Bind On-Demand
Health Plan

(Administered by Bind Benefits)

Summary Plan Description
For Retired and Inactive Former CenturyLink Employees

CenturyLink, Embarq, Qwest Post 1990 Management, Qwest Post 1990 Occupational Retirees (including inactive and COBRA Participants)

CenturyLink, Inc.

Effective January 1, 2020

This SPD must be read in conjunction with the ***Retiree Retiree General Information SPD***, which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

CenturyLink®

Issued August 04, 2020

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1. INTRODUCTION

CenturyLink, Inc. (hereinafter "CenturyLink" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the self-funded Bind On-Demand Health Plan and includes a description of the available prescription drug benefits(together, the medical and prescription benefits in this document are referred to as the **"Plan").** The prescription drug benefits are technically provided as a benefit option under the CenturyLink Health Care Plan, a separate medical plan from the Bind On-Demand Health Plan. However, the two medical plans work together to administer these benefits.

This SPD must be read in conjunction with the **Retiree General Information SPD** which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

The effective date of this SPD is January 1, 2020. In the event of any discrepancy between this SPD and the official *Plan Document*, the *Plan Document* shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the **Retiree General Information SPD** and materials you receive at Annual Enrollment) (hereafter "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under the Plan. These documents make up your official Summary Plan Description for the Bind On-Demand Health Plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This Bind On-Demand Health Plan benefit option and the prescription drug Benefits under the Plan are self-funded; however, certain other benefit plan options under the Plan may be insured.

A. The Patient Protection and Affordable Care Act Known as the "Affordable Care Act"

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan provides minimum essential coverage. In addition, The Affordable Care Act establishes a minimum value standard of benefits to a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

> This SPD is for eligible former CenturyLink (including the Qwest Represented Retired and Inactive Former Employees). Active Employees should refer to their own applicable SPDs, with distinct terms and conditions.

B. Company's Reserved Rights

CenturyLink reserves the right to amend or terminate any of the Benefits provided in the Plan – with respect to all classes of Covered Person, retired or otherwise – without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreement.

The Plan Administrator, the CenturyLink Employee Benefits Committee, and its delegate(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan and all benefit options — including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the **Retiree General Information SPD**.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or benefit premiums under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Service Center to correct the error or omission. *There are deadlines to file claims and benefit related actions; please refer to* Section titled "**Time Deadline to File a Benefit Claim and Time Deadline to File a Benefit-Related Lawsuit**" on page 61 of this SPD and in *the Retiree Retiree General SPD for more information about the timing of these deadlines.*

C. The Required Forum for Legal Disputes

After the claims and appeals procedures are exhausted and a final decision has been made by the Plan Administrator, if an Eligible Participant wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

D. How to Use This Document

The SPD is designed to provide you with a general description, in non-technical language of the Benefits provided under the Bind On-Demand Health Plan benefit option without describing all the details set forth in the *Plan Document*. The SPD is not the *Plan Document*. Other important details can be found in the *Plan Document* and the **Retiree General Information SPD**. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan. If any terms of the *Plan Document* conflict with the contents of the SPD, the *Plan Document* will always govern.

Capitalized terms are defined in the Glossary and/or throughout this SPD and in the **Retiree General Information SPD**. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or CenturyLink.

References to "you" and "your" are references to people who are Covered Persons as the term is defined in the **Retiree General Information SPD**.

You are encouraged to keep all the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, Summaries of Benefits Coverage, Annual Enrollment Guides and addendums) for future reference. Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.

Please note that your health care Provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

See the **Retiree General Information SPD** for more information as noted in the section titled "General Plan Information" and throughout this document.

E. Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, Retiree, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is approved or (global) payable under the Plan. A determination by the Claims Administrator or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Plan does not mean that the recommended course of treatments, services or procedures should not be provided to the individual or that

they should not be provided in the setting or facility proposed. ***Only you and your health care Provider can decide what is the right health care decision for you.*** *Decisions by the Claims Administrator or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.*

F. CenturyLink's Right to Use Your Social Security Number for Administration of Benefits

CenturyLink retains the right to use your Social Security Number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security Numbers for benefit administration purposes, CenturyLink generally takes the position that ERISA preempts such state laws.

