CASE NO. 85525; *Combined with* CASE NO. 85656

IN THE SUPREME COURT OF NEVADA

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC. D/B/A UNITEDHEALTHCARE; UMR, INC. D/B/A UNITED MEDICAL RESOURCES; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; AND HEALTH PLAN OF NEVADA, INC.,

Appellants/Petitioners,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD., D/B/A RUBY CREST EMERGENCY MEDICINE.

Respondents/Real Parties in Interest.

Appeal from the Eighth Judicial District Court, Clark County
District Court Case No. A-19-792978
Hon. Nancy L. Allf, District Judge

APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF

VOLUME 6 OF 13

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CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 28th day of August, 2023, service of the foregoing **Appendix of Exhibits to Respondents' Answering Brief – Volume 6 of 13** was made by electronic service through Nevada Supreme Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

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Employee of BAILEY❖KENNEDY

EXHIBIT 36

EXHIBIT 36

DEF035370

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Plaintiffs' Exhibit

PX 120

Summary Plan Description

IMPORTANT BENEFITS INFORMATION

AT&T Mobility Medical Program

This Summary Plan Description (SPD) is an update to the AT&T Mobility Medical Program (Program), a component program under the AT&T Umbrella Benefit Plan No. 3. This SPD replaces your existing SPD and all of its Summaries of Material Modifications.

Please keep this SPD for future reference.

NIN: 78-41196

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

What Is This Document?

This SPD is a guide to your Program benefits. This SPD, together with the SMMs issued for this Program, constitute your SPD for this Program, as well as the AT&T Umbrella Benefit Plan No. 3 (Plan) with respect to benefits provided under this Program. See the "Eligibility and Participation" section for more information about Program eligibility.

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

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

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

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

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

What Action Do I Need to Take?

You should review this SPD.

How Do I Use This Document?

As you read this SPD, pay special attention to the key points at the beginning of most major sections and shaded boxes that contain helpful examples and important notes. While AT&T has provided these tools to help you better understand the Program, it is important that you read the SPD in its entirety, so that you can understand the Program details. Throughout this SPD, there are cross references to other relevant sections in the SPD. You will find opportunities to easily navigate to information. If you are viewing the SPD online, you may click on cross-referenced sections and the Table of Contents to navigate to more information within the SPD. If you are viewing the printed version of this SPD, you may locate these sections by using the Table of Contents. Keep your SPDs and SMMs for your future reference. They are your primary resource for your questions about the Program.

Throughout this SPD, you will see this icon when you have the opportunity to access information that is not a part of this SPD. When clicking on links represented by this icon, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD. **NOTE:** In this SPD, links to external information are located on page 13, page 23, page 61, page 112, page 116, page 118, and page 132.

Questions?

If you have questions regarding your Program benefits, eligibility or contributions, contact the applicable administrators. Contact information is provided in the "Contact Information" section.

Si usted tiene alguna dificultad en entender cualquier parte de este documento, entre en contacto por favor con el Administrador en la seccion de "Contact Information."

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

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

This is a Summary Plan Description (SPD) for the AT&T Umbrella Benefit Plan No. 3 (Plan). The Plan was established on Jan. 1, 2014 when it was split from the AT&T Umbrella Benefit Plan No. 1, which was established on Jan. 1, 2001, and incorporates certain welfare plans sponsored by AT&T Inc. Benefits under the Plan are provided through separate component programs. A program is a portion of the Plan that provides benefits to a particular group of participants or beneficiaries. Each program under the Plan applies to a specified set of benefits and group of Employees.

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

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

Keep this SPD with your important papers and share it with your covered dependents.

Use this SPD to find answers to your questions about your Program Benefits in effect as of Jan. 1, 2018, unless otherwise noted. This SPD replaces all previously issued SPDs and Summary of Material Modifications (SMMs) for the portion of the Program covered in this SPD. To learn whether this SPD describes the Program provisions that apply to you, see the "Eligibility and Participation" section and your Participating Company or Former Participating Company and your Employee group listed in "Appendix A" *Participating Companies and Former Participating Companies*.

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

Company Labels and Acronyms Used in This SPD

Most of the information in this SPD applies to all participants. However, some Program provisions regarding eligibility, contributions, enrollment changes and Benefit levels may differ depending on your employment status, job title, employing company and service history. When the SPD identifies differences that apply to participants of an employing Company or an employee group, acronyms are used to refer to the employing Company or the employee group rather than the official name of the employing Company or group. See "Appendix A" *Participating Companies and Former Participating Companies* for the list of Participating Company names and employee groups and their associated acronyms. If you are not sure what information applies to you, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Section References

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

Terms Used in This SPD

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

Program Responsibilities

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

CONTENTS

HIGHLIGHTS

This SPD describes the Program effective Jan. 1, 2018, unless otherwise noted. Some of the more significant changes to the SPD document since the last restatement of this SPD effective June 1, 2017 are listed below.

- Revision of the list of Participating Companies and Bargaining Units.
- Bargaining changes not included in an SMM:
  - The AT&T Mobility (Virgin Islands) – CWA District 3 group is no longer eligible for the Program.
- The changes previously described in the following SMM(s) are now incorporated in this SPD:
  - Changes to AT&T Health and Welfare Plans for Mobility Bargained Employees and Eligible Former Employees covered by the CWA 2016 National Bargained Benefit Plan Collective Bargaining Agreement, NIN 78-38900.

ELIGIBILITY AND PARTICIPATION

KEY POINTS

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

Eligibility at a Glance

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

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

Special eligibility rules apply to employees who transfer or change positions under circumstances specified in the National Transfer Plan in your collective bargaining agreement. If you transfer between bargained groups, contact the Eligibility and Enrollment Vendor.

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

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

Rehired Eligible Former Employees

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

- You are an Employee of a Participating Company in the Program in a position that would otherwise make you eligible for Benefits under this Program, and
- At the time of your latest hire, you were eligible for post-employment benefits under a plan program sponsored by AT&T Inc. or a member of the AT&T Inc. Controlled Group of Companies.

If you are a Rehired Retiree, the provisions of the *AT&T Rehired Eligible Former Employee Supplement* supersede the rules in this SPD, including but not limited to whether you are eligible for coverage under this or another program. Contact the Eligibility and Enrollment Vendor to obtain the *AT&T Rehired Eligible Former Employee Supplement*. It will be mailed to you at no cost. See the Eligibility and Enrollment Vendor table in the "Contact Information" section for contact information.

To access the *AT&T Rehired Eligible Former Employee Supplement*, go to http://insiderimg.web.att.com/editorial/images/cobrand/empnet/161213_20161202-SMM-Rehired_Retiree_Supplement-NIN_78-39617.pdf

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

You will not be eligible for benefits from a program under AT&T Umbrella Benefits Plan No. 1 while you are an Active Employee, except in certain limited circumstances.

Eligible Employees

Eligibility Rules	
Eligible Employees	
You are an Eligible Employee if...	You are a Regular, Full-time or Part-time Bargained Employee who is Actively at Work and employed by a Participating Company.
Dual Enrollment - Special Rule	
Dual Enrollment	While you may be eligible under more than one status (for example, as an Employee and a dependent), the Program only allows you to be enrolled under a single status. See the "Dual Enrollment" section for more information.

Applicable Age and Service Based Eligibility

The Age and Service Based Eligibility requirements applicable for each covered group are as described below.

Former National Bargained Plan Employees Hired on or After Jan. 1, 2005

You qualify for Age and Service Based Eligibility if you meet both the age and corresponding Term of Employment requirements of the Modified Rule of 75, as shown in the table below, at the time you terminate employment.

Modified Rule of 75		
Minimum Age		Term of Employment
Any age	And	At least 30 years
50	And	At least 25 years
55	And	At least 20 years
65	And	At least 10 years
Age and Term of Employment are based on completed whole years.		

Former National Bargained Plan Employees Hired Before Jan. 1, 2005

If you are a former National Bargained Plan Employee hired before Jan. 1, 2005, the Age and Service Based Eligibility requirements applicable to you depend upon whether you are any of the following:

- A former Southwestern Bell Wireless (SWBW) Program participant.
- A Transition Group Employee.
- Subject to the Program's special transfer rule.

These requirements are explained in detail in the following sections.

Former Southwestern Bell Wireless Program Participants

If you were a Southwestern Bell Wireless Resources, LLC Program participant as of Dec. 31, 2004, you are eligible for Program coverage if you satisfy the Modified Rule of 75, as described above.

Transition Group Employees

If you are a Transition Group Employee, you are eligible to participate in the Program if you meet the Age and Service Based Eligibility requirements for your Transition Group. A Transition Group Employee is an Employee who, on or before Dec. 31, 2001, was contributed directly to Cingular Wireless LLC from BellSouth Corporation or SBC Communications Inc. (excluding Employees of CCPR Services, Inc., USVI Cellular Telephone Corp., Houston Cellular or BellSouth Wireless Data – Cingular Interactive). Transition Group 4 also includes other Employees hired on or after Jan. 1, 2002 and before Jan. 1, 2005, who were eligible for medical coverage under the former Nonbargained Plan. Eligibility for Program coverage varies based on your Transition Group Employee classification as described in the following table.

Transition Group	Age and Service Based Eligibility Requirements
Transition Group 1 Employees	Transition Group 1 Employees are not eligible for coverage under the Program. However, if you were classified as a Transition Group 1 Employee who met the Age and Service Based Eligibility requirements for Post-Employment Benefits (without regard to Cingular Wireless Accelerated Bridging and One-Time Prior Service Recognition Program) on or before Dec. 31, 2001, you may be eligible for benefits provided by your former SBC Communications Inc. or BellSouth Corporation parent Company. Refer to the AT&T Medical Program for the Post-Employment Benefits requirements.
Transition Group 2 Employees	You are eligible to participate in the Program if you were classified as a Transition Group 2 Employee because as of Dec. 31, 2001 you either (1) were within five years of meeting the BellSouth or SBC Age and Service Based Eligibility requirements for Post-Employment Benefits (without regard to the Cingular Wireless Accelerated Bridging and One-Time Prior Service Recognition Program); or (2) had at least 15 years of service (without regard to the Cingular Wireless Accelerated Bridging and One-Time Prior Service Recognition Program) and you meet the following age and service requirements for your group as of your termination of Employment: • Former BLS Employees must meet the BLS Rule of 75 (defined below); • Former SBC Employees must meet the Modified Rule of 75 defined above.
Transition Group 3 Employees	You are eligible to participate in the Program if (1) you were classified as a Transition Group 3 Employee because as of Dec. 31, 2001 you had at least five years of service with BellSouth or SBC (without regard to the Cingular Wireless Accelerated Bridging and One-Time Prior Service Recognition Program); and (2) you terminated employment with the Company after age 55; and (3) your Term of Employment with the Company was at least 10 years as of your termination of employment.
Transition Group 4 Employees	You are eligible to participate in the Program if (1) you were classified as a Transition Group 4 Employee because either as of Dec. 31, 2001 you did not meet the Transition Group 1, 2 or 3 service requirements or you were hired on or after Jan. 1, 2002 and before Jan. 1, 2005 and were eligible for medical coverage under the former Nonbargained Program; (2) you terminated employment with the Company after age 55; and (3) your Term of Employment with the Company was at least 10 years as of your termination of employment.

BLS Rule of 75
You meet the BLS Rule of 75 if you had at least 10 years Term of Employment and the sum of your age and Term of Employment (in whole years and whole months) at termination of employment equals or exceeds 75 years. **Examples:** • If age 46½ and have 28½ years Term of Employment — Meets the Rule of 75 • If age 64 and 11 years Term of Employment — Meets the Rule of 75 • If age 68 and 7 years Term of Employment — Does **NOT** meet the Rule of 75 because Term of Employment does not equal at least 10 years

IMPORTANT: The only former Employees covered by Transition Group 1, 2 or 3 are those who, on or before Dec. 31, 2001, were contributed directly to Cingular Wireless, LLC from BellSouth Corporation or SBC Communications Inc. (excluding employees of CCPR Services, Inc., USVI Cellular Telephone Corporation, Houston Cellular or BellSouth Wireless Data – Cingular Interactive) as part of the formation of Cingular Wireless, LLC and who met the applicable Age and Service Based Eligibility requirements. The Group 1, 2 and 3 transition benefits are contingent upon continuous active employment with Cingular Wireless, LLC. Upon any break in service for any duration, an Employee will no longer have the Group 1, 2 or 3 transition status. Upon rehire with Cingular, an Employee will be treated as a newly hired Employee for Program coverage.

Transfer Rules

Management Employee to Bargained Employee

If you are a Transition Group Employee and you transferred from a Nonbargained Employee (Management Employee) to a Bargained Employee classification, on or after Jan. 1, 2005 while employed at Cingular Wireless LLC, you keep your Transition Group Employee status (1-4) and your eligibility for Program coverage is determined under the Transition Group rules described above. If you were not identified as a Transition Group Employee as of Dec. 31, 2001 or you did not maintain continuous Term of Employment after that date, then you are eligible for Program coverage only upon satisfying the Modified Rule of 75 as described above under Former National Bargained Plan Employees hired on or after Jan. 1, 2005.

Transfer from Bargained to Management Employee

- You are not eligible for this Program. Refer to the Summary Plan Description for the AT&T Eligible Former Employee Medical Program for further information.

How to Determine if Your Dependents Are Eligible for This Program

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

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

The Company reserves the right to verify eligibility of any enrolled dependents at any time. See the "Dependent Eligibility Verification" section for more information. Once a dependent is enrolled, it is your responsibility to contact the Eligibility and Enrollment Vendor to cancel coverage whenever you have a dependent that is no longer eligible, including, for example, when

you are divorced. See the "Enrollment and Changes to Your Coverage" section for more information.

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

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

Eligible Dependents

Eligibility Rules	
Eligible Dependents	
Your dependents who meet the eligibility rule are eligible for Program coverage.	(1) Your Spouse/Legally Recognized Partner (LRP). (2) Your Child(ren) until the end of the month in which the Child reaches the age of 26 regardless of marital status. The term Child(ren) means any of the following until the end of the month in which they reach age 26: • Your biological Child(ren). • Child(ren) placed with you for purposes of adoption. • Child(ren) you have legally adopted. • Your stepchild(ren). • The Child(ren) of your LRP. • Child(ren) for whom either you or your Spouse/LRP is a Legal Guardian. The term does not include wards of the state or foster Child(ren) who are not placed for adoption. • Child(ren) you are required to cover under the terms of a QMCSO. (3) Your unmarried Disabled Child(ren) who is mentally, physically and/or medically incapable of self-support and fully dependent on you for financial support provided he or she was both: (1) covered under the Program; and (2) was disabled before the end of the month in which he or she reached the age of 26. You must provide satisfactory evidence of disability in order for your Disabled Child(ren) to be eligible for coverage under the Program. In addition, an independent medical examination of your dependent may be required. See the "Certification of Disabled Dependents" section for information on how to certify disability.

Dual Enrollment

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

The Program does not permit you or a dependent to be enrolled in the Program as an Employee, Eligible Former Employee or Eligible Dependent at the same time.

KEY POINTS

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

Program Options

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

The coverage options listed below are available under the Program.

The Company Self-Funded Health Care Network (HCN) is available to all Eligible Employees and Eligible Former Employees (excluding Employees and former Employees who reside in Puerto Rico or Hawaii). The HCN includes the Network and ONA Options. The options available to you will be determined based on the ZIP code for your home address in Company records. If your ZIP code is in the Network Area, you will be able to elect the HCN Network option. If your ZIP code is outside the Network Area, you will be able to elect either the HCN Network or ONA options.

If you reside in Puerto Rico or Hawaii, you will be able to elect a Fully-Insured Managed Care Option.

Fully-Insured Managed Care Option

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

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

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

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

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

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

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

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

What Coverage Levels Are Available

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

The Program offers the following levels of coverage.

- Individual – You only
- Individual + Spouse/LRP – You and your Spouse or LRP

- Individual + One or More Eligible Dependent Child(ren) – You and your dependent Child(ren)
- Family – You, your Spouse/LRP and one or more dependent Child(ren)

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

Enrollment at a Glance

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

Enrollment Rules for You

	Enrollment
Newly Eligible Enrollment	• As a newly eligible employee, you will have three opportunities to enroll • Within 31 days of the later of your Hire Date or the date appearing on your enrollment materials - for coverage to be effective on your date of hire; or • Within 31 days of the later of your 90th day of employment or the date on your enrollment materials for coverage to be effective on the first day of the month in which you attain 90 days Term of Employment; or • Within 31 days of the later of your six month day of employment or the date on your enrollment materials for coverage to be effective on the first day of the month in which you attain 6 months Term of Employment. If you miss the 31-day deadline, you will not be able to enroll until Annual Enrollment, unless you are permitted to enroll due to a "Change-in-Status".
Annual Enrollment	During Annual Enrollment - for coverage to be effective on the first day of the following Plan Year.
Change-in-Status Enrollment	See the "Change-in-Status Enrollment" section.

Annual Enrollment

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

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

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

IMPORTANT: If you have a Change-in-Status Event on or after Sept. 1 and want to change your coverage, you need to make two separate elections:

1) Change your current coverage in effect through the end of the Plan Year, and

2) Update your Annual Enrollment elections for coverage beginning Jan. 1.

You can enroll online via the Eligibility and Enrollment Vendor website or by calling the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Change-in-Status Enrollment

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

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

Notice of A Change-In-Status Event

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

There are some exceptions to this rule:

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

The Effective Date of Your Change-In-Status Enrollment

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

To change your enrollment, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

As noted above, your change in enrollment request is subject to review by the Eligibility and Enrollment Vendor. This review could have an impact on the effective date of your enrollment. For example, if you request enrollment for your newly eligible Child, your enrollment is subject to the same rules that apply to newly Eligible Employees and dependents, including the Dependent Eligibility Verification Process. Therefore, it is especially important to submit the necessary

documents that prove eligibility for your dependent in a timely manner. Failure to submit the documents on time may delay his or her effective date of coverage under the Program beyond the effective dates listed below. See the "Dependent Eligibility Verification" section for more information.

If you request your enrollment change within the specified time frame and you provide all documentation requested by the Eligibility and Enrollment Vendor within the time required, your new enrollment will become effective either on:

- The date of the Change-in-Status Event in the case of birth, adoption or placement for adoption.
- On the first of the month after the event for all other Change-in-Status Events.
- If you do not notify the Eligibility and Enrollment Vendor within the time frames noted above, you must wait until the next Annual Enrollment or another Change-in-Status Event to change your enrollment.

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

A change in enrollment may lead to an adjustment to your required contributions and may also affect the tax treatment of your new contribution amount. For information about how your specific enrollment change may affect the amount of your contributions, contact the Eligibility and Enrollment Vendor.

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

Enrollment Rules for Your Dependents

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

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

Your dependent enrollment elections can be made:

- During Annual Enrollment – for coverage beginning the first day of the following Plan Year.
- Within 31 days of the later of your Hire Date or the date on your enrollment materials — for coverage beginning on your date of hire.
- After a Change-in-Status Event. See the "Change-in-Status Events" section for additional information, including a list of Change-in-Status Events and the changes in coverage you are allowed to make. A Change-in-Status-Event includes the date you are first eligible for the Company contribution toward your medical coverage.

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

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

Dependent Eligibility Verification

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

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

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

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

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

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

For more information on dependent eligibility and documentation required for verification, go to https://www.yourdependentverification.com/PlanSmart/Report/frm_rpt_pdf.aspx?rpt_path=%5c%5cdvsncc%5cplansmart_prd%5cPlanSmart%5cPortalDocsLibrary%5cPeriod+11+Catchup+Doc+Reqts+3.14.17.pdf

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

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

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

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

Certification of Disabled Dependents

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

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

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

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

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

If you Experience a Change-in-Status Event

Permissible Change-in-Status Enrollment Events

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

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

- **The enrollment change must be consistent with the event.** The Change-in-Status Event must:
  - Affect eligibility and coverage under the Program; and
  - Must be on account of and consistent with the event.

- **Request your enrollment before the deadline.** Your request for a change in your enrollment must occur within 31 days of the Change-in-Status Event. However, Child(ren) acquired through birth or adoption (or placement of a Child in the Employee's or Eligible Former Employee's home pending adoption) may be enrolled within 60 days after the event.
- **Document your event.** While not always required, the Program has the right to request documentation that supports your Change-in-Status Event. For example:
  - Adding a newborn dependent Child will require a copy of the Child's birth certificate
  - Adding a new Spouse will require a copy of a marriage certificate
  - Waiving coverage under the Program in favor of coverage under another employer's medical plan may require proof of enrollment in the other medical plan.

LEAVE OF ABSENCE

KEY POINTS

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

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

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

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

Extended Coverage for Employees on Active Military Duty

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

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

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

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

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

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

This is a brief overview of the provisions of USERRA. For information concerning coverage for Employees who are absent from employment by reason of service in the Uniformed Services and their Eligible Dependents, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

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

During a leave covered by the Family and Medical Leave Act (FMLA leave), the Company will maintain your coverage under the Program for up to 12 weeks of leave on the same terms and conditions as applicable to similarly situated Active Employees who are not on FMLA leave. If you receive pay while on an FMLA leave, your required contributions will continue to be taken from your pay. If you do not receive pay while on an FMLA leave, you will be billed and required to pay your required contributions.

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

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

Continuation of Coverage under COBRA

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

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

For More Information

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

You also may send correspondence to:

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

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

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

CONTRIBUTIONS

KEY POINTS

- *Your contribution is the amount you are required to pay monthly for Program coverage.*
- *A number of factors impact your contribution cost, including the coverage option you choose, the number of Eligible Dependents you cover, and your Medicare enrollment status.*

The amount you contribute toward the Cost of Coverage depends on the difference between the total annual Cost of Coverage and the Company contribution for a given year. The Company contribution is affected by:

- The date you were hired, rehired or transferred.
- Your employment status (for example, Actively at Work).
- The number of hours that you are scheduled to work.
- The medical option you are enrolled in.
- Whether or not you cover dependents.
- Whether you or your covered dependent is Medicare Eligible.

- Whether your coverage is continued through Company Extended Coverage (CEC) or COBRA.

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

You will receive information about contributions at Annual Enrollment each year, any time the Eligibility and Enrollment Vendor determines that you have a Change-in-Status Event that allows you to make an enrollment election and anytime you make a change that results in a contribution change. Refer to your enrollment materials for information concerning the contribution amount that applies to you. You also may obtain an electronic or printed personalized contribution statement any time through the Eligibility and Enrollment Vendor. These documents are considered to be a component of your Summary Plan Description. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

How Contributions Are Made

Employee

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

If you are an Employee, your contributions will be deducted from your paycheck on a before-tax basis, unless you elect to make your contributions on an after-tax basis. If you are an Employee who is subject to income tax in Puerto Rico, your contributions may be made only on an after-tax basis.

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

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

Before-Tax and After-Tax Contributions

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

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

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

*Puerto Rico employee contributions are paid on an after-tax basis.

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

Contribution Policy

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

If you transfer between bargained groups, contact the Eligibility and Enrollment Vendor.

The following applies to you and your Class I Dependents.

Company Self-Funded Option

Employee Classification		Contribution Rules
Regular and Term Employee (less than 90 days Term of Employment)	Full-time or Part-time	You pay 100% of the monthly Cost of Coverage.
Regular and Term Employee (at least 90 days Term of Employment and less than 6 months Term of Employment)	Full-time	You pay the following monthly contribution **Option 1** Individual: Same as Regular and Term Employee (at least 6 months Term of Employment) contribution rate - see below Individual + Child(ren), Individual + Spouse & Family: 100% of the monthly Cost of Coverage less the current Company subsidy for individual coverage (2018: Individual + Child(ren): $553.79, Individual + Spouse: $1,219.20, Family: $1,240.84) **Option 2** Individual: Same as Regular and Term Employee (at least 6 months Term of Employment) contribution rate - see below Individual + Child(ren), Individual + Spouse & Family: 100% of the monthly Cost of Coverage less the current Company subsidy for individual coverage (2018: Individual + Child(ren): $483.70, Individual + Spouse: $1,109.00, Family: $1,129.34) See enrollment materials for your monthly contribution

Employee Classification		Contribution Rules
Regular and Term Employee (at least 6 months Term of Employment)	Full-time	**Employees hired, rehired, or transferred before Jan. 1, 2017** You pay the following monthly contribution **Jan. 1, 2018 through Dec. 31, 2018** **Option 1** Individual: $88 Individual + Child(ren): $150 Individual + Spouse: $241 Family: $256 **Option 2** Individual: $44 Individual + Child(ren): $75 Individual + Spouse: $121 Family: $128 **Jan. 1, 2019, through Dec. 31, 2019** **Option 1** Individual: $98 Individual + Child(ren): $168 Individual + Spouse: $269 Family: $286 **Option 2** Individual: $57 Individual + Child(ren): $97 Individual + Spouse: $156 Family: $166 **Beginning Jan. 1, 2020** **Option 1** Individual: $110 Individual + Child(ren): $188 Individual + Spouse: $302 Family: $321 **Option 2** Individual: $70 Individual + Child(ren): $120 Individual + Spouse: $193 Family: $205

Employee Classification		Contribution Rules
Regular and Term Employee (at least 6 months Term of Employment)	Full-time	**Employees hired, rehired or transferred on or after Jan. 1, 2017** You pay the following contributions **Jan. 1, 2018 through Dec. 31, 2018** **Option 1** Individual: $121 Individual + Child(ren): $207 Individual + Spouse: $333 Family: $352 **Option 2** Individual: $77 Individual + Child(ren): $132 Individual + Spouse: $211 Family: $224
		Jan. 1, 2019 through Dec. 31, 2019 **Option 1** Individual: $126 Individual + Child(ren): $215 Individual + Spouse: $346 Family: $368 **Option 2** Individual: $85 Individual + Child(ren): $145 Individual + Spouse: $233 Family: $247 **Beginning Jan. 1, 2020** **Option 1** Individual: $132 Individual + Child(ren): $226 Individual + Spouse: $362 Family: $384 **Option 2** Individual: $93 Individual + Child(ren): $159 Individual + Spouse: $255 Family: $271

Employee Classification		Contribution Rules
Regular and Term Employee (at least 6 months Term of Employment)	Part-time (20 or more scheduled hours per week)	You pay 50% of the monthly Cost of Coverage.
	Part-time (less than 20 scheduled hours per week)	You pay 100% of the monthly Cost of Coverage.

Some Employee classifications may not apply (for example, Term). See the "Eligible Employees" section for your specific eligibility requirements.

Surviving Dependent Contributions

Company contributions toward the Cost of Coverage are available to your surviving dependents receiving Company Extended Coverage (CEC) for up to 12 full months following your death, as long as a surviving dependent remains eligible for and enrolled in CEC. Your surviving dependent(s) who continue coverage under CEC after the 12-month period will pay 100% of the Cost of Coverage with no Company contribution.

As described in the "Surviving Dependent Coverage" section, CEC is integrated with COBRA continuation coverage. As a result, COBRA contributions will be reduced by the amount of Company contributions available under CEC. Once Company contributions under CEC end, your surviving dependent(s) will pay 100% of the Cost of Coverage for continued COBRA coverage for up to 24 months (total of 36 months).

Tax Consequences of Coverage for Partners and Their Dependents

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

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

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

Contribution Surcharges

Your level of contribution toward Program coverage can be affected by incentives designed to promote Employee wellness. These incentives, discussed in detail in the "Health and Wellness Programs" section, provide for surcharges and credits to your medical contributions. These include:

- Your certification during Annual Enrollment that you meet the definition of a non-tobacco user or have satisfied other tobacco user cessation requirements as specified in the "Health and Wellness Programs" section of this SPD. If you do not certify that you are a non-tobacco user or take the alternative steps described in the "Health and Wellness Programs" section you will have a surcharge of up to $600 annually (a $50 monthly increase) applied to your medical contribution beginning Jan. 1, 2018.

  If you did not certify during the last annual enrollment that you are not a tobacco user, the surcharge will **automatically** apply if you are enrolled in the Program.

The "Health and Wellness Programs" section includes information on available alternatives, privacy, and protection of genetic information.

Your level of contribution can also be impacted if you enroll a Spouse/LRP for coverage under the Program.

- Beginning Jan. 1, 2019, if you enroll a Spouse/LRP in coverage, you must verify when you first enroll your Spouse/LRP or during Annual Enrollment that your Spouse/LRP does not have access to medical coverage through his/her current employer. Otherwise, you will be treated as if you have a Spouse/LRP to whom the conditions of the Spouse/LRP surcharge apply, and the surcharge shown in the table below will be assessed for each month in which your Spouse/LRP is enrolled in any coverage option. The Change-in-Status Event provisions also apply and you can remove the surcharge during the year if your Spouse/LRP loses access to coverage under another employer's plan. Likewise, you are responsible for reporting if your enrolled Spouse/LRP gains coverage through another employer during the year.
- You **must** take action to avoid a surcharge. If you do not respond during your enrollment period, the surcharge will apply.

	2017	2018	2019	2020
Tobacco Surcharge	$50 per month	$50 per month	$50 per month	$50 per month
Working Spouse Surcharge	None	None	$100 per month	$100 per month

Employees on Leave of Absence

If you are on an approved leave of absence (LOA), you will receive a notice explaining what Program coverage you are eligible to continue and any contributions that you are required to pay for this coverage. If contributions are required, the Eligibility and Enrollment Vendor will send you a monthly bill. Payment is due on the first of the month for the following month of coverage. For example, the bill you receive on June 15 applies to coverage for the month of July. Payment is due by July 1.

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

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

Individuals Covered Through COBRA

If you or your Eligible Dependents are continuing coverage through COBRA, you or your Eligible Dependents will be required to pay for the coverage through the direct billing process administered by the Eligibility and Enrollment Vendor. See the "Extension of Coverage — COBRA" section for more information about COBRA rights. Additional information on paying for COBRA coverage is provided in the "Paying for COBRA Continuation Coverage" subsection. See the "How Contributions are Made" section for details on the direct billing process. If you have questions concerning billing or payment of COBRA continuation coverage, you can contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

BENEFITS AT A GLANCE

KEY POINTS

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

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

- **A summary, not an exhaustive list, of the most commonly used medical and MH/SA Covered Health Services.** See the "What Is Covered" section for more detailed information on what is covered. Even if a Service is listed as a Covered Health Service, certain exclusions or limitations may apply that affect Benefits payable under the Program. Other Services are specifically excluded from coverage regardless of the circumstances. For information on what is not covered, as well as circumstances affecting whether a Service is covered, see the "Exclusions and Limitations" section.
- **A summary of limitations specific to the Covered Health Services in the table.** This information is not exhaustive. See the "What Is Covered" section for more detailed information on limitations to the Covered Health Services.

- **Cost-sharing information.** You and the Program share in the cost of care as summarized in the table(s) below. The following *Benefits at a Glance* table(s) provides information on how you and the Program share in the cost of the most commonly used Services. However, circumstances specific to your situation may impact your level of cost sharing. To better understand these cost-sharing features and how they impact your Benefits, see the "Cost Sharing" section of this SPD.
- **Information on when Notification or Preauthorization is required.** The Program requires notification or Preauthorization for certain Services or circumstances. If you do not provide Notification or Preauthorization when it is required, your Benefits may be reduced or denied. The "Notification and Preauthorization Requirements" section of this SPD provides more detailed information.

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

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

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

Table 1 – HCN Option 1

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

	Network	Non-Network	DNA	Limitations and Exceptions
Cost Sharing				
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	
Annual Deductible	Medical, including MH/SA For Individual/ Individual + Child(ren)/Individual + Spouse/Family: 2018: $650/$1,300/ $1,300/$1,300 2019: $700/$1,400/ $1,400/$1,400 2020: $750/$1,500/ $1,500/$1,500	Medical, including MH/SA For Individual/ Individual + Child(ren)/Individual + Spouse/Family: 2018: $2,275/$4,550/ $4,550/$4,550 2019: $2,450/$4,900/ $4,900/$4,900 2020: $2,625/$5,250/ $5,250/$5,250	Medical, including MH/SA For Individual/ Individual + Child(ren)/Individual + Spouse/Family: 2018: $650/$1,300/ $1,300/$1,300 2019: $700/$1,400/ $1,400/$1,400 2020: $750/$1,500/ $1,500/$1,500	Unless otherwise noted, the Annual Deductible applies.
Annual Out-of-Pocket Maximum	Medical, including MH/SA Includes Annual Deductible For Individual/ Individual + Child(ren)/Individual + Spouse/Family: 2018: $3,250/$6,500/ $6,500/$6,500 2019: $3,500/$7,000/ $7,000/$7,000 2020: $3,750/$7,500/ $7,500/$7,500	Medical, including MH/SA Includes Annual Deductible For Individual/ Individual + Child(ren)/Individual + Spouse/Family: 2018: $9,750/$19,500/ $19,500/$19,500 2019: $10,500/$21,000/ $21,000/$21,000 2020: $11,250/$22,500/ $22,500/$22,500	Medical, including MH/SA Includes Annual Deductible For Individual/ Individual + Child(ren)/Individual + Spouse/Family: 2018: $3,250/$6,500/ $6,500/$6,500 2019: $3,500/$7,000/ $7,000/$7,000 2020: $3,750/$7,500/ $7,500/$7,500	

	Network	Non-Network	DNA	Limitations and Exceptions
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	
Co-payments	Co-payments apply for certain Covered Health Services described in this table. Additional information is also provided in the "Cost Sharing" section of this SPD.	Co-payments apply for certain Covered Health Services described in this table. Additional information is also provided in the "Cost Sharing" section of this SPD.	Co-payments apply for certain Covered Health Services described in this table. Additional information is also provided in the "Cost Sharing" section of this SPD.	
Preventive Care Services				
Preventive Care	0% Coinsurance	Not covered	0% Coinsurance	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.
Emergency Services				
Emergency Room (Emergency Medical Condition)	10% Coinsurance	10% Coinsurance	10% Coinsurance	
Ambulance Services (Emergency)	10% Coinsurance	10% Coinsurance	10% Coinsurance	

	Network	Non-Network	DNA	Limitations and Exceptions
Non-Emergency Services				
Emergency Room (Non-Emergency)	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Urgent Care Facility (Non-Emergency)	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Ambulance Services (Non-Emergency)	Not covered	Not covered	Not covered	
Inpatient Services				
Facility Charge	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Room and Board	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Lab and X-Ray	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Physician and Surgeon Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	

	Network	Non-Network	DNA	Limitations and Exceptions
Outpatient Services				
Office Visit				
Office Visit (Non-Specialist)	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Office Visit (Specialist)	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Outpatient Care				
Outpatient Surgery	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Outpatient Lab and X-Ray Services (excluding Preventive Care)	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Outpatient Chemotherapy	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	

	Network	Non-Network	DNA	Limitations and Exceptions
Mental Health and Substance Abuse Services				
Mental Health				
Mental Health Outpatient Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Mental Health Inpatient Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Substance Abuse				
Substance Abuse Outpatient Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Substance Abuse Inpatient Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Family Planning/ Maternity Services				
Office Visit (Pre/Postnatal)	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	For routine prenatal care, check with Benefits Administrator.

	Network	Non-Network	DNA	Limitations and Exceptions
Hospital Delivery Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Infertility Services	Not covered	Not covered	Not covered	
Rehabilitation Services				
Physical Therapy	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Occupational Therapy	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Speech Therapy	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Cardiac Rehabilitation Therapy	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Pulmonary Rehabilitation	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Post-Cochlear Implant Aural Therapy	Not covered	Not covered	Not covered	

	Network	Non-Network	DNA	Limitations and Exceptions
Additional Services				
Acupuncture	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Chiropractic	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Durable Medical Equipment	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	
Home Health Care	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	Non-Network: Limited to 60 visits per year.
Hospice Services	10% Coinsurance	Not covered	10% Coinsurance	
Organ and Tissue Transplant Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	Network/ONA: See *Appendix C* for additional Benefits that may be available if you use a Designated Network Provider.

	Network	Non-Network	ONA	Limitations and Exceptions
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	10% Coinsurance	2018: 50% Coinsurance 2019: 50% Coinsurance 2020: 50% Coinsurance	10% Coinsurance	Network: Limited to 100 days per calendar year (combined Network and Non-Network Services). Non-Network: Facility charge applies. Limited to 60 days per calendar year (combined Network and Non-Network Services). ONA: Limited to 100 days per calendar year.
Routine Foot Care	Not covered	Not covered	Not covered	Except for severe systemic disease

Table 2 – HCN Option 2

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

	Network	Non-Network	ONA	Limitations and Exceptions
Cost Sharing				
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of this SPD for more information.	
Annual Deductible	Medical, including MH/SA and Rx For Individual/ Individual + Child(ren)/Individual + Spouse/Family: $1,300/$2,600/ $2,600/$2,600	Medical, including MH/SA and Rx For Individual/ Individual + Child(ren)/Individual + Spouse/Family: $3,900/$7,800/ $7,800/$7,800	Medical, including MH/SA and Rx For Individual/ Individual + Child(ren)/Individual + Spouse/Family: $1,300/$2,600/ $2,600/$2,600	Unless otherwise noted, the Annual Deductible applies.
Annual Out-of-Pocket Maximum	Medical, including MH/SA and Rx; Includes Annual Deductible For Individual/ Individual + Child(ren)/Individual + Spouse/Family: $6,450/$12,900/ $12,900/$12,900; Individual + Child(ren), Individual + Spouse and Family capped at $6,450 per Individual	Medical, including MH/SA and Rx; Includes Annual Deductible For Individual/ Individual + Child(ren)/Individual + Spouse/Family: $19,350/$38,700/ $38,700/$38,700	Medical, including MH/SA and Rx; Includes Annual Deductible For Individual/ Individual + Child(ren)/Individual + Spouse/Family: $6,450/$12,900/ $12,900/$12,900; Individual + Child(ren), Individual + Spouse and Family capped at $6,450 per Individual	
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of this SPD.	

	Network	Non-Network	ONA	Limitations and Exceptions
Co-payments	Co-payments apply for certain Covered Health Services described in this table. Additional information is also provided in the "Cost Sharing" section of this SPD.	Co-payments apply for certain Covered Health Services described in this table. Additional information is also provided in the "Cost Sharing" section of this SPD.	Co-payments apply for certain Covered Health Services described in this table. Additional information is also provided in the "Cost Sharing" section of this SPD.	
Preventive Care Services				
Preventive Care	0% Coinsurance	Not covered	0% Coinsurance	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.
Emergency Services				
Emergency Room (Emergency Medical Condition)	10% Coinsurance	10% Coinsurance	10% Coinsurance	
Ambulance Services (Emergency)	10% Coinsurance	10% Coinsurance	10% Coinsurance	
Non-Emergency Services				
Emergency Room (Non-Emergency)	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Urgent Care Facility (Non-Emergency)	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Ambulance Services (Non-Emergency)	Not covered	Not covered	Not covered	
Inpatient Services				
Facility Charge	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Room and Board	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Lab and X-Ray	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Physician and Surgeon Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Outpatient Services				
Office Visit				
Office Visit (Non-Specialist)	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Office Visit (Specialist)	10% Coinsurance	50% Coinsurance	10% Coinsurance	

	Network	Non-Network	ONA	Limitations and Exceptions
Outpatient Care				
Outpatient Surgery	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Outpatient Lab and X-Ray Services (excluding Preventive Care)	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Outpatient Chemotherapy	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Mental Health and Substance Abuse Services				
Mental Health				
Mental Health Outpatient Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Mental Health Inpatient Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Substance Abuse				
Substance Abuse Outpatient Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Substance Abuse Inpatient Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Family Planning/ Maternity Services				
Office Visit (Pre/Postnatal)	10% Coinsurance	50% Coinsurance	10% Coinsurance	For routine prenatal care, check with Benefits Administrator.
Hospital Delivery Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Infertility Services	Not covered	Not covered	Not covered	
Rehabilitation Services				
Physical Therapy	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Occupational Therapy	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Speech Therapy	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Cardiac Rehabilitation Therapy	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Pulmonary Rehabilitation	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Post-Cochlear Implant Aural Therapy	Not covered	Not covered	Not covered	

	Network	Non-Network	ONA	Limitations and Exceptions
Additional Services				
Acupuncture	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Chiropractic	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Durable Medical Equipment	10% Coinsurance	50% Coinsurance	10% Coinsurance	
Home Health Care	10% Coinsurance	50% Coinsurance	10% Coinsurance	Non-Network: Limited to 60 visits per year.
Hospice Services	10% Coinsurance	Not covered	10% Coinsurance	
Organ and Tissue Transplant Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	Network/ONA: See *Appendix C* for additional Benefits that may be available if you use a Designated Network Provider.
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	10% Coinsurance	50% Coinsurance	10% Coinsurance	Network: Limited to 100 days per calendar year (combined Network and Non-Network Services). Non-Network: Facility charge applies. Limited to 60 days per calendar year (combined Network and Non-Network Services). ONA: Limited to 100 days per calendar year.
Routine Foot Care	Not covered	Not covered	Not covered	Except for severe systemic disease

Your Program Coverage Overview

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

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

- The *Benefits at a Glance* table only provides a high-level summary of your Benefits. To best understand the full extent of Covered Health Services and any limitations or exclusions applicable to your Benefits, see the "What Is Covered" and "Exclusions and Limitations" sections of this SPD.
- You and the Program share the cost of most Covered Health Services. See the "Cost Sharing" section for information on how you and the Program share in this responsibility. The following are exceptions to the general cost-sharing provisions contained in this section of the SPD:
    - Preventive Care Services are covered at 100 percent of the Allowable Charge if these Services are provided by a Network Provider. However, the Program will pay no Benefits, and you will be responsible for the full cost of Services, if Preventive Care Services are provided by a Non-Network Provider (unless you have ONA coverage). If you have ONA coverage, Preventive Care Services are provided without cost sharing, regardless of whether you use a Network or Non-Network Provider. However, your Benefits will be limited to the amount of the Allowable Charge. For information specific to your Preventive Care Services Benefits, see the *Benefits at a Glance* table and "Preventive Care Services" section.
    - Emergency Services are covered the same whether you receive care at a Network or Non-Network facility, as long as the Service is provided for an Emergency Medical Condition. See the "Definitions" section for the definition of Emergency Medical Condition and Emergency Services. For more information on your Benefits for Emergency Services, see the "Emergency Services" section.
    - The Program gives you access to a Network of Physicians and other health care Providers to maximize your Benefits under the Program. You are not required to designate a Primary Care Physician to receive Program Benefits. However, if you use Network Providers, you will receive the Network level of Benefits and generally pay less out of pocket for Covered Health Services. Also, the Benefits Administrator and the Network Provider negotiate an agreed amount for the Provider's Services, and your Network Provider will not charge you for any amounts that are more than the Negotiated Rate. For more information, see the "What You Need to Know About Providers" section.
    - If you receive Services from a Non-Network Provider, you generally will pay more for Covered Health Services because your portion of the cost sharing may be greater and Providers have not agreed to a Negotiated Rate for Covered Health Services. You also may be required to pay any amount above the Allowable Charge determined by the Benefits Administrator. For more information, see the "Non-Network Coverage" section.

- If you reside in an area that is not within a Network Area and are enrolled in ONA coverage, you have the flexibility to choose either a Network or Non-Network Provider whenever you receive care and receive the same level of Benefits. If your care is provided by a Network Provider, you will generally pay less out of pocket because you will receive the advantage of a Negotiated Rate. You also are not required to designate a Primary Care Physician to receive Program Benefits. For more information, see the "Outside Network Area (ONA) Coverage" section.

- Services are not considered a Covered Health Service unless they are determined to be Medically Necessary. See the "Medically Necessary" section for more information.

- Some Services require Notification and/or Preauthorization for maximum coverage under the Program. See the "Notification and Preauthorization Requirements" section for information.

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

Conditions for Program Benefits

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

- You are a Covered Person, which means you meet all eligibility requirements for Program coverage and are properly enrolled for coverage.

- You continue to meet all of the eligibility requirements and all required contributions for your coverage are paid timely.

- You receive Covered Health Services while your Program coverage is in effect — after you meet eligibility requirements and before coverage ends, as described in the "When Coverage Ends" section.

- You or your Provider file a timely Claim for Benefits, as described in the "Claims for Benefits" section and provide any required information in support of your Claim.

COST SHARING

KEY POINTS

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

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

This section describes cost-sharing features that are built into the Program. See the *Benefits at a Glance* table(s) for specific amounts. This section does not include cost sharing information for

benefits provided under any Fully-Insured Managed Care Options available under the Program. See the "Fully-Insured Managed Care Option" section for information.

Annual Deductible

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

There are separate Network and Non-Network Annual Deductibles:

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

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

With Individual + 1 and Family coverage, a Covered Person is eligible to receive Benefits once their Eligible Expenses satisfy the individual Annual Deductible. The Individual + 1 or Family Annual Deductible, as applicable, is met once any combination of Covered Persons' Eligible Expenses meets the Individual + 1 or Family Annual Deductible amount. It is not necessary that any one individual reach the individual Annual Deductible, but no one individual may contribute more than the individual Annual Deductible amount.

- If more than one covered family member is injured in the same accident, only one individual Annual Deductible must be met before the Program begins to pay Benefits for Services (subject to the Annual Deductible) resulting from the accident during that calendar year.

HCN Option 1

Medical and MH/SA Allowable Charges apply to the Annual Deductible. Prescription Drug Allowable Charges will not apply to the new medical and MH/SA Annual Deductible. The tables following the example summarize what does and does not apply to the Annual Deductible.

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

For example, suppose Joe covers his wife, Elaine, and their son, Tom, in the Program with a family Network Annual Deductible of $1,500. Joe has the first medical procedure in his family for the year and pays out of pocket $500 in Allowable Charges for Network care, which applies toward the family Network Annual Deductible.

If Elaine then has a procedure for Network care where she pays out of pocket $750 in Allowable Charges, her expenses apply toward the family Network Annual Deductible.

Now, when Joe, Elaine or Tom needs care, once any family member or a combination of family members has paid out of pocket $250 in Allowable Charges for Network care, Joe, Elaine and Tom will begin receiving Benefits because the $1,500 Network family Annual Deductible will have been met.

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

	Counts toward the Non-Network Annual Deductible?	
	Yes	No
Amounts that exceed Allowable Charges for Eligible Expenses		X
Co-payment		X
Contributions		X
Ineligible Expenses		X
Network Allowable Charges		X

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

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

If family members are enrolled in different Program options, the Annual Deductible of the option covering an individual will apply only to that individual and other family members enrolled in the same option. In addition, expenses that apply to each family member's individual Annual Deductible will only apply to meeting the family Annual Deductible of those family members enrolled in the same Program option. Family members enrolled in a separate Program option will have a separate Annual Deductible. Allowable Charges incurred by a family member will apply only to the Annual Deductible that applies to that individual and not to the separate Annual Deductible applicable to the family member(s) enrolled in a different Program option.

HCN Option 2

HCN Option 2 has a separate Annual Deductible for each option (Network, ONA and Non-Network). Amounts incurred under one option do not apply to the other option.

The Annual Deductible is integrated with Mental Health Substance Abuse, Prescription Drug, and CarePlus. The tables below summarize what does and does not apply to the Annual Deductible.

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

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

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

Coinsurance

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

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

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

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

For example, if the Program pays 90 percent of Allowable Charges if you use a Network Provider and 80 percent if you use a Non-Network Provider, and you visit a Network Provider for a Covered Health Service, the Network Provider will accept a Negotiated Rate. If the Negotiated Rate is $10,000 and there is no Annual Deductible requirement or you have met your Annual Deductible, the Program will pay $9,000 (90% x $10,000). You will be responsible for the $1,000 Coinsurance amount (10% x $10,000).

If you visit a Non-Network Provider, the Provider's billed charge may be higher than the Allowable Charge. If the Allowable Charge is $10,000, the Provider bills $14,000 and you have met your Non-Network Annual Deductible, the Program will pay $8,000 (80% x $10,000). You will be responsible for the $2,000 Coinsurance amount (20% x $10,000) plus the remaining $4,000 difference between the amount billed ($14,000) and the Allowable Charge ($10,000).

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

Co-payments

A Co-payment is a flat dollar amount you pay for certain Services. Co-payments vary depending on the Covered Health Service. See the *Benefits at a Glance* table(s) following the "Conditions for Program Benefits" section for Co-payment amounts.

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum limits the amount you pay for Covered Health Services each year. Once your payments for Covered Health Services reach the Annual Out-of-Pocket Maximum, the Program pays 100 percent of Allowable Charges for most Covered Health Services for the rest of the year unless you change your Program option.

Notwithstanding the Annual Out-of-Pocket Maximum limit for the Program, the Allowable Charges for Eligible Expenses you pay out of pocket for Covered Health Services by Network Providers in a calendar year may not exceed the limit specified for each year by PPACA ($7,350 for individual coverage and $14,700 for family coverage in 2018). This overarching Annual Out-of-Pocket Maximum includes all Network Co-payments, Annual Deductibles, and Coinsurance for Essential Health Benefits (e.g., medical, mental health/substance abuse, prescription drug, non-excepted dental and vision) and must accumulate to a single overarching Annual Out-of-Pocket Maximum or have limits imposed on the component pieces that will not exceed the foregoing cap when combined.

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

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

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

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

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

HCN Option 1

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

HCN Option 2

There are different individual and family Annual Out-of-Pocket Maximums. If your coverage category is either Individual + 1 or Individual + 2 or more, only the family Annual Out-of-Pocket Maximum applies, and you must meet the family Annual Out-of-Pocket Maximum before the Program pays 100 percent of Allowable Charges for Eligible Expenses. The family Annual Out-of-Pocket Maximum is considered to be met when the expenses of any combination of covered family members meet the family Annual Out-of-Pocket Maximum, whether or not any individual family member has met his or her individual Annual Deductible. However, the Annual Out-of-Pocket Maximum is capped for each individual family member at the individual Annual Out-of-Pocket Maximum, as stated in the Benefits at a Glance table, which means that the Program will pay 100 percent of Allowable Charges for Eligible Expenses for an individual family member who reaches the capped amount, but the family Annual-Out-of-Pocket Maximum must be met before the Program pays 100% of these expenses for all other family members.

Amounts that apply to the Annual Out-of-Pocket Maximum include amounts you pay toward the cost of medical and MH/SA Eligible Expenses. Prescription Drug Eligible Expenses will no longer apply to the new medical and MH/SA Annual Out-of-Pocket Maximum.

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

Table 1 – HCN Option 1

	Network	Non-Network	ONA
Counts toward the Annual Out-of-Pocket Maximum?			
Amounts that exceed allowable charges for eligible expenses	No	No	No
Annual Deductible	Yes	Yes	Yes
Coinsurance	Yes	Yes	Yes
Contributions	No	No	No
Ineligible expenses	No	No	No
Non-Network Allowable Charges	No	Yes	Yes
Network Allowable Charges	Yes	No	Yes
Outpatient prescription drug expenses	No	No	No
Notice or preauthorization penalties	No	No	No
Emergency, physician office visits, urgent care facility copays	Not applicable	No	Not applicable
Co-payments (Inpatient/Hospital and Outpatient Surgery Facility Charges)	Not applicable	No	Not applicable
Balance-billed charges	No	No	No
Health care this plan doesn't cover	No	No	No

Table 2 – HCN Option 2

	Network	Non-Network	ONA
Counts toward the Annual Out-of-Pocket Maximum?			
Amounts that exceed allowable charges for eligible expenses	No	No	No
Annual Deductible	Yes	Yes	Yes
Coinsurance	Yes	Yes	Yes
Contributions	No	No	No
Ineligible expenses	No	No	No
Non-Network Allowable Charges	No	Yes	Yes
Network Allowable Charges	Yes	No	Yes
Outpatient prescription drug expenses	Yes	Yes	Yes
Notice or preauthorization penalties	No	No	No
Emergency, physician office visits, urgent care facility copays	Not applicable	No	Not applicable

	Network	Non-Network	ONA
Counts toward the Annual Out-of-Pocket Maximum?			
Co-payments (Inpatient/Hospital and Outpatient Surgery Facility Charges)	Not applicable	No	Not applicable
Balance-billed charges	No	No	No
Health care this plan doesn't cover	No	No	No

Allowable Charge for Eligible Expenses for Participants Enrolled in a Health Care Network

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

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

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

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

Benefit Maximums

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

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

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

MEDICAL BENEFITS

KEY POINTS

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

OVERVIEW

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

- ***Network vs. Non-Network Providers.*** *Even when you are enrolled in Network coverage, you are not required to use Network Providers. However, you generally pay more if you use Non-Network Providers, except for Emergency Services. Note: Emergency Services are paid at the same level regardless of the Provider's Network status.*
- ***Health Care Network vs. Out-of-Network Area Coverage.*** *You are assigned Network coverage if your home ZIP code falls in the Network Area. If your home ZIP code does not fall in the Network Area, you are assigned Outside Network Area (ONA) coverage, but you may elect Network coverage.*
- ***Allowable Charge.*** *Program Benefits are based on the Allowable Charge, which is determined by the Benefits Administrator. Amounts above the Allowable Charge do not count toward the Annual Deductible or Annual Out-of-Pocket Maximum. See the "Cost Sharing" section for more information.*

- **Shared Cost of Benefits.** *Generally, you and the Program share the cost of Medical Benefits, including Mental Health/Substance Abuse Covered Health Services. When you are enrolled in a Health Care Network Option and use Network Providers or you are enrolled in coverage under a Preferred Provider Organization option, you pay a flat fee, called a Co-payment, for most office visits, urgent care, emergency room or Hospital-based Services. When you use Non-Network Providers or are enrolled in an ONA option, you may pay a Co-payment or a portion of Eligible Expenses (Coinsurance) after you have met your Annual Deductible. You generally no longer have to pay Coinsurance but will continue to be subject to applicable Co-payments after you have met your Annual Out-of-Pocket Maximum. However, only Allowable Charges count toward the Annual Deductible and Annual Out-of-Pocket Maximum, and the Program will not pay Benefits for charges in excess of Allowable Charges. If you use a Non-Network Provider, you generally may be required to pay more than the Allowable Charges in addition to your Coinsurance. For more information on the cost-sharing provisions applicable to you, see the Benefits at a Glance table and the "Cost Sharing" section below. If you are enrolled in an Indemnity option, you pay a percentage of Eligible Expenses (Coinsurance) for Medical Benefits, including MH/SA. Once you have reached your applicable Annual Out-of-Pocket Maximum you will not be required to pay additional Coinsurance for Allowable Charges subject to that Annual Out-of-Pocket Maximum; however, any applicable Co-payments will continue to apply. Only Allowable Charges count toward the Annual Deductible and Annual Out-of-Pocket Maximum, and the Program will not pay Benefits for charges in excess of Allowable Charges.*

- **Annual Deductible.** *Except for eligible Preventive Care Services, you may have to meet an Annual Deductible before the Program begins to pay Benefits depending on your coverage option. There are separate individual and family Annual Deductibles. Note: Deductibles and Out-of-Pocket Maximums start over each year. See the Benefits at a Glance table and the Annual Deductible subsection for information.*

- **Preventive Care Services.** *Eligible Preventive Care Services are covered at 100 percent and are not subject to an Annual Deductible, Co-payment, or in some cases, Coinsurance when you use Network Providers or if you are enrolled in ONA coverage or Indemnity coverage. If you are enrolled in Network coverage, Preventive Care Services generally are not covered when you use Non-Network Providers. See the Benefits at a Glance table for information.*

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

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

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

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

What You Need to Know About Providers

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

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

A list of Network Providers is available online at the applicable Benefits Administrator's website.

To access a list of Network providers online, choose the applicable Benefits Administrator link below.

UnitedHealthcare:
https://connect.werally.com/plans/uhc

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

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

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

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

How Network Areas Are Determined

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

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

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

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

Network Benefits

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

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

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

With the exception of Emergency Services, charges for other Covered Services, including outpatient lab, X-ray and Diagnostic Services, are reimbursed based on whether or not the Provider is part of the Network. For example, outpatient lab, X-ray and Diagnostic Services rendered by a Network Provider will be reimbursed at the Network Benefits level, but Services rendered by a Non-Network Provider will be reimbursed at the Non-Network level. This is true regardless of whether the Services are associated with an office visit performed by a Network Provider or you have been referred for the service by a Network Provider. Emergency Services are always paid at the Network level. To learn more, see the "Emergency Services" section.

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

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

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

Designated Network Providers

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

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

Non-Network Provider Benefits Paid as Network Benefits

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

Non-Network Coverage

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

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

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

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

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

Outside Network Area (ONA) Coverage

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

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

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

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

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

Electing to Enroll in Network Coverage

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

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

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

Comparison of Network, Non-Network and ONA Benefits

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

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

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

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

Comparison of Claims/Financial Responsibility

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

Mary receives a bill for a $12,000 Hospital stay. Assuming she has already met her Annual Deductible, the following table shows what she could pay depending on the Provider she uses. The numbers and percentages used in this table are illustrative only. The actual amounts applicable under the terms of the Program will govern.

	Network	Non-Network	ONA (Network Provider Used)	ONA (Non-Network Provider Used)
Provider charge for Covered Health Service	$12,000	$12,000	$12,000	$12,000
Allowable Charge (determined by Benefits Administrator for Covered Health Service)	$9,000	$10,500	$9,000	$10,500
Percentage of Allowable Charge paid by the Program	90%	80%	90%	90%
Total amount paid by the Program	$8,100	$8,400	$8,100	$9,450
Mary's percentage/Coinsurance of Allowable Charge	10%	20%	10%	10%
Amount exceeding Allowable Charge	$0	$1,500	$0	$1,500
Total amount Mary owes Provider	$900	$3,600	$900	$2,550

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

Choosing Your Providers

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

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

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

How Your Choice of Providers Affects Your Benefits

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

- **Network Providers.** Your medical or MH/SA Benefits Administrator has identified a group of Providers who are in Network and have agreed to provide Covered Health Services at a Negotiated Rate (or discounted rate). Generally, these Negotiated Rates are lower than what Non-Network Providers would charge. This means you pay less. The Network Provider will generally bill and be reimbursed by the Benefits Administrator.
- **Non-Network Providers.** When you receive Covered Health Services from a Non-Network Provider, the Provider's fees are not subject to Negotiated Rates. The Program only pays up to the amount that the Benefits Administrator determines is the Allowable Charge for a

given Service in your area. This means that if your doctor charges above this determined Allowable Charge, you may have to pay the remainder. In most cases, you also will have to file a Claim for Benefits with the Benefits Administrator.

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

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

Showing Your ID Card

You will receive an identification (ID) card from your medical Benefits Administrator after you enroll. Be sure to carry your ID card with you at all times and show it to your Provider when you receive Services. Your ID card includes important information about your Program Benefits and lets your Provider know that you are enrolled in the Program and that Negotiated Rates may apply. To help fight health care fraud, never lend your ID Card to another person, and, notify your medical Benefits Administrator if your card or insurance information is lost or stolen.

Transition of Care

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

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

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

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

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

Non-MH/SA Transition of Care Procedures

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

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

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

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

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

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

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

MH/SA Transition of Care Procedures

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

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

Notification and Preauthorization Requirements

The Program requires you to provide Notification to or obtain Preauthorization from the Benefits Administrator before you receive certain Covered Health Services. The Notification and Preauthorization process is in place to verify that Services are Medically Necessary and that

treatment provided is the proper level of care. For more information on how a Service is determined to be Medically Necessary, see the "Medically Necessary" section of this SPD.

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

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

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

Notification and Preauthorization Process

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

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

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

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

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

Notification and Preauthorization Requirements Table

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

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

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

	Notification and Preauthorization Requirements	Timing	Penalties
Alternate Care in Lieu of Hospitalization	**Preauthorization**: Required	As soon as possible and before Services are received	Benefits will be denied
Ambulatory Surgical Centers	See the *Outpatient Procedures/Surgery* row	See the *Outpatient Procedures/Surgery* row	See the *Outpatient Procedures/Surgery* row
Emergency Room	**Notification**: Not required unless admitted. See the *Hospital Admission after an Emergency* row for more information.	See the *Hospital Admission after an Emergency* row for more information	See the *Hospital Admission after an Emergency* row for more information
Home Health Care	**Preauthorization**: Required	Five business days before Home Health Care treatment begins	Benefits will be denied
Hospital Admission after an Emergency	**Notification:** Required	Within 24 hours of Admission	Benefits payable will be reduced by 20%
Maternity Hospital Admission	**Notification:** Required	As soon as reasonably possible if the inpatient stay for the mother or newborn exceeds 48 hours for normal vaginal delivery or 96 hours for cesarean section	Benefits payable will be reduced by 20%

	Notification and Preauthorization Requirements	Timing	Penalties
Organ and Tissue Transplant	**Notification:** Required. There are specific guidelines regarding Benefits for transplant Services. In order to receive special Services you must notify the Medical Benefits Administrator. Additional Benefits are available for certain Programs, see *Appendix C* for more information.	As soon as the possibility of a transplant arises (and before the transplant center performs a pretransplantation evaluation)	No penalty for failing to notify the Medical Benefits Administrator If Hospital Admission is required, see the *Scheduled Hospital Admission* row for penalty for failure to notify, which will apply
Outpatient Procedures/Surgery	**Preauthorization**: Required for certain procedures. See the "Notification and Preauthorization Requirements" section for a list of procedures requiring prior Notification.	Five business days before procedure or as soon as reasonably possible	Benefits payable will be reduced by 20%
Reconstructive Procedures	**Notification:** Required	Five business days before receiving Services. When you provide Notification, the Benefits Administrator can verify that the Service is a reconstructive procedure rather than a cosmetic procedure.	No penalty for failing to notify for reconstructive procedures If Hospital Admission is required, see the *Scheduled Hospital Admission* row for penalty for failure to notify, which will apply.
Scheduled Hospital Admission	**Preauthorization**: Required	For elective Admissions: five business days before Admission	Benefits payable will be reduced by 20%
Skilled Nursing Facility or Extended Care Facility	**Preauthorization**: Required for elective Admissions and nonelective Admissions	**Preauthorization**: Five business days before elective Admission, one business day or same day for nonelective Admission	Benefits will be denied
Surgery	See the *Scheduled Hospital Admissions* or *Outpatient Procedures/Surgery* row.	See the *Scheduled Hospital Admissions* or *Outpatient Procedures/Surgery* row.	See the *Scheduled Hospital Admissions* or *Outpatient Procedures/Surgery* row.
For a complete list of Services not listed in this table, see the "Notification and Preauthorization Requirements" section below.			

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

Prior Notification Requirements

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

In addition, although not required, there are some Covered Health Services for which advance Notification is recommended. Letting your medical or MH/SA Benefits Administrator know about procedures before you receive them lets your Benefits Administrator assess if Preauthorization is required and ensures you are receiving the most appropriate Program Benefits.

If you use a Non-Network Provider or are enrolled in ONA coverage, you must preauthorize your care with the Benefits Administrator before you receive the following medical surgical procedures:

- Carpal tunnel (relief of nerve pressure in the wrist)
- Cholecystectomy (gall bladder removal)
- Cardiac catheterization (diagnostic procedure passing a catheter into the heart through a blood vessel) or angioplasty (widening of a blood vessel)
- EGD-endoscopic procedure of the stomach or intestine (examination with a small camera)
- Heart surgery
- Hip replacement
- Hysterectomy
- Knee arthroscopy
- Knee replacement
- Laminectomy (spinal operation to remove part of the vertebrae)
- Myringotomy (surgery of the eardrum to relieve pressure)
- Nasal endoscopy/ethmoidectomy (sinus surgery)
- Pelvic laparoscopy (pelvic surgery through a small incision)
- Removal of tonsils and/or adenoids
- Septoplasty (surgery to correct the septum in your nose)
- Spinal fusion
- Tympanostomy (insertion of an ear tube)

Note: The above list of surgical procedures that require prior Notification does not apply to Former SNET Employees who were covered by the applicable labor agreement between Cingular

Wireless and the CWA covering CWA District 1 (formerly SNET) who retired on or before Dec. 31, 2005.

Post-Notification

In some cases, you must notify your medical or MH/SA Benefits Administrator after you receive a Service. See the *Notification and Preauthorization Requirements* table for specific Services that require post-Notification.

Preauthorization Requirements

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

Predetermination of Benefits

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

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

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

Medically Necessary

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

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

Definition of Medically Necessary

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

- In accordance with Generally Accepted Standards of Medical Practice.

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

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

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

Services Considered Not Medically Necessary

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

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

Examples of Services Considered Not Medically Necessary

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

- Hospital Admissions to observe or evaluate a medical condition that could have been provided safely and adequately in another setting such as a Hospital's outpatient department.
- Hospital Admissions primarily for diagnostic studies (X-rays, laboratory and pathological Services, and machine diagnostic tests) that could be safely done in another setting on an outpatient basis.

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

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

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

Determination of Medically Necessary Covered Health Services

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

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

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

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

Health and Wellness Programs

The Company offers health and wellness programs designed to promote Employee wellness. These health and wellness programs are currently available to Active Employees eligible to participate in the Program, who either enroll in a Company-sponsored medical coverage option or a fully-insured medical coverage option (FIMCO), such as an HMO, or waive medical coverage. Program Employees who select a FIMCO coverage option or waive coverage will have access to limited non-medical services available through the online portal only.

Services covered under the Program currently include what is listed below and may change from time to time at the sole discretion of the Company:

- Wellness programs
  - Medical decision support
  - Lifestyle coaching from the Health and Wellness vendor including topics such as weight management, exercise, stress management, tobacco cessation
- Disease management provided by the medical Benefits Administrator
  - Asthma
  - Heart failure
  - Coronary artery disease
  - Diabetes
  - Chronic obstructive pulmonary disease
- Healthcare price transparency tool
  - Quality ratings and estimated costs for healthcare providers, physicians and specialists
  - Reviews for nearby doctors, facilities and services
- Health assessment and portal

For additional important information about the health and wellness programs available, contact the Health and Wellness vendor and for information about disease management contact the medical Benefits Administrator. For contact information see the "Contact Information" section.

The following is additional information concerning the health assessment also referred to as a health questionnaire, available under the Program:

Health Assessment/Questionnaire

The first step in achieving your wellness goals is for you to understand the current state of your health. In order to encourage you to obtain that awareness, the Company provides the opportunity to complete the health questionnaire offered by the Program's Health and Wellness vendor. This health questionnaire can be accessed via the online portal home page – look for Take the Health Questionnaire – and is provided by the Program at no additional cost to you. See the *Health and Wellness vendor* table in the "Contact Information" section for contact information.

You may also answer questions related to certain biometric measures normally obtained as part of an annual physical (provided you also completed the required information as described above). These are:

- Blood pressure
- Systolic
- Diastolic
- Cholesterol
- HDL
- LDL
- Glucose

You may incur additional costs during your annual physical if you request these biometric measures and these tests are not considered preventive care for your health status. It is not necessary to see your physician for the sole purpose of completing the health questionnaire. You may use the most recent biometric numbers you have on file to complete the questionnaire.

The health questionnaire is a tool to help you gain a clear picture of your overall health and is administered the Program's Health and Wellness vendor. Your individual responses are protected under the privacy and security rules of the Health Insurance Portability and Accountability Act (HIPAA). For additional important information about the health questionnaire, contact the Health and Wellness vendor.

See the "Appendix D" *Notice for AT&T Wellness Programs,* which informs you of the information that will be collected, how it will be used, who will receive it and what will be done to keep it confidential.

IMPORTANT: The Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Titles I and II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information for the health and wellness program. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health and Wellness Programs

The Company offers a health and wellness incentive program designed to promote wellness in Employees. Mobility employees are eligible to participate in the health and wellness programs.

Tobacco User Medical Contribution Surcharge

To encourage Employees to be tobacco free, the Program applies a Tobacco User medical contribution surcharge for Employees. The Tobacco User medical contribution surcharge will be waived, as described in the section below, if:

- the Employee certifies that they are not a tobacco user, or
- the Employee completes a tobacco cessation program.

Definition of Tobacco User: A tobacco user is someone who has used tobacco products once a month or more on average at any time since Jan. 1, 2017. Tobacco products include cigarettes, cigars, pipes, e-cigarettes, vaporizers and smokeless tobacco. Occasional tobacco users, those who use tobacco products less than once a month on average, are considered non-tobacco users.

Whether or not you are a tobacco user, you must take action to avoid a surcharge. The Tobacco User Medical Contribution Surcharge is a $50 increase in your 2018 plan year monthly contributions for each Employee (up to $600 annually).

How to Avoid the Tobacco User Surcharge

If you are not a tobacco user: During annual enrollment, certify that you are not a tobacco user, based on the new definition above.

If you are a tobacco user, you must complete all of the following before Dec. 31, 2017: 4 Sharecare Tobacco Cessation Calls (1 intake call and 3 follow-up calls) and 3 specific Quitnet participation actions (download quit guide, set a quit date, review medication plan options – determine if quitting with medication is right for you.) All actions must be completed to remove the surcharge.

If you complete these activities by Dec. 1, a surcharge will not be applied to your 2018 medical contributions. If the activities are completed after Dec. 1, the monthly surcharge will be waived starting with the month after you complete all the required activities. The removal of the surcharge and any applicable refunds will be reflected on your paydraft as soon as administratively feasible.

If you do not take any action (complete the Tobacco Cessation calls and the Quitnet participation items) by the end of the plan year and the record at the annual enrollment vendor does not show that you certified that you are not a tobacco user, you will be classified as a tobacco user and the surcharge will apply. However, if you complete these actions after Dec. 31, 2017 but any time **before** July 1, 2018, you can still eliminate a partial, prorated surcharge amount. The completion date period and eligible surcharge amounts waived are reflected in the schedule below. The removal of the monthly surcharge and any applicable refunds will be reflected on your paydraft as soon as administratively feasible.

Participant Completion Dates		Annual Tobacco User Surcharge Waived through Tobacco Cessation Activities	Months in 2018 Surcharge will be Waived	Initial Month Waiver will Apply to*
1/1/2017	12/31/2017	$600	12	January 2018
1/1/2018	1/31/2018	$550	11/12	February 2018
2/1/2018	2/28/2018	$500	10/12	March 2018
3/1/2018	3/31/2018	$450	9/12	April 2018
4/1/2018	4/30/2018	$400	8/12	May 2018
5/1/2018	5/31/2018	$350	7/12	June 2018
6/1/2018	6/30/2018	$300	6/12	July 2018
7/1/2018	12/31/2018	$0	0	n/a

Note:

- *The waiver of the surcharge may not be reflected on your paystub in the month shown. It will be reflected as soon as administratively feasible.*
- *After June 30, the surcharge will apply for the remainder of the year.*

Newly eligible participants (for example, new hires and transfers), who are not enrolled in time to participate in 2018 Annual Enrollment, are subject to the tobacco surcharge; however, the requirements to remove the surcharge are different. When you enroll in coverage you must either:

- **If you are not a tobacco user:** During enrollment, certify that you are not a tobacco user
- **If you are tobacco user:** You must pledge to enroll in the tobacco cessation program provided by the health and wellness vendor.

The Tobacco Cessation calls and the Quitnet participation are provided by the Program's Health and Wellness Vendor and are not charged to you. This includes items provided by the Health and Wellness Vendor, such as Nicoderm Patch and Nicorette Gum or Lozenges to assist you in quitting tobacco usage. If you are a tobacco user and are eligible to enroll in coverage under the Program effective Jan. 1, 2018, the Program has arranged for Tobacco Cessation services to be available to you for the period of Jan. 1, 2017 through Dec. 31, 2017. If you do not actually enroll in coverage for 2018, these services will not be available starting January 2018.

If you have questions, refer to the *Health and Wellness Vendor* table in the "Contact Information" section.

Additional Information Concerning the Tobacco User Medical Contribution Surcharge

If you need an Alternative Means to satisfy the requirements

AT&T is committed to helping you achieve your best health. If the Tobacco User Medical Contribution Surcharge applies to your coverage and you think you might be unable to meet a standard for a reward (including waiver of the surcharge) under this Program, you might qualify for an opportunity to achieve the same reward by different means. Contact the Health and Wellness Vendor (see the *Health and Wellness Vendor* table in the "Contact Information" section

for contact information) and they will work with you (and, if you wish, with your doctor) to find an alternative with the same reward that is right for you in light of your health status.

The Genetic Information Nondiscrimination Act of 2008

AT&T neither requires nor requests that you provide genetic information or family medical history for any purpose in connection with the medical contribution credit or the tobacco medical contribution surcharge. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and health plans from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to the survey or providing information concerning the tobacco surcharge. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

How the Tobacco User Medical Contribution Surcharge is applied

The Tobacco User Medical Contribution Surcharge is an increase to your monthly contributions for medical coverage. If you do not take the steps required to waive the surcharge, it will be applied for each month that you are enrolled in any coverage option under the Program, beginning Jan. 1, 2018. The Tobacco User Medical Contribution Surcharge will end when your coverage is terminated, but will apply if you are subsequently re-enrolled in coverage. See the *Surcharges and Credits* subsection of the "Contribution" section for more information.

Your Privacy

Your individually identifiable data may be provided to other vendors that contract with the Program to provide administrative services (such as the Benefit Administrators) to facilitate their provision of services under the Program. These services include programs that provide enhanced support to Participants (for example, special services that could assist with early identification and treatment of health-related conditions such as diabetes, heart disease, chronic obstructive pulmonary disease, asthma and cancer, and assistance with finding providers that specialize in the treatment of such conditions).

Such data will be used by the Program for the purpose of:

- Evaluating the operation of the Program to identify potential plan improvements, and
- Evaluating the health needs of the AT&T population generally to determine appropriate programs that can better meet those needs.

Any personal health information you provide to Health and Wellness Vendors or its subcontractors will be protected in accordance with HIPAA's requirements. See *Protecting Privacy of Your Protected Health Information-Notice of HIPAA Privacy Rights* for more information.

In addition, see the "Appendix D" *Notice for AT&T Wellness Programs,* which informs you of the information that will be collected, how it will be used, who will receive it and what will be done to keep it confidential.

WHAT IS COVERED

KEY POINT

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

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

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

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

Covered Health Services for Active Employees Under the National Bargained Benefit Plan

The following subsections describe Covered Health Services under the Program that apply to Active Employees whose Benefits are provided under the National Bargained Benefit Plan.

Preventive Care Services

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

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

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

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

Special coverage provisions apply to Preventive Care Services. Preventive Care Services are covered at 100 percent of the Allowed Amount without participant cost sharing such as a Co-payment, Coinsurance or Annual Deductible, but only when you receive Preventive Care Services on an outpatient basis from a Network Provider. Benefits for Preventive Care Services are subject to other Program requirements, such as setting and appropriateness.

No coverage is provided for Preventive Care Services if you receive these Services from a Non-Network Provider, unless you are enrolled in coverage that does not utilize a Network, such as an indemnity or out-of-network area (ONA) option. If you are enrolled in coverage that does not utilize a Network, Preventive Care Services are covered at 100 percent of the Allowed Amount, regardless of the Network status of the Provider.

Preventive Care Transition of Care

If a Service is added to Preventive Care Services under the Program while you are undergoing a course of care and, as a result, the Service will no longer be covered if you use a Non-Network

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

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

Disease Management

Personal Health Support is an enhanced clinical management experience provided by the Medical Benefits Administrator that connects AT&T employees and their families to health care answers, personalized nurse support and resources for chronic conditions, common illnesses or other medical issues.

Contact Personal Health Support to:

- Receive individualized personal nurse support for chronic or complex conditions
- Get 24/7 symptom triage
- Find the right care for you and your family
- Get the most out of your health plan
- Receive coaching for common medical issues

Conditions supported:

- Asthma
- Bariatric surgery
- Cancer
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease
- Diabetes
- End-stage renal disease
- Heart disease
- Heart failure
- High blood pressure
- High cholesterol

- Kidney disease
- Maternity support
- Neonatal care
- Transplant
- Other healthcare issues

To access Personal Health Support, call 877-506-7221 or the number on the back of your UnitedHealthcare ID card.

Note: Similar services that are described elsewhere in the SPD continue to be available; however, they are enhanced and provided through Personal Health Support. These services also can be accessed as noted in the description of the service.

Emergency Services

Emergency Room (Emergency Medical Condition)

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

Emergency Services due to an Emergency Medical Condition that are provided by a Non-Network Provider will be covered at the Network level of Benefits, that is, the Network cost-sharing requirements will apply no matter where you receive treatment. See the "Cost Sharing" section for information. The Allowable Charge for covered Non-Network Emergency Services Benefits will be no less than the highest of:

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

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

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

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

Emergency Room (Nonemergency)

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

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

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

Urgent Care Facility

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

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

Ambulance Services

- Ground Ambulance Services Benefits are payable under the Program when determined by the medical Benefits Administrator to be Medically Necessary for adequate treatment of an Emergency Medical Condition to the first local Hospital where treatment is provided. Ground Ambulance Service is also covered for transfers between Hospitals and certain other health care institutions, provided you are so critically ill that the ground Ambulance Service is necessary to your well-being, the institution to which you are taken has some special facility for treatment of your particular condition that is not available to you otherwise, and that institution is the normal or usual place that other Covered Persons living in the area would be taken for your particular specialized treatment.
- Air Ambulance Service used in lieu of ground Ambulance Service Benefits are payable under the Program when such Service is determined by the medical Benefits Administrator to be Medically Necessary for adequate treatment of an Emergency Medical Condition. See the *Benefits at a Glance* table for more information.

Inpatient Services

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

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

Room and Board

- Hospital daily room and board (up to the regular Semi-private Room rate).

Lab and X-Ray

- X-ray exams, X-ray therapy radiation therapy and treatment
- Laboratory tests
- Processing and administering blood and blood derivatives if not replaced

Physician and Surgeon Services

- Intensive care
- General nursing care
- Presurgical Physician consultations and in-Hospital Physician visits

Other Inpatient Services

Other inpatient Hospital Services include:

- Special diets.
- Operating, delivery, recovery and treatment rooms, equipment and supplies.
- Anesthetics.

- All FDA-approved drugs and medicines for in-Hospital use.
- Dressings, ordinary splints and casts.
- Oxygen and oxygen therapy.
- Electrocardiograms and electroencephalograms.
- Chemotherapy. Eligible Expenses for drugs for chemotherapy obtained through a prescription are payable under the Prescription Drug coverage. See the "Prescription Drug Coverage" section for more information.
- Physical Therapy.
- Hemodialysis treatment.
- Eyecare. The Program covers eye treatments that are Covered Health Services, such as eye surgery.
- Medical Services associated with dental treatment of accidental Injury that occurred while covered under the Program, or when a Physician other than a dentist certifies that hospitalization for medical treatment is Medically Necessary to safeguard the life or health of the patient because of the existence of a specified nonmedical organic impairment, such as heart trouble or hemophilia.

Outpatient Services

The Program provides Benefits for care as an outpatient. In many instances, you can avoid an overnight Hospital stay by having a Service or surgery performed as an outpatient at a Hospital, a stand-alone Ambulatory Surgical Center or a Provider's office.

Certain outpatient Services are Preventive Care Services. See the "Preventive Care Services" section for information. Certain outpatient Services require Notification or Preauthorization. See the "Notification and Preauthorization Requirements" section for information.

The Program covers the following outpatient Services:

Office Visits

- Services of a Physician for an office visit or house call for diagnosis and/or treatment of an Injury, Illness or disease, including Pregnancy.
- Services of a qualified physiotherapist (physical therapist) or a licensed Speech Therapist when prescribed by a Provider and the Services are not Educational in nature.

Other Outpatient Services

- Surgery.
- Pre-Admission and diagnostic X-ray and laboratory tests, including allergy testing.
- Hemodialysis treatment.
- Chemotherapy and radiation therapy. Eligible Expenses for drugs for chemotherapy obtained through a prescription are payable under the Prescription Drug coverage. See the "Prescription Drug Coverage" section for more information.

- Prostheses and their replacements when required due to the normal growth process of a Child or when required as a result of a change in physical condition due to Injury, Illness or disease.
- Allergy testing and treatment if prescribed by a Physician.
- Eyecare. The Program covers eye treatments that are Covered Health Services, such as eye surgery, but not expenses associated with a vision therapy program.
- Initial pair of eyeglasses or contact lenses following eye surgery or Injury.
- Dental Services. The removal of bony impacted, or partially bony impacted wisdom teeth are covered under the Program.
- An appliance to replace a lost body organ or part to help a disabled person return to functioning capacity — for example, an artificial limb or eye. Only the charge for the first appliance in the patient's lifetime is covered for each body organ or part, except for replacements needed due to a change in the patient's physical condition (including normal physical growth).
- Oxygen and the charges for giving it, including rental of required equipment.
- Nursing Services (including private duty nursing). The Services of an RN or LPN given through a Home Health Care Agency.
- Emergency room treatment. See the "Emergency Services" section for more information.
- Medical Services for treatment of accidental Injury that occurred while covered under the Program.
- Medical Services associated with dental treatment of accidental Injury that occurred while covered under the Program, or when a Physician other than a dentist certifies that outpatient medical treatment is Medically Necessary to safeguard the life or health of the patient because of the existence of a specified nonmedical organic impairment, such as heart trouble or hemophilia.

Mental Health and Substance Abuse (MH/SA) Services

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

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

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

Alternative to Mental Health Inpatient Care

The MH/SA Benefits Administrator may suggest alternative treatment options instead of inpatient care.

Approved Providers

You will want to verify that your Provider's credentials meet the requirements for reimbursement under the Program. Approved Providers include the following:

- Licensed professional counselor
- Licensed marriage, family and child counselor
- Licensed doctoral-level psychologist (Ph.D., Ed.D., Psy.D.)
- Licensed psychiatric nurse with a Master of Science in nursing and an RN license
- Licensed masters-prepared social worker (Some states may have additional requirements or may certify rather than license these professionals.)
- Licensed Marriage and Family Therapist (LMFT)
- Psychiatrist, M.D. or D.O. licensed to practice patient care psychiatry
- Mental Health Nursing with Prescription Authority (APRN)

Inpatient Mental Health/Substance Abuse Services

Covered MH/SA inpatient Hospital care includes Hospital daily room and board (up to the regular Semi-private Room rate), general nursing care, intensive care and other inpatient Services, including the following:

- Initial evaluation/assessment
- Medical history and physical
- All FDA-approved drugs and medicines for in-Hospital use
- Laboratory/pathology tests
- Electrocardiograms and electroencephalograms
- Individual therapy
- Family therapy
- Group therapy
- Neuropsychological testing
- Psychological testing
- Radiology
- Psychiatrists/Physicians
- Recreational/Occupational Therapy
- Psychosocial programs/Services

- Discharge planning
- Aftercare (for substance abuse programs)

Outpatient Mental Health/Substance Abuse Services

Benefits are available for Mental Health Services and Substance Abuse Services received on an outpatient basis in a Provider's office or at an Alternative Facility, including the following:

- Mental health, substance abuse and chemical dependency evaluations and assessment
- Diagnosis
- Treatment planning
- Referral Services
- Medication management
- Short-term individual, family and group therapeutic Services (including intensive outpatient therapy)
- Crisis intervention
- Psychological testing

Family Planning/Maternity Services

Family Planning

- Voluntary sterilization and related examinations. Voluntary sterilization is covered for females as Preventive Care Services except when due to a medical condition that is not considered to be preventive.
- Office visits for birth control. This will be considered Preventive Care Services if provided as part of a routine wellness visit (including well-woman exams) or billed separately and coded appropriately as preventive medicine Counseling. See the "Preventive Care Services" section.

Maternity Services

- Obstetrical and newborn care in the Hospital.
- Certified Nurse-Midwife within the scope of the Nurse-Midwife's certification.
- Prenatal and postnatal care (certain prenatal care may be covered as Preventive Care Services). See the "Preventive Care Services" section for information.
- Routine nursery care of the newborn during the mother's postdelivery confinement.

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

See the "Newborns' and Mothers' Health Protection Act" section of this SPD for information on your rights regarding Hospital stays after normal vaginal delivery or cesarean section.

Rehabilitation Services

The Program covers the following rehabilitation Services:

- Medical care and treatment by an Occupational or Physical Therapist.
- Services of a qualified Speech Therapist when prescribed by an attending Physician, the Services are not Educational in nature and Services are expected to result in significant physical improvement in the condition within two months of the start of treatment.

Additional Services

Alternate Care

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

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

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

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

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

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

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

- Alternate Care is determined not to be a Covered Health Service or is otherwise excluded under the Program.
- Payment of Alternate Care Benefits is not cost effective, as determined in the sole discretion of the Benefits Administrator or its designee.
- Any established durations or other limitation set forth in the Alternate Care Plan agreement has been met or exceeded.

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

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

Chiropractic Treatments

The Program covers chiropractic treatments. Limits apply to Network and Non-Network Services combined. See the *Benefits at a Glance* table for those limits.

Congenital Heart Disease Resources Program

The Congenital Heart Disease (CHD) program is the medical Benefits Administrator's program made available to Covered Persons under the Program. The CHD Program provides information to Covered Persons with congenital heart disease and offers access to Designated Network Providers for the treatment of congenital heart disease. See "Appendix C" *Special Medical Administrator Offerings* for information about the medical Benefits Administrator's CHD Program. You can also contact the medical Benefits Administrator for information about congenital heart disease Services.

Durable Medical Equipment Rentals or Purchase

The Program covers charges for rental or initial purchase (or necessary repair) of Durable Medical Equipment prescribed by a Physician for treatment of an Illness or Injury. Coverage does not include any changes made to the Covered Person's home, automobile or personal property, such as air conditioning or remodeling. Equipment rental coverage is limited to the purchase price of the Durable Medical Equipment.

Gender Dysphoria (Gender Confirmation) Surgery and Secondary Sexual Characteristic Services

To be covered under the Program, the gender dysphoria (gender confirmation) surgery and secondary sexual characteristic services must be Medically Necessary. The determination of whether the treatment is Medically Necessary will be made by the Benefits Administrator based on generally accepted medical standards of care such *as The World Professional Association for Transgender Health (WPATH)* (formerly known as the *Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders*).

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

- Be at least 18 years of age.
- Have a diagnosis of Gender Dysphoria.

- Undergo a minimum of 12 months of continuous hormone replacement therapy when recommended by a mental health professional and provided under the supervision of a Physician.
- Complete a minimum of 12 months of successful, continuous, full-time, real-life experience in their new gender, with no returning to their original gender.
- Regularly participate in psychotherapy, as recommended by a treating medical or mental health Practitioner.

Your Benefits Administrator may have specific guidelines regarding Benefits for treatment of Gender Dysphoria services. Contact your Benefits Administrator for further information about these guidelines and to obtain required prior authorization and/or notification. For information on how to contact the Benefits Administrator, see the "Contact Information" section.

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

Hearing Benefit

The Program covers the initial hearing aid(s) following Illness or Injury and the exams for their prescription or fitting.

Home Health Care

The following Home Health Care expenses will be covered to the extent that they would have been covered if the person had received such Services in a Hospital:

- Medical supplies
- Drugs and medications ordered by a Physician other than those available through the Prescription Drug Benefits
- Laboratory Services given or ordered by a Hospital
- Home health aide Services (four hours counts as one visit)
- Nursing or related skilled Services (each visit counts as one visit, regardless of the length of the visit)

See the "Notification and Preauthorization Requirements" section for information.

Hospice Care

The Program covers Hospice Services if the attending Physician has certified that the patient is terminally ill with six months or less to live. Services for the patient must be given in a licensed Hospice facility or in the patient's home.

Organ and Tissue Transplant Services

Covered Health Services include organ and tissue transplants when ordered by a Physician. Transplantation Services must be received at a Designated Network Provider to receive the maximum level of Benefits available under this provision. Benefits are available at other facilities if approved by the medical Benefits Administrator. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service and is not an Experimental or Investigational Service or an Unproven Service.

- Heart transplants.
- Lung transplants.

- Heart/lung transplants.
- Liver transplants.
- Small bowel transplants.
- Liver/small bowel transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/pancreas transplants.
- Bone marrow/peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Other transplant procedures not listed above are covered when the medical Benefits Administrator determines that it is Medically Necessary. Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. Cornea transplants do not need to be provided at a Designated Network Provider in order to receive Network Benefits.

If care is provided at a Designated Network Provider, you may be eligible for reimbursement of travel expenses to and from the Designated Network Provider. In addition, the Program also pays for a travel companion's eligible travel and hotel expenses. Depending on the circumstances, travel and lodging Benefits may be taxable compensation under the Internal Revenue Code. Contact the Benefits Administrator for further information. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

Additional Benefits may be available when you use a Designated Network Provider chosen by the medical Benefits Administrator. For a description of those additional Benefits, see "Appendix C" *Special Medical Administrator Offerings* for information.

EXCLUSIONS AND LIMITATIONS

KEY POINTS

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

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

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

This list does not include exclusions for outpatient Prescription Drug expenses. See the Prescription Drug "Exclusions and Limitations" section for a list of Prescription Drug exclusions. This section also does not include exclusions and limitations information provided under any Fully-

Insured Managed Care Options available under the Program. See the "Fully-Insured Managed Care Option" section for information.

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

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

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

Exclusions and Limitations for Active Employees Under The National Bargained Benefit Plan

The following information summarizes exclusions and limitations under the Program that apply to National Bargained Benefit Plan Employees.

General Health Care Exclusions

- Services that are determined to be inappropriate in the sound discretion of the Benefits Administrator.
- Expenses for services that you have no legal responsibility to pay or for which a charge would not ordinarily be made in the absence of coverage under this Program.
- Expenses for services that exceed the Allowable Charge or any specified limitation or penalty imposed under the Program.
- Charges for nontreatment purposes, including missed appointments, room or facility reservations, completion of Claim forms or record processing.
- Charges for examinations, evaluations and reports not required for health reasons, such as employment, school or insurance examinations.
- Charges for services incurred as a result of the failure to comply with Medicare utilization review requirements.
- Charges for services needed as a result of an Injury, Illness or disease arising out of the participation in or attempt to commit a felony or assault.
- Charges for covered expenses under any provision of the Program if already paid pursuant to any other provision of the Program.
- Services for which coverage is available:
  - Under AT&T CarePlus – A Supplemental Benefit Program.
  - Under a Company-sponsored disability plan for treatment resulting from a job-related accidental Injury.
- Charges for services payable under workers' compensation or similar laws.

- Services provided in connection with an occupational Injury, Illness or disease arising out of and in the course of employment with an employer if the employer pays for such charges or you waive or fail to assert your rights with respect to such charges.
- Charges paid or payable under any government law or regulation.
- Services available from or covered by any governmental agency or plan.
- Expenses for services received after the date a Covered Person's coverage ends, including Services for medical conditions that began before the date the individual's coverage under the Program ends (except for Hospital room and board charges as a Hospital inpatient if already confined to a Hospital when coverage ends).
- Expenses for services (including Hospital confinement) received before the recipient's effective date of coverage under the Program.
- Services that are not Covered Health Services, except as may be specifically provided in "What Is Covered" section.
- Treatment of any Injury, Illness or disease caused by service in the armed forces of any government or by an act of war, whether declared or undeclared, including armed aggression, riot or insurrection unless you are on Company business, including travel, assignment and relocation outside of the United States.

Specific Health Care Exclusions

Alternative Treatments

- Acupuncture for any purpose except anesthesia.
- Aromatherapy.
- Holistic medicine, services, supplies or treatment.
- Hypnotism.
- Massage therapy.
- Rolfing (holistic tissue massage).
- Other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to manipulative treatment and nonmanipulative osteopathic care for which Benefits are provided as described in the "What Is Covered" section.

Dental

- Dental care except as specifically provided under the Program as described in the "What Is Covered" section.
- Services for treatment of temporomandibular joint disorders (TMJ) or other conditions involving joints or muscles of the jaw by any method or procedure other than surgery.

Devices, Appliances and Prosthetics

- Appliances for snoring except when provided as a part of treatment for documented obstructive sleep apnea.
- Orthotic appliance(s) that straighten or reshape a body part.
- Smoking cessation services, products or drugs except as covered under Preventive Care Services. See the "Preventive Care Services" section for more information.

Drugs

- Charges for over-the-counter medications and pharmaceutical purchases, whether prescribed by a Physician or otherwise, except for insulin, Diabetic Supplies such as blood testing aids and diagnostic urine tests, and hypodermic needles and syringes prescribed by a Physician for use with covered injectables, and except as set forth in the "Prescription Drug Coverage" section.

Foot Care

- Routine foot care except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under the "What Is Covered" section.

Medical Supplies and Equipment

- Prescribed or nonprescribed medical supplies and disposable supplies such as elastic stockings, ace bandages or gauze and dressings.

Mental Health/Substance Abuse (MH/SA)

- Any nonprescription or over-the-counter drug, supplement or other medicinal treatment.
- Any testing, evaluation, consultation, therapy, rehabilitation, remedial education, Services, supplies or treatment for developmental disabilities, communication disorders or learning disabilities available from or through the educational system (whether public, parochial or private), and/or required to be made available from or through the educational system pursuant to Public Law 94-142, regardless of whether or not there is any cost to the Covered Person or the Covered Person takes advantage of such testing, rehabilitation, remedial education, Services or treatment.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment for personal or professional growth and development.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment provided by the Covered Person's parent, siblings, Child(ren), current or former Spouse, or current or former Partner.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment relating to employment, regardless of whether Investigational or pre- or post-employment.
- Any testing, evaluation, consultation, therapy, services, supplies or treatment that are covered as benefits under a plan or other coverage that is primary to coverage under the Program. See the "Coordination of Benefits" section for information concerning Coordination of Coverage.
- Any testing, therapy, service, supply or treatment of organic disorders, dementia and primary neurologic/neurodevelopment/neurocognitive disorders, except for associated treatable and acute behavioral manifestations.

- Any testing, therapy, service, supply or treatment provided as a result of any workers' compensation law or similar legislation or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof (exclusive of Medi-Cal/Medicaid) or caused by the conduct or omission of a third party for which the Covered Person has a claim of damages or relief, unless the Covered Person provides the Program or its designee with a lien against such claim for damages or relief in a form and manner satisfactory to the Program and its designee.
- Any testing, therapy, service, supply or treatment that does not meet national standards for mental health professional practice or that have not been found to be efficacious or beneficial by one or more of the plans or its designees or authorized management entity's clinical quality or review committees based on a review of peer-reviewed literature and clinical information available.
- Court-ordered psychiatric or substance abuse evaluation, treatment and testing except when the Program or its designee determines that such Services are Medically Necessary for the treatment of a DSM-V mental health diagnosis according to established clinical criteria and clinical policies of the Program or its designee.
- Custodial Care. Defined as any services, supplies, care or treatment rendered to a Covered Person who:
    - Is disabled mentally or physically as a result of a DSM-V-TR (or ICD-10) MH/SA diagnosis and such disability is expected to continue and be prolonged.
    - Requires a protected, monitored or controlled environment whether inpatient, outpatient or at home.
    - Requires assistance with activities of daily living.
    - Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the Covered Person to function outside the protected, monitored or controlled environment.
- Experimental or Investigational testing, therapy, service, supply or treatment defined as an unproven therapy or treatment that may or may not be superior to a current gold standard therapy and that meets one or more of the following criteria:
    - Not generally accepted by the medical community as effective and proven.
    - Not recognized by professional medical organizations as conforming to accepted medical practice.
    - Not approved by the FDA or other requisite government body.
    - In clinical trials or needs further study.
    - Rarely used, novel or unknown and lacks authoritative evidence of safety and efficacy.
- Inpatient Prescription Drugs not dispensed as part of the treatment for a DSM-V mental health diagnosis in the course of a preauthorized covered inpatient Admission.
- Outpatient Prescription Drugs.

- Private duty nursing except when preauthorized by the Program or its designee as Medically Necessary.
- Psychological testing except when preauthorized as Medically Necessary by the Program or its designee.
- Services, supplies or treatment for or related to education or training for professional licensure, certification, registration or accreditation.
- Treatment or consultations provided via telephone, electronic transmission or other non-in-person modalities, unless determined as Medically Necessary.

Nutrition

- Food of any kind. Foods that are not covered include:
  - Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, unless they are the only source of nutrition. Infant formula available over the counter is always excluded.
  - Foods to control weight, treat obesity (including liquid diets).
  - Vitamins and minerals.
  - Meals you can order from a menu for an additional charge during an inpatient stay.
  - Other dietary and electrolyte supplements.
  - Services of nutritionists or dieticians except as covered under Preventive Care Services or otherwise specifically provided under the Program.
  - Digestive aids.

Personal Care, Comfort or Convenience

- Supplies, equipment and similar incidentals for personal comfort, including when provided while an inpatient in a Hospital. Examples include the following:
  - Air conditioners
  - Air purifiers and filters
  - Batteries and battery chargers
  - Beauty/barber service
  - Dehumidifiers and humidifiers
  - Ergonomically correct chairs
  - Non-Hospital beds, comfort beds, motorized beds and mattresses
  - Breast pumps (except when covered under Preventive Care Services; see the "Preventive Care Services" section)
  - Car seats
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners

- Exercise equipment and treadmills
- Guest service
- Hot tubs, Jacuzzis, saunas and whirlpools
- Medical alert systems
- Music devices
- Personal computers
- Pillows
- Power-operated vehicles
- Radios
- Strollers
- Safety equipment
- Telephone
- Television
- Vehicle modifications such as van lifts
- Video players
- Home modifications to accommodate a health need (including, but not limited to, ramps, elevators, swimming pools)

Physical Appearance

Cosmetic procedures, except as described in the "What Is Covered" section, are excluded from coverage. Examples include:

- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Pharmacological regimens.
- Nutritional procedures or treatments.
- Tattoo or scar removal procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Hair removal or replacement by any means.
- Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Skin abrasion procedures performed as a treatment for acne.
- Treatments for hair loss.
- Varicose vein treatment of the lower extremities when it is considered cosmetic.

- Replacement of an existing intact breast implant if the earlier breast implant was performed as a cosmetic procedure. Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See the "What Is Covered" section for more information.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation.
- Wigs regardless of the reason for the hair loss.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

- Any procedure to restrict the intake of food or other nutritional material or to divert the passage of such material through the digestive tract, including, but not limited to, gastric bypass, gastric balloons, jejunal bypass, laparoscopic banding and stomach stapling.
- Experimental or Investigational Services. This exclusion applies even if Experimental or Investigational Services, treatments, devices or pharmacological regimens are the only treatment options for your condition. When a Covered Person is enrolled in a clinical trial, this exclusion does not apply to routine patient costs for Services provided in connection with the clinical trial consistent with the coverage provided under the Program that are typically covered for a Covered Person who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Experimental, Investigational or Unproven Service itself; 2) Services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a Service that is inconsistent with the generally accepted and established standards of care for a particular diagnosis otherwise covered under the Program.
- Medical and surgical treatment for snoring except when provided as a part of treatment for documented obstructive sleep apnea.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).

Reproduction

- Services and associated expenses for infertility treatment, including assisted reproductive technology, regardless of the reason for treatment. This exclusion does not apply to Services required to treat or correct underlying causes of infertility.
- Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).
- In vitro fertilization regardless of the reason for treatment.
- Surrogate parenting, donor eggs, donor sperm and host uterus.
- The reversal of voluntary sterilization.
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.

Transplants

- Services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Program.)

Travel

- Certain Designated Network Provider and travel and lodging expenses are not covered, including, but not limited to, the following:
  - Charges for personal comfort and convenience items.
  - Charges that are not incurred during the patient's stay at a Designated Network Provider, except travel days.
  - Charges that have not been included in the patient's or the travel companion's itinerary as preauthorized by the medical Benefits Administrator.
  - Charges in connection with transportation for the patient other than the trip to and/or from the Designated Network Provider except as approved by the medical Benefits Administrator.
  - Charges in connection with transportation for the travel companion other than the trip required to accompany the patient to and/or from the Designated Network Provider except for covered travel and lodging expenses.
  - Charges in connection with the repair or maintenance of a motor vehicle.
  - Charges for personal expenses incurred by the travel companion to maintain the patient's or the travel companion's home during the patient's stay at the Designated Network Provider, including Child care charges, house-sitting charges and kennel charges.
  - Reimbursement of any wages lost by the patient or the travel companion during the patient's stay at the Designated Network Provider.

Types of Care

- Charges for Physical Therapy and Speech Therapy that are Educational in nature.
- Chiropractic care that is considered maintenance, preventive, palliative, passive or supportive in nature as determined by the medical Benefits Administrator.
- Chiropractic and osteopathic manipulative treatment to treat an Illness.
- Custodial Care as defined in the "Definitions" section.
- Cosmetic surgery or treatment unless required to correct Injury caused by an accident, or to correct birth defects or deformities. Charges for reconstructive surgery after other surgery covered under the Program has been performed on the same part of the anatomy for treatment of an Illness, Injury or disease will not be excluded if they otherwise qualify as covered expenses except as specifically covered under the Program.
- Care in an institution that is primarily a place of rest, a home for the aged, a nursing or convalescent home, a skilled nursing home or any similar place except as specifically provided under the Program.

- Domiciliary care.
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer.
- Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint except as a treatment of obstructive sleep apnea.
- Rest cures.
- Outpatient rehabilitation Services for the treatment of a condition that ceases to be therapeutic and instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.
- Speech Therapy to treat stuttering, stammering or other articulation disorders.

Vision and Hearing

- Charges for eye surgery when the primary purpose is to correct myopia, hyperopia or astigmatism, including, but not limited to, radial keratotomy and LASIK.
- Cochlear implants.
- Eyeglasses, contact lenses or exams for the prescription or their fitting except for the initially prescribed pair of eyeglasses or contact lenses after eye surgery or Injury and the exams for the prescription or their fitting.
- Hearing aid expenses except when provided under the "Hearing Benefit" section.

All Other Exclusions

- Charges for services other than those determined by a Benefits Administrator to be a Covered Health Service for the treatment of Injury, Illness or disease other than Preventive Care Services as specified under the Program.
- Charges for services for a covered individual whose primary coverage is through a Fully-Insured Managed Care Option when the charges are excluded by such option due to noncompliance with that option's guidelines.
- Educational or Developmental Services.
- Services of Christian Science Practitioners.
- Charges for the evaluation of the suitability of an individual and/or the individual's condition for any Service excluded from coverage under the Program.

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

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

KEY POINTS

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

Prescription Drug Benefits at a Glance

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

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

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

- If you are enrolled in HCN Option 1 see Table 1 – HCN Option 1.
- If you are enrolled in HCN Option 2 see Table 2 – HCN Option 2.

Table 1 – HCN Option 1

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

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Annual Out-of-Pocket Maximum	Individual and Family: $1,200/$2,400 • Combined with Mail Order Prescription Drug Service. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. Expenses that do not apply to the Annual Out-of-Pocket Maximum • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic Drug penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy.	Not applicable	Individual and Family: $1,200/$2,400 • Combined with Network Retail Pharmacy. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. Expenses that do not apply to the Annual Out-of-Pocket Maximum • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic Drug penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy.
Supply Limit	Up to a 30-day supply; limited to two (2) fills for maintenance prescriptions then must use Mail Order. Subject to the Specialty Prescription Drug provisions	Up to a 30-day supply	Up to a 90-day supply; subject to the Specialty Prescription Drug provisions
Generic Drug	$10 Co-payment per prescription	You pay the full cost of drug then file a Claim for reimbursement 50% covered of discounted price; up to a 30-day supply	$20 Co-payment per prescription

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Preferred Brand Drug	$35 Co-payment per prescription	You pay the full cost of drug then file a Claim for reimbursement 50% covered of discounted price; up to a 30-day supply	$70 Co-payment per prescription
Non-Preferred Brand Drug	$60 Co-payment per prescription	You pay the full cost of drug then file a Claim for reimbursement 50% covered of discounted price; up to a 30-day supply	$120 Co-payment per prescription
Co-payment Exceptions	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.
Other Requirements			
Mandatory Generic/Brand Restriction	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.
Generic/Brand Exceptions	Available. See the "Generic/Brand-Name Exception" section.	Available. See the "Generic/Brand-Name Exception" section.	Available. See the "Generic/Brand-Name Exception" section.
Mandatory Mail	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Rx Clinical Programs	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.
Specialty Pharmacy	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy. See the "Specialty Prescription Drug Services" section for information.	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy. See the "Specialty Prescription Drug Services" section for information.	Specialty Prescription Drugs are automatically processed through the Specialty Pharmacy when you use the Prescription Drug Benefits Administrator's Mail Order Prescription Drug Service. See the "Specialty Prescription Drug Services" section for Co-payment information.

Table 2 – HCN Option 2

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Cost and Coverage			
Annual Deductible	Combined with Network medical, MH/SA, and CarePlus. See the "Benefits at a Glance" table of the medical and MH/SA coverage section for amounts. Annual Deductible applies before Co-payments apply.	Combined with Network medical, MH/SA, and CarePlus. See the "Benefits at a Glance" table of the medical and MH/SA coverage section for amounts. Annual Deductible applies before Co-payments apply.	Combined with Network medical, MH/SA, and CarePlus. See the "Benefits at a Glance" table of the medical and MH/SA coverage section for amounts. Annual Deductible applies before Co-payments apply.

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Annual Out-of-Pocket Maximum	Combined with Network medical, MH/SA, and CarePlus. See the "Benefits at a Glance" table of the medical and MH/SA coverage section for amounts.	Combined with Network medical, MH/SA, and CarePlus. See the "Benefits at a Glance" table of the medical and MH/SA coverage section for amounts.	Combined with Network medical, MH/SA, and CarePlus. See the "Benefits at a Glance" table of the medical and MH/SA coverage section for amounts.
Supply Limit	Up to a 30-day supply; limited to two (2) fills for maintenance prescriptions then must use Mail Order. Subject to the Specialty Prescription Drug provisions	Up to a 30-day supply	Up to a 90-day supply; subject to the Specialty Prescription Drug provisions
Generic Drug	$9 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	$18 Co-payment per prescription
Preferred Brand Drug	$35 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	$70 Co-payment per prescription
Non-Preferred Brand Drug	$70 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	$140 Co-payment per prescription
Co-payment Exceptions	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Other Requirements			
Mandatory Generic/Brand Restriction	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.
Mandatory Mail	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.
Rx Clinical Programs	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.
Specialty Pharmacy	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail. See the "Specialty Prescription Drug Services" section for Co-payment information.	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail. See the "Specialty Prescription Drug Services" section for information.	Specialty Prescription Drugs are automatically processed through the Specialty Pharmacy when you use the Prescription Drug Benefits Administrator's Mail Order Prescription Drug Service. See the "Specialty Prescription Drug Services" section for Co-payment information.

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

- "Filling Your Prescriptions" section for more information on the following:
  - Retail Prescription Drug Services.
  - Mail Order Prescription Drug Services.
  - Specialty Prescription Drug Services.
- "Cost Sharing – Prescription Drugs" section for information on how you and the Program share in the cost of your Prescription Drug coverage.
- "What Is Covered – Prescription Drugs" section for a list of Prescription Drug categories that are covered under the Prescription Drug Benefit.
- "What Is Not Covered – Prescription Drugs" section for a list of Prescription Drugs that are ***not*** covered under the Prescription Drug Benefit.

- "Contact Information" section if you have any specific questions for the Prescription Drug Benefits Administrator.
- "Claims for Benefits" section if your Prescription Drug Benefit is denied in whole or in part.

Cost Sharing – Prescription Drugs

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

This section describes cost-sharing features that are built into the Program. See the "Prescription Drug Benefits at a Glance" section for specific amounts.

Annual Deductible

The Annual Deductible is the amount that you (and your covered family members) pay each year before the Program begins to pay Prescription Drug Benefits. The Prescription Drug Benefit is subject to an Annual Deductible and is not coordinated with Medicare. See the "Prescription Drug Benefits at a Glance" section for Annual Deductible amounts.

Co-payments

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

Annual Out-of-Pocket Maximum

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

You will still be responsible for any expenses that would not have applied toward the Out-Of-Pocket Maximum. Notwithstanding the Annual Out-of-Pocket Maximum limit for the Program, the Allowable Charges for Eligible Expenses you pay out of pocket for Covered Health Services in a calendar year may not exceed the limit specified for each year by PPACA ($7,350 for individual coverage and $14,700 for family coverage in 2018). This overarching Annual Out-of-Pocket Maximum includes all Network Co-payments, Annual Deductibles, and Coinsurance for Essential Health Benefits (e.g., medical, mental health/substance abuse, prescription drug, non-excepted dental and vision) and must accumulate to a single overarching Annual Out-of-Pocket Maximum or have limits imposed on the component pieces that will not exceed the foregoing cap when combined.

Prescription Drug Program Coverage

Covered and Excluded Medications

The Prescription Drug Program offers coverage of drugs that are:

- Required by federal law to be dispensed with a written prescription.
- Approved by the Food and Drug Administration (FDA).
- Dispensed pursuant to a prescription issued by a Prescriber.
- Dispensed consistent with Evidence-based Medical Guidelines.

- Dispensed subject to the professional judgment of the dispensing Pharmacist according to applicable laws, regulations and limitations.
- Included on the Standard Formulary or the Advanced Control Specialty Formulary issued by the Prescription Drug Benefits Administrator.

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

Classification of Prescription Drugs

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

Generic Drugs

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

To maximize your Benefits under the Program, Generic Drugs must be considered. If certain higher-cost drugs are prescribed and a lower-cost alternative is available, you will be required to first try the lower-cost drug at least one time before the higher-cost Brand-Name Drug will be covered.

Brand-Name Drugs

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

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

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

You may access your Preferred Drug Benefit Guide, containing the published list of covered Prescription Drugs, at http://www.caremark.com/portal/asset/attrx_drug_list.pdf.

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

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

Preferred Brand Drug

A Preferred Brand Drug is a Brand-Name Drug that is included on the Prescription Drug Benefits Administrator's *Preferred Drug Benefit Guide*. Preferred Brand Drugs generally do not have a

Generic Drug equivalent. Preferred Brand Drugs have been reviewed and approved by a group of independent, unaffiliated clinical Physicians and Pharmacists based on their proven clinical and cost effectiveness.

Non-Preferred Brand Drug

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

To maximize your Benefits under the Program, Generic Drugs and Preferred Brand Drugs must be considered. If certain higher-cost drugs are prescribed and a lower-cost alternative is available, you may be required to first try the lower-cost drug at least one time before the higher-cost Non-Preferred Brand Drug will be covered.

Brand-Name Drugs Purchased When a Generic Drug Is Available

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

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

Generic Step Therapy for Certain Prescriptions

If a Generic Drug is available, you may be required to first try the Generic Drug before a Brand-Name Drug will be covered. This program is called Generic Step Therapy. If your Prescriber believes that a drug requiring Generic Step Therapy is Medically Necessary, you may contact the Prescription Drug Benefits Administrator and receive a waiver for the Generic Step Therapy requirement if the Prescription Drug Benefits Administrator determines that the use of the prescribed drug is Medically Necessary.

The Prescription Drug Benefits Administrator determines the conditions for which Generic Step Therapy may apply. Currently, those conditions are:

Acid Reflux	Acne	Allergy	Blood Pressure
Cholesterol	Depression	Enlarged Prostate	Glaucoma
Headache	Glaucoma	Insomnia	Osteoporosis
Pain	Urinary Incontinence		

Brand-Name Drugs Purchased When a Generic Drug Is Unavailable

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

Brand-Name Drugs When Medically Necessary

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

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

Generic/Brand-Name Exception

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

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

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

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

Note: The Company offers this exception at its own discretion and can remove it at any time.

Medication Management Services

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

- Drug Utilization Review – A safety feature that checks each new prescription against a record of your other Prescription Drugs and alerts the Pharmacist to potential drug interactions and other medication-related concerns.
- Specialty Pharmacy Services – A program to provide medications that treat complex conditions and usually require special handling. See the "Specialty Prescription Drug Services" section.
- Prescription Drug Coverage Review – A program that uses Evidence-based Medical Guidelines specifications to review if drug dosage and duration prescribed for certain conditions is appropriate.

Prescription Drug Benefits Administrator

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

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

Filling Your Prescriptions

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

The Prescription Drug Benefit consists of the following Services:

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

Retail Prescription Drug Services

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

Network Pharmacy

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

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

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

Non-Network Pharmacy

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

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

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

Mail Order Prescription Drug Services

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

To access the Mail Order Prescription Drug Service Claim Form, go to https://www.caremark.com/portal/asset/mof_unauth.pdf and request your prescription be filled by the Mail Order Pharmacy.

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

Filling Initial Prescriptions Under the Mail Order Prescription Drug Service

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

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

After your first fill at a retail pharmacy, go to https://www.caremark.com/portal/asset/mof_unauth.pdf to access the Mail Order Prescription Drug Service Claim Form and request your prescription be filled by the Mail Order Pharmacy.

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

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

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

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

(1) The prescription was written more than 12 months before it was filled.

(2) The time permitted under applicable state law for controlled substances has expired.

(3) The Prescription Drug is prohibited by applicable law or regulation.

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

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

Replacement/Early Refill Policy

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

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

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

Specialty Prescription Drug Services

Specialty Prescription Drugs, often called biologic or biotech drugs, are high-cost oral, injectable and infused medications.

Advanced Control Specialty Formulary

A new formulary has been implemented that addresses both appropriate utilization and preferred drug selections. This formulary includes at least one specialty drug in each therapeutic class, but may not include all FDA-approved specialty drugs in each therapeutic class. New-to-market drugs will initially not be included on the formulary until they are reviewed and a determination is made by the Prescription Drug Benefits Administrator. This determination usually occurs within 90 days, but as quickly as two weeks for drugs with significant treatment improvement. The Prescription Drug Benefits Administrator may make changes to the formulary to promote appropriate utilization of Specialty Prescription Drugs.

To access the Advanced Control Specialty Drug Formulary, go to http://www.caremark.com/portal/asset/ATT_PDL_ACSF.pdf

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

Excluded Specialty Drugs When Medically Necessary

If your Prescriber believes an excluded specialty drug is Medically Necessary, you may contact the Prescription Drug Benefits Administrator and receive a waiver for the formulary requirement if the Prescription Drug Benefits Administrator determines that the drug is Medically Necessary in your circumstance.

Specialty Prescription Drug Step Therapy

The Specialty Prescription Drug formulary may also require step therapy, so a Preferred Specialty Drug may be required before a Non-Preferred Specialty Drug prescription is filled. This specialty drug step therapy program promotes the use of safe, therapeutically equivalent and lower-cost Preferred Brand Drug before using a higher-cost, non-preferred medication. If your Prescriber believes a drug requiring specialty step therapy is Medically Necessary, you may contact the Prescription Drug Benefits Administrator and receive a waiver for the specialty step therapy requirement if the Prescription Drug Benefits Administrator determines that the drug is Medically Necessary in your circumstance.

To access the Specialty Drug Formulary, go to http://www.caremark.com/portal/asset/Advanced_Control_Specialty_Performance_Drug_List.pdf

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

The Prescription Drug Benefits Administrator determines the conditions for which specialty step therapy may apply. Conditions may include, but are not limited to, the following:

Acromegaly	Human Growth Hormones	Osteoporosis
Autoimmune	Huntington's Disease	PCKS9 Inhibitors
Cystic Fibrosis	Interferons	Prostate Cancer
Hematology	Multiple Sclerosis	Pulmonary Arterial Hypertension
Hepatitis C	Oncology	Rheumatoid Arthritis
Hereditary Angioedema	Osteoarthritis	

Additional conditions also managed under the Specialty Prescription Drug Service are conditions such as Hepatitis, radiation and chemotherapy prescriptions for cancer treatments. In general, you must fill these prescriptions through the Specialty Prescription Drug Service.

Some key characteristics of specialty drugs include:

- Need for frequent dosage adjustments and drug monitoring.

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

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

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

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

Guidelines for Purchasing Specialty Prescription Drugs

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

- Because of their high cost and potential for side effects, Specialty Prescription Drugs are at risk for waste and excessive cost, both to the participant and the Program. As a result, Specialty Prescription Drugs are limited to a 30-day Fill, except where FDA dosing guidelines require more than a 90 day Fill. Some oncology Specialty Prescription Drugs, which are especially prone to side effects, may be limited to a first Fill of 15 days. See the chart below to determine your Co-payment should your Specialty Prescription Drug be limited to a 15- or 30-day supply.
- The Specialty Prescription Drug Co-payment is based on the number of days covered by the Fill as follows:

Number of Days Supply	Co-payment Amount
Oncology prescription first Fill limit 15 days or less	One-sixth of the applicable Mail Order Co-payment
30 days or less	One-third of the applicable Mail Order Co-payment
If FDA dosing guidelines require more than a 90-day supply	100 percent of the Mail Order Co-payment

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

- For Specialty Prescription Drugs that have been formulated and have a required FDA dosing guideline greater than a 90-day supply (i.e., drugs that are administered once yearly), the Specialty Pharmacy Co-payment will be the same Co-payment amount as the 90-day Mail Order Co-payment.

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

Pharmacy Choice Can Affect Your Prescription Drug Benefits

If you fill a prescription for an eligible Prescription Drug at a Non-Network Retail Pharmacy, you must pay the Pharmacy's full, nondiscounted charge and file a Claim for Benefits. The Program reimbursement, if any, will be limited to 50 percent of the Network Retail Cost of the Prescription Drug if you are enrolled in HCN Option 1. If you are enrolled in HCN Option 2 then the Program reimbursement, if any, will be limited to 75 percent of the Network Retail Cost of the Prescription Drug or the applicable Copayment, if greater.

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

Prescription Drug Benefit Coverage and Medicare Part D

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

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

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

What Is Covered – Prescription Drugs

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

- Written by a Prescriber;
- Required by federal law to be dispensed with a written prescription;
- Consistent with Evidence-based Medical Guidelines;
- Approved by the Food and Drug Administration (FDA);
- Dispensed subject to the professional judgment of the dispensing Pharmacist according to applicable laws, regulations and limitations; and
- Included in the Prescription Drug Benefit Administrator's Standard Formulary and Advanced Control Specialty Formulary.

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

Standard Formulary

The Prescription Drug Benefits Administrator's Standard Formulary will cover at least one drug in each therapeutic class, but it may not cover all Brand-Name Drugs in every therapeutic class if there are other, equivalent Generic or Brand-Name Drugs available on the formulary. Also, new-to-market Brand-Name Drugs will not be covered until they are reviewed and a determination is made whether they will be included on the formulary by the Prescription Drug Benefits Administrator. If you or your Prescriber believes that a drug not included on the formulary is Medically Necessary, you may contact the Prescription Drug Benefits Administrator. If the Prescription Drug Benefits Administrator determines that the prescribed drug is Medically Necessary in your circumstance, the Program will waive the formulary requirement and the provisions applicable to a Non-Preferred Brand Drug will apply.

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

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

The Standard Formulary covers many, but not all, Prescription Drugs currently on the market. The categories listed below generally represent those Prescription Drugs commonly utilized under the Program, but it is not an exhaustive list of therapeutic categories or the drugs within those

categories. For information about your Prescription Drugs covered under the Program, see "What Is Covered" and "What Is Not Covered" in this section. For information about a specific Prescription Drug, contact the Prescription Drug Benefits Administrator. See the *Prescription Drug Benefits Administrator* table in the "Contact Information" section for contact information.

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

Personal-Choice Drugs

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

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

- Anti-wrinkle agents
- Cosmetic Botox
- Depigmenting agents
- Erectile dysfunction medications
- Fertility medications
- Hair-growth agents
- Hair removal agents
- Influenza treatments
- Nail fungal treatments
- Nutritional supplements (both oral and injectable)

- Ostomy and irrigation supplies
- Prescription Drug devices
- Respiratory therapy supplies (Aerochamber, Inspirease, Spacer, Peak Flow Meter, Nebulizer)
- Vaccines

Preventive Care Drugs

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

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

Examples of Preventive Care Drugs covered by the Program include:

- Folic acid vitamins prescribed due to Pregnancy or as a daily supplement for women planning to become pregnant.
- Contraceptives approved by the Food and Drug Administration prescribed to keep you from becoming pregnant.
- Aspirin prescribed as heart-attack prevention.
- Iron supplementation for Children ages six to 12 months who are at risk for iron deficiency anemia.
- Oral fluoride supplementation for Children older than six months whose primary water source is deficient in fluoride.
- Tobacco cessation intervention for anyone who uses tobacco.
- Immunizations such as Hepatitis A, Hepatitis B, Pneumococcal, Diphtheria, Tetanus, Pertussis, etc.
- Vitamin D for adults age 65 and older in community dwellings who are at increased risk for falls.
- Bowel preparation medications for adults age 50 through 74 for colorectal cancer screenings.
- Medications for primary prevention of breast cancer for women 35 and older.

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

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

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

What Is Not Covered – Prescription Drugs

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

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

Exclusions and Limitations	
Exclusions and Limitations:	Notes
Charges for the administration or injection of any drug	May be covered under Medical. Not covered under the Prescription Drug Program. See the "What Is Covered" subsection in the medical and MH/SA coverage section.
Cosmetic Botox	
Depigmenting Agents	
Diet and weight loss medications	Requires Prior Authorization; If Prior Authorization is not approved by the Prescription Drug Benefits Administrator, medications are classified as Personal-Choice Drugs. See the "Personal-Choice Drugs" section for information.
Drugs in excess of the day supply limit for drugs purchased at a Retail Pharmacy or through the Mail Order Prescription Drug Service	Except for Seasonale and Seasonique or their generic equivalent. See the Supply Limit in the "Prescription Drug Benefits at a Glance" section.
Drugs paid for by any local, state or federal government agency	Except Medicaid programs or where otherwise required by law
Drugs that are not federal legend drugs (that is, over-the-counter drugs)	The Program also covers certain over-the-counter medications that are considered Preventive Care Drugs if a prescription is provided. See the "Preventive Care Drugs" section for more information about preventive medications.
Drugs to treat nail fungal infections	
Erectile dysfunction medications	
Fertility medications	
Generic Zyban and Chantix	Not covered after two 12-week cycles per year are exhausted. After two 12 week cycles, classified as a Personal-Choice Drug. See the "Personal-Choice Drugs" section for more information.
Hair growth stimulants	
Hair removal agents	
Immunization agents, vaccines, biologicals, blood or blood plasma	May be covered under Medical. See the "What Is Covered" subsection in the medical and MH/SA coverage section.
Influenza treatment	Except Tamiflu. Flu shots may be covered under Medical.
Injectable medications that cannot be self-administered	Unless classified as a Specialty Prescription Drug or covered under the Medical portion of the Program. See the "What Is Covered" subsection in the medical and MH/SA coverage section.
Insulin Pumps	May be covered under the Medical portion of the Program. Not covered under the Prescription Drug Program.
Lancet devices	
Maintenance Drugs not purchased through the Prescription Drug Benefits Administrator's Mail Order Program	Except for the first two Fills of a prescription for the Maintenance Drug at a Network Retail Pharmacy

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

Exclusions and Limitations	
Exclusions and Limitations:	Notes
Specialty Prescription Drugs in excess of day supply limit for drugs purchased through the Specialty Prescription Drug Service	Except if the drug is a Specialty Prescription Drug for which the Program allows an extended days' supply. See the "Specialty Prescription Drug Services" section.
Support garments, and other nonmedicinal substances, regardless of intended use	
Therapeutic devices or appliances	May be covered under Medical. Not covered under the Prescription Drug Program.
Topical retinoids	Age limit applies to Retin A and its generic equivalents. The Prescription Drug Program Benefits Administrator must approve the use of Retin A and its generic equivalents for individuals age 26 or older.
Vitamins	Except vitamins that require a prescription or if covered as preventive medication. See the "Preventive Care Drugs" section for more information about preventive medications.

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

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

KEY POINTS

- *Two types of Claims may be made and appealed under the Program: Claims for Eligibility and Claims for Benefits.*
- *If your Claim is denied, you may appeal the decision within 180 days of receipt of the denial notice. It is important to follow the claims and appeal procedures below.*
- *You must file your Appeal within the time limit stated.*
- *You must exhaust all Appeal processes offered by the Program before filing a lawsuit.*

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

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

> **IMPORTANT:** If you have completed all of the claims and appeal procedures explained in the following sections and your Appeal is denied, you have the right to file suit in federal court if you are denied eligibility to participate or if you are denied benefits under the Program.

Claims for Eligibility

When to File a Claim for Eligibility

If you or your dependents attempt to enroll or participate in the Program and are told you or your dependent is not eligible to enroll or participate in the Program, you may call the Eligibility and Enrollment Vendor to attempt to resolve the issue. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section. If the issue is not resolved to your satisfaction, you may file a written Claim for Eligibility.

> **IMPORTANT:** The Eligibility and Enrollment Vendor should only be contacted for denials related to enrollment or participation in the Program. For benefit-related situations, you will need to contact the Benefits Administrator. Please see the "Claims for Benefits" section for the Claim for Benefits process.

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

How to File a Claim for Eligibility

To file a Claim for Eligibility, you must submit your written Claim for Eligibility, along with any documentation that supports your Claim for Eligibility, to the Eligibility and Enrollment Vendor at the address listed in the "Contact Information" section. To submit a Claim for Eligibility you must file a completed Claims Initiation Form (CIF) or other written document asserting your Claim, along with any supporting documentation, with the Eligibility and Enrollment Vendor. A CIF is available from the Eligibility and Enrollment Vendor on request.

The Eligibility and Enrollment Vendor will notify you of its decision within 30 days of the date it receives your Claim for Eligibility. The Eligibility and Enrollment Vendor may extend this period once (for up to 15 days) if it determines that special circumstances require more time to decide your Claim for Eligibility. If this happens, you will receive a written notice of the special circumstances requiring the extra time and when to expect a response.

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

Once the information is received, the Eligibility and Enrollment Vendor will decide your Claim within the time remaining in the initial 30-day or extended 45-day review period, whichever applies.

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

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

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

What Happens If Your Claim for Eligibility Is Denied

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

- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.

- If applicable, a description of any additional information needed to make your Claim for Eligibility acceptable and the reason the information is needed.
- A description of the Program's Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

How to Appeal a Denied Claim for Eligibility

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

See the *Eligibility and Enrollment* Vendor table in the "Contact Information" section for contact information.

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

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

Internal Appeals Process

Eligibility and Enrollment Appeals Committee (EEAC) members, who were not involved in the initial decision to deny your Claim for Eligibility, will review and decide your Appeal. In the review of your Appeal, the EEAC will not afford deference to the denied Claim.

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

The EEAC's decision on your Appeal will be in writing and will include the specific reasons and references to Program provisions relied on to make the decision. The EEAC's decision will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your Claim for Eligibility. The EEAC has been delegated the exclusive right to interpret and administer applicable provisions of the Program, and its decisions are conclusive and binding and are not subject to further review under the Program. If your Appeal is denied, it is final and is not subject to further

review. However, you may have further rights under ERISA, as described in the "ERISA Rights of Participants and Beneficiaries" section.

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

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

External Review Process for Certain Eligibility Claims

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

Claims for Benefits

This section explains how to file a Claim for Benefits and how to file an Appeal if your Claim for Benefits is denied. You must file your Appeal within the time limit stated below.

How to File a Claim for Benefits

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

The following are not considered a Claim for Benefits:

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

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

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

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

Your UnitedHealthcare (UHC) claim form is available at https://www.e-access.att.com/usersvcs/cspsaml/?service=upoint&servicetype=prod&RelayState=https%3A%2F%2Fsso.hewitt.com%2Fportal%3FpageCd%3DL_IST_PAGE_SPD62

By clicking the link above, you are leaving the SPD document and are going to a third-party managed website to view information and materials that are not part of the SPD.

Claim Filing Limits

You or your Provider must submit your Claim for Benefits within one year after the date of Service or the date you receive the prescription.

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

Information to Include in Your Claim for Benefits

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

Medical Claim Requirements (including MH/SA Claims)	Prescription Drug Claim Requirements

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

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

Payment of Benefits

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

The Benefits Administrator will make a Benefit determination as set forth in the "Benefit Determinations" section. Once a Claim for Benefits is approved, Benefits will be paid directly to you unless either:

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

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

Benefit Determinations

Post-Service Claims

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

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

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

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

Pre-Service Claims

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

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

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

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

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

Urgent Care Claims That Require Immediate Action

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

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

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

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

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

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

Concurrent Care Claims

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

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

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

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

What Happens If Your Claim for Benefits Is Denied

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

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

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

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

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

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

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

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

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

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

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

How to File an Appeal for Benefits

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

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

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