal for Level Two when you receive your denial at Level One.

External Appeals

If you are dissatisfied with the Plan's appeal decision, an "External Appeal" may be available. External Appeal is available if a service or supply has been denied as Experimental/Investigative. The External Appeal option also extends to services denied as not Medically Necessary if the cost of the medical service is over $10,000 or if the service at issue has not been received and non-receipt of the medical service would jeopardize the patient's life or health. It is coordinated by the Claim Administrator and involves a review of the case by an independent reviewer. External Appeal is available after all other appeal rights with the Claim Administrator are exhausted. In a case of urgently needed care, the Administrator may elect to bypass some levels of appeal to send a case directly to an External Appeal. An External Appeal is not available for services or supplies that are limited or excluded by contract.

Claims and Appeals for Eligibility and other Non-Benefit Issues

Any claims for eligibility under the Plan or other non-benefit claims must be filed with the Plan Administrator. The Plan Administrator will respond to all such claims within the time frames that apply for benefit claims described above. All appeals of such claims must also be filed with the Plan Administrator within 180 days of the denial. The Plan Administrator will respond to all such appeals within the time frames that apply for benefit claims described above.

Exhaustion of Administrative Remedies

Before filing any claim or action in court or in another tribunal with respect to the Plan, you must first

fully exhaust all of your actual or potential rights under the claims procedures provided above by filing an initial claim and then seeking a timely appeal of any denial. This relates to claims for benefits under the Plan and to any other issue, matter, or dispute with respect to the Plan (including any Plan eligibility, interpretation or amendment issue). This exhaustion requirement shall apply even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a particular issue, matter or dispute. After you have filed your initial claim, the Plan Administrator will inform you of any specific claims procedures that will apply to your particular issue, matter or dispute, or it will apply the claims procedures above that apply to claims for benefits.

Limitations on Actions

You cannot bring legal action to recover any benefit (including benefits based on eligibility) under the Plan if you do not file a valid claim and seek timely review of a denial of that claim as provided above.

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

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

Any claim or action relating to the Plan (including claims for eligibility, benefits or other matters) must only be brought or filed in the United States District Court for the District of Connecticut.

Anti-Assignment Rules

Your rights and benefits under a medical option are personal to you and your enrolled family members and they cannot be assigned, sold or transferred (in whole or in part) to any person, including your health care provider. The only exception is under a qualified medical child support order For this purpose, your plan rights and benefits include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal and any other plan rights and benefits, whether actual or potential. Any purported assignments of rights and/or benefits under the plan will be void and will not apply to the plan. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed to anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the plan, the plan administrator or a claims administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Limited Authorization of Payments and Health Care Provider Agreements

To the extent allowed by the claims administrator, you may authorize your claims administrator to make payments directly to a health care provider for covered services. Further, even without such authorization, a claims administrator may make direct payments to a health care provider for covered services according to the claims administrator's rules and procedures at the applicable time. Authorization of payments to a health care provider or direct payments to a health care provider are not assignments of benefits. Even though you may authorize a health care provider to receive a payment or reimbursement of covered services and even though a claims administrator may pay a health care provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a health care provider cause the provider to become a plan participant or plan beneficiary (or assignee of a participant or beneficiary) under ERISA.

In addition, sometimes your health care provider requests that you sign various agreements and other documentation as a condition of receiving health care services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider but that do not include the plan administrator or the Company) are not binding on and will have no legal effect whatsoever on any terms, conditions or requirements of the plan or any claims administrator. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed for anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the plan, the plan administrator or a claims administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Authorized Representative Rules

If you need to appoint an authorized representative for purposes of an internal claim or appeal for health and welfare benefits or for purposes of an external appeal for medical benefit claims, you must follow the rules and procedures of the applicable Claims Administrator for such claim or appeal. To the extent a Claims Administrator has no rules or procedures, then the rules and procedures of this section will apply.

If you need to appoint any authorized representative for any purpose other than as listed in the prior paragraph, your appointment of an authorized representative must:

- Be in writing and dated,
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative,
- Be signed by you, and must be notarized by a notary public,
- Satisfy any other legal requirement applicable to appointments under state or federal law, and
- Be approved by the Plan Administrator in writing.

A plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

Administrative Information

Employer Name, Address and Identification Number

Frontier Communications Parent, Inc. sponsors the Plan described in this SPD. The employer identification number assigned to Frontier Communications by the IRS is #86-2359749

Frontier Communications Parent, Inc.
401 Merritt 7
Norwalk, CT 06851
(203) 614-5600

Plan Administrator

The Plan Administrator is Frontier Communications Parent, Inc., or its delegate. Administration of the Plan is the responsibility of the Plan Administrator.

The Plan Administrator may be contacted by phone or in person through the Company's Benefits Department. Call 203-614-5600. You may write to the Plan Administrator at the following address:

Frontier Communications Parent, Inc.
Attn: Plan Administrator
401 Merritt 7
Norwalk, CT 06851

Agent for Service of Legal Process

Process can be served on the Plan Administrator by directing service to:

Frontier Communications Parent, Inc.
Attn: General Counsel
401 Merritt 7
Norwalk, CT 06851

Union Agreements

Employees represented for collective bargaining purposes are eligible to participate in the Plan only to the extent the language of the applicable collective bargaining agreement and the official plan document specifically provide for such participation.

Plan Funding

In all cases, the Company makes the decisions about how the Plan is designed, including retiree and dependent eligibility and participation in the Medical Options.

Contributions to the Plan are made by the Company and participants. Administrative expenses are included in the price of coverage.

The cost of benefits under the Plan are paid out of the general assets of the Company, and are not pre–funded or insured. The programs are administered through contracts with a third party. The name and address of the Claims Administrator is provided below. The administrative services provided by the Claims Administrator include claims processing and payment.

Claims Administrator

The Claims Administrator is the claims fiduciary relating to benefit claims and appeals. The Claims Administrator may be contacted as follows:

Anthem Blue Cross and Blue Shield
370 Bassett Road
North Haven, CT 06473-4201
866-236-4368

Provider or member appeals should be submitted to:

National Account Appeals
PO Box 33200
Louisville, KY 40232-3200

Plan Information

The name of the Plan is the Frontier Retiree Medical Plan, Plan Number 530. The Plan is an employee welfare benefit plan under ERISA. The Plan Year is the calendar year. This Retiree Medical Access Plan is only one medical option maintained under the Plan.

Plan Termination and Amendment

The Company reserves the right in whole or in part to discontinue or terminate the Plan or any Medical Option, to modify the Plan or any Medical Option to provide different cost-sharing between the Company and participants, or to reduce, amend or modify the Plan or any Medical Option in any respect. This may be done at any time and without advance notice. Any such action may be taken by the Company and any officer of the Company who has the authority or who has been delegated the authority to take such action.

Benefits for claims occurring after the effective date of a Plan amendment or termination are payable in accordance with the terms of the Plan as modified by the amendment or termination.

All statements in this SPD and all representations by the Company or its personnel are subject to this right of termination and amendment. This right applies without limitation, even after an individual's circumstances have changed by retirement, disability or otherwise.

Plan benefits do not become vested and nothing in this document should be construed as a promise to

future benefits.

No Guarantee of Employment

Nothing in this section or the SPD may or can be construed or interpreted as a guarantee of future employment with the Company or continued employment for any duration.

Your Rights Under ERISA

The following statement is required by federal law and regulation. As a participant in the Plan described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled as follows:

Receive Information about Your Plan and Benefits

Plan participants are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Plan participants are entitled to 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 summary plan descriptions. The administrator may make a reasonable charge for the copies.

Plan participants are entitled to receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Plan participants are entitled to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 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.

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 employee benefit plans. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and solely in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may

fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan benefit 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 the 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a 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 a federal court.

If it should happen that plan fiduciaries misuse plan 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 the court finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the 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 area 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.

Schedule A – Eligible Retirees

You are classified as an Eligible Retiree for this medical option if you – (1) are under age 65, (2) are not eligible for Medicare, (3) have met requirements for retirement as determined by the Company, and (4) satisfy the following requirements –

Non-Bargaining Employees:

- You were eligible to participate in the Company's group medical plan for active employees immediately prior to your retirement; and
- You either:
    - Were transferred from Global Crossing and were designated as eligible to retire as of July 1, 2006; or
    - Were classified as a former Legacy Verizon Employee with change in control protections who was employed by GTE Corporation as of May 18, 1999, and was eligible to retire and receive retiree medical benefits or was within five (5) years of eligibility for such retiree medical benefits at such time; and
- You are notified by the Company that you are eligible for this Medical Option.

Bargaining Employees (other than IBEW Local 503 and Workers United 2174):

- You retired from the Company pursuant to a collective bargaining agreement requiring your coverage under this Medical Option, and you have satisfied the requirements for coverage under the Plan pursuant to the requirements of the applicable collective bargaining agreement.

Bargaining Employees, Local IBEW 503, International Brotherhood of Electrical Workers, AFL-CIO:

- CBA Ratification Date: May 20, 2021.
- Eligible members of IBEW Local 503 are eligible for this Medical Option for forty-eight (48) months following the effective date of your retirement from Frontier. Coverage terminates for you and all enrolled dependents at the end of the 48-month period. If a retiree dies prior to the forty-eight (48) months the coverage will end for all enrolled dependents. For additional details please review your applicable collective bargaining agreement.

Bargaining Employees, Workers United Local 2714:

- CBA Ratification Date: August 11, 2021.
- Eligible members of Workers United Local 2714 are eligible for this Medical Option following retirement until the retiree reaches normal Medicare age. If the retiree becomes eligible for Medicare due to disability before the normal age for Medicare eligibility, coverage for eligible dependents will continue until the retiree reaches normal age for Medicare. In the event the retiree dies before becoming eligible for Medicare, retiree health coverage for eligible dependents will continue until the month in which the retiree would have reached the normal Medicare age.
- In addition, dependent retiree health care coverage will end if the dependent becomes eligible for Medicare prior to the retiree becoming eligible for Medicare. Coverage terminates for you and all enrolled dependents when the retiree is eligible for Medicare. For additional details please review your collective bargaining agreement.

To enroll for coverage, Eligible Retirees are required to complete the required enrollment process by contacting Milliman at 1-866-333-2074 Option 2. You must enroll by the date established by the Plan

Administrator for initial enrollment. An Eligible Retiree that enrolls is also referred to as the "Member." See the Eligibility and Enrollment Section of this SPD for additional requirements and details.