2. GENERAL PLAN INFORMATION

This SPD **must** be read in conjunction with the **Retiree General Information SPD** which explains details of your coverage and provides a listing of the other benefit options under the plan.

Refer to the **Retiree General Information SPD** for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Coordination of Benefits
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- A Statement of Your ERISA Rights
- Notice of HIPAA Rights
- Your Rights to COBRA and Continuation Coverage
- Statement of Rights Under the Women's Health and Cancer Rights Act
- Statement of Rights Under the Newborns' and Mother's Health Protection Act
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified Medical Child Support Order (QMCSO)

You can call the CenturyLink Service Center at 866-935-5011 or 800-729-7526, option 2 and option 1 to request a paper copy of the **Retiree General Information SPD** or you can go online at **centurylinkhealthandlife.com** to obtain an electronic copy.

A. You May Not Assign Your Benefits to Your Provider

Participants and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care provider (your "Providers") any right you have (or may have) to:

1. receive any benefit under this Plan,
2. receive any reimbursement for amounts paid for services rendered by Providers, or
3. request any payment for services rendered by Providers.

The Plan prohibits Participants and Eligible Dependents from voluntarily or involuntarily assigning to Providers any right you have (or may have) to submit a claim for benefits to the Plan, or to file a lawsuit against the Plan, the Company, the Plan Administrator, the Claims Administrator (Bind), the Pharmacy Claims Administrator, the appeals administrator or any other Plan fiduciary, administrator, or sponsor with respect to Plan benefits or any rights relating to or arising from participation in the Plan. If Participants and Eligible Dependents attempt to assign any rights in violation of the Plan terms, such attempt will be not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Plan provision will not interfere with the Plan's right to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate an assignment of Participants' and Eligible Dependents' rights to the Provider or waive the Plan's rights to enforce the Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to Participants and Eligible Dependents and shall satisfy the Plan's obligations under the Plan.

B. Consequences of Falsification or Misrepresentation

You will be given advance written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit false, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of your or your Dependent's coverage.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the CenturyLink Service Center at 866-935-5011 or 800-729-7526, Option 2 and Option 1, within 45 days, regardless if you have an obligation to provide health insurance coverage to your ex-spouse through a Court Order.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, or omitted to update a dependent's status, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan or to refund premiums.
- While a court may order that health coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company or the Plan.
- You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to the Plan Administrator and or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility and to verify claims.

Note: *All Participants by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.*

For other loss of coverage events, refer to the **Retiree General Information SPD** as applicable.

C. You Must Follow Plan Procedures

Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal health information private and protected. For example, contacting someone at the Company other than the Claims Administrator or Plan Administrator (or their duly authorized delegates) in order to try to get a Benefit claim issue resolved is not following the Plan's procedures. If you do not follow the Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected.

D. Plan Number

The Plan Number for the Bind On-Demand Health Plan is 514.

3. CLAIMS ADMINISTRATOR AND CONTACT INFORMATION

The Claims Administrator customer service staff — Bind Help — is available to answer your questions about your coverage Monday through Friday: 6:00 AM – 9:00 PM (CST). Hours are subject to change without prior notice.

Contact information	
Bind On-Demand Health Coverage Plan (Medical) **Member Service**	**Phone:** 833-576-6519 6:00 a.m.-9:00 p.m. (Central) Monday-Friday **Website: MyBind.com** **Mobile App:** Download the MyBind mobile app from the Apple App Store or Google Play Store.
OptumRx (Pharmacy) Member Service	**Refer to "PRESCRIPTION DRUGS" on page 45 of this SPD for more information. The Pharmacy Claims Administrator.**
Bind Website and App	**Once enrolled:** You are encouraged to visit **MyBind.com** or download the MyBind mobile app from the Apple App Store or Google Play Store for easy access to what is covered , how much it costs and where you can get care. **When enrolling: CenturyLink.com/ChooseBind** **Access Code:** CTL2020

Contact information	
Bind (Medical Claims Administrator) Mailing Address	**For Medical Claims:** To file medical claims, appeal requests and any written inquiries to: **Attention: Claims** **Bind Benefits, Inc.** P.O. Box 211758 Eagan, MN 55121 **For Medical Appeals/Complaints:** To file a medical appeal for Bind On-Demand, mail the appeal to: **Attn: Appeals** **Bind Benefits, Inc.** P.O. Box 211758 Eagan, MN 55121 For more information on how to appeal a claim, refer to "**CLAIMS PROCEDURES**" on page 54 of this SPD.
OptumRx (Pharmacy Claims Administrator) Mailing Address	**For Prescription Claims:** To file a prescription drug appeal, mail the appeal to: **UnitedHealthcare Appeals** P.O. Box 30432 Salt Lake City, UT 84130-0432

4. BIND ON-DEMAND HEALTH PLAN BENEFIT OPTION

A. Eligibility

Core

If you are eligible for medical coverage under the Plan, (refer to the **Retiree General Information SPD** for more information regarding eligibility under the Plan and other important information), you may have several choices of which medical benefit option to enroll in.

Add-Ins

Once you enroll in Core, then you and any eligible covered dependents are also eligible to sign up for Add-Ins. [Please refer to the "**Here's How It Works**," on page 8, and "**What Are My Benefits?**" on page 8 for detailed explanations of **Core** and **Add-Ins**.] Add-In coverage is temporary coverage (120 days from enrollment) available for 30 select, plannable procedures that you can add if and when you or a dependent need one of those procedures. An additional copay and a set number of ongoing, post-tax payroll deductions will apply for Add-In coverage. For more information about how Add-Ins work, please see "**ADD-INS**" on page 37.

You may sign up for Add-Ins during the Plan Year only if you or an eligible covered dependent has an Adverse Health Factor.

You may purchase an Add-In prior to the Plan Year effective date once eligibility and Core enrollment information is received by Bind. Add-in coverage purchased prior to the Plan Year start date will become effective on the first day of the Plan Year and remain in effect for 120 days.

To enroll themselves and any eligible dependents in an Add-In, eligible employees should refer to the "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**" on page 5 for information on how to connect with Bind by web, mobile app, and phone.

B. When Does My Coverage Begin and End: Start Dates

Core

Refer to the **Retiree General Information SPD** for more information regarding eligibility under the Plan and other important information.

Add-Ins

YOU MUST PURCHASE ADD-IN COVERAGE AT LEAST THREE DAYS PRIOR TO THE DATE OF WHEN SERVICES WILL BE RENDERED. If you are enrolled in Core you can enroll in an Add-In by connecting with Bind via web, mobile app, or phone using the information found in the Claims Administrator and Contact Information section. [Please refer to the "**Here's How It Works**," on page 8, and "**What Are My Benefits?**" on page 8 for detailed explanations of **Core** and **Add-Ins**.]
Your Add-In coverage will begin on one of the following dates based on when you sign up:

- If you enroll in Core and purchase an Add-Ins during open enrollment or prior to the Plan Year Effective Date as a new enrollee to the Bind Plan, your Add-In coverage begins on the first day of the Plan Year provided that the Add-In was purchased at least three days prior to the Plan Year Effective Date.
- If you are already enrolled in Core and purchase an Add-In during the Plan Year, your Add-In coverage will begin on the third business day after you purchase the Add-In and will continue for 120 days after the sign up even if the date of Add-In procedure falls in a subsequent Plan Year.

You can see the Effective Dates of your Add-In(s) at any time connecting with Bind via web, mobile app, or phone using the information found in the Claims Administrator and Contact Information section.

C. When Does My Coverage Begin and End: End Dates

Core

Refer to the **Retiree General Information SPD** for more information regarding eligibility under the Plan and other important information

Add-Ins

Your coverage for an Add-In will terminate on the earliest of the following dates:

- **The date your enrollment in Core ends**
- **You reach the end of the Add-In coverage period which is 120 days from effective date**

The remainder of this SPD provides more details about the specific benefits and provisions of the Bind On-Demand Health Coverage Plan benefit option.

5. BIND ON-DEMAND HEALTH PLAN: PLAN FEATURES AND HOW THE PLAN WORKS

Bind's On-Demand Health Plan design allows each enrolled Covered Person to select from a broad menu of coverage options uniquely suited to their needs. The Bind Plan has features that you know

and understand – comprehensive coverage, a zero deductible, copays for Covered Services and an annual out-of-pocket maximum. The on-demand feature allows you to add additional coverage if and when needed.

A. Here's How It Works

When a Covered Person enrolls in Bind, they automatically receive Core coverage. Core coverage provides substantial coverage of physician and hospital services – including for example preventive care, emergency and urgent care, office visits, inpatient and outpatient hospital visits and prescription drugs. Core coverage also provides substantial coverage for common conditions and events, such as maternity care, cancer treatment and physical therapy. Core coverage does not provide coverage for certain excluded medical procedures specified below. However, coverage for many of the excluded procedures is available by signing up for "Add-In" (short for "additional insurance") coverage.

Add-Ins are separate coverage options for 31 less common procedures including, for example, hernia repairs, hysterectomies, lumbar spine fusion and knee and shoulder arthroscopies. Covered Persons can sign up for Add-In coverage at the time of enrollment (initial enrollment, Open Enrollment or special enrollment) or at any time during the Plan Year if the Covered Person experiences an Adverse Health Factor. You must purchase Add-In coverage at least three days prior to the date of when services will be rendered. Each Add-In has a separate copay, which is applied your annual out-of-pocket maximum. When you sign up for an Add-In, you will also be required to pay an additional premium which will be spread over a number of months. To summarize, Bind's On-Demand Health Plan includes both Core coverage, and to the extent a Covered Person pre-purchases one or more Add-Ins, Add-In coverage in any combination selected by the Covered Person. Each combination of Core coverage and Add-In coverage is a "benefit package" under the Plan. This allows you to tailor coverage to your needs.

Covered Person and Bind share in the cost of the Plan. Your contribution amount depends on the benefit package you select and the dependents you choose to enroll. Your contributions for Core and applicable Add-In coverage are either deducted from your pension checks on an after-tax basis or direct billed to you.You can obtain current contribution rates by contacting the Plan Administrator.

B. What Are My Benefits?

The Plan includes Core coverage, and if elected and pre-purchased by a Covered Person, Add-In coverage. Plan benefits are payable only for Covered Services that are Medically Necessary.

There is no deductible for either Core or Add-In coverage. Copays are required for both Core and Add-In coverage. Plan payment begins after you have satisfied the required copay(s).

Discounts are negotiated with In-Network Providers. If you use In-Network Providers, you will pay lower copays and the Provider will not charge you any additional fees. If you use an Out-of-Network Provider for core services, you will pay (in addition to your copay) all charges that exceed the Usual and Customary amount. Copays for Core coverage, prescription drugs, and Add-Ins can be found in the following sections:

- Core coverage: Section 12.B
- Prescription drugs: Section 21.A
- Add-Ins: Section 19.A

Add-In services and procedures must be received from In-Network Providers.

Once your copays reach your applicable out-of-pocket maximum, the Bind plan pays 100% of Eligible Charges for both Core and Add-In coverage. Expenses you pay for Out-of-Network services in excess of the Usual and Customary amount are not counted towards the satisfaction of the out-of-pocket maximums.

C. Network and Out-of-Network Benefits and Providers (for those residing in a Network area)

> **Important**
> Bind works to provide you with access to Network Providers. You will notice the Bind website listed throughout the SPD, **MyBind.com** which can be accessed by you to obtain benefit information, ***locate Network Providers***, view ID Cards, and research health topics. Please access the website identified on the back of your ID card.

In-Network Benefits

As a Covered Person in this Plan, you may choose any eligible Provider of health services each time you need to receive a Covered Service. The choices you make may affect the amount you pay, as well as the level of benefits you receive. You will receive the best benefit from this Plan when you receive care from In-Network Providers; in most instances, your out-of-pocket expenses will be less. The Plan features a large network of In-Network Providers.

These Providers will:

1. Accept payment based on the allowed amount previously contracted;
2. File claims for you; and
3. Be paid based on negotiated rate.

In-Network Providers may take care of Prior Authorization, Pre-admission Notification, preadmission certification, and/or Emergency admission notification requirements for you. Therefore, it is important that you confirm the Provider's status before you receive services. A Provider's status may change. For current In-Network Provider information, refer to **CenturyLink.com/ChooseBind** or connect with Bind via web, mobile app, or phone using the information found in the Claims Administrator and Contact Information section.

You must show your identification "ID" card every time you request health care services from a network Provider. If you do not show your ID card, network Providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Out-of-Network Benefits

If you choose to seek Core services outside the network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Charge. The amount in excess of the Eligible Charge could be significant, and this amount may not apply to the Out-of-Network, out-of-pocket maximum. You may want to ask the Out-of-Network Provider about their billed charges before you receive care.

Out-of-Network Benefits apply to Covered Services that are provided by a non-network or Out-of-Network Provider, or Covered Services that are provided at a non-network facility.

Out-of-Network Providers are not required to file claims. In that case, contact Bind Help for a claim form to file the claim. This may require an itemized bill from the Provider.

Depending on the geographic area and the service you receive, you may have access through the network partner's Shared Savings Program to non-network providers who have agreed to discount their charges for covered health services. If you receive covered health services from these providers, the copay will remain the same as it is when you receive covered health services from non-network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive covered health services from Shared Savings Program providers than from other non-network providers because the eligible expense may be a lesser amount. Refer to the "**GLOSSARY**" on page 73 of this SPD for details about how the Shared Savings Program applies.

Add-Ins are not covered if you see an Out-of-Network Provider.

D. Virtual Network Benefits

If you live outside of the Bind plan area ("out of area") the Plan will still pay Benefits for you and your covered dependents at Network levels. This "Virtual Network" is designed to help Employees who live in rural areas with no access to Network providers. You may be asked to pay the provider at the time of service and then submit a claim to the Plan for reimbursement.

Covered services will be subject to "Eligible Expenses" as described in the Glossary. You will automatically be enrolled in the Virtual Network if this is applicable (otherwise this is not available to you) your ID will include an "out of area" designation if this applies.

E. Network and Out-of-Network Providers/Facilities (for Virtual Network)

You have the freedom to choose the Physician, facility or health care professional you prefer each time you need to receive Covered Health Services.

The choice you make to receive these Network Benefits or Out-of-Network Benefits affect the amounts you pay.

Generally, when you receive Covered Health Services from a Network provider (including facilities), you pay less than you would if you receive the same care from an Out-of-Network provider. However, since you may not have direct access to the Network providers, your level of Benefits will be the same if you visit a Network provider or Out-of-Network provider. Because the total amount of Eligible Expenses may be less when you use a Network provider, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

Note: You may find some types of Network providers near you or you can travel further to seek care from a Network provider if you wish.

> **Note:** Network providers are independent practitioners and are not Employees of CenturyLink or the Claims Administrator.

Out-of-Network Provider

These Providers are not listed by Bind on **MyBind.com**. It is best to confirm with the Provider's office before you receive services if they are In-Network or an Out-of-Network provider. Provider network status is subject to change.

Possible Limitations on Provider Use

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered

Health Services. If you don't make a selection within 31 days of the date you are notified, the Claims Administrator will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the Out-of-Network level.

6. HEALTH REIMBURSEMENT ACCOUNT (HRA) AND BIND

If you elect the Bind On-Demand Health Plan and have a CDHP Health Reimbursement Account (HRA) balance these dollars will follow you. Your account dollars will not be available until after the run out period (for claims to clear under the CDHP Plan benefit option).

This typically takes 90 days. Under the Bind On-Demand Plan you will not receive a Health Care Savings Card to use.

Note: This roll over provision also applies if your coverage ends and you elect one of these Plan benefit options under COBRA or

Starting April 15th, 2020, you will have access to your HRA account balance. You can then use that money to pay yourself back for eligible Bind health care expenses.

To be reimbursed from your available HRA funds simply submit a reimbursement form, called a *Request for Withdrawal Form*, for the HRA Eligible Expenses that have been incurred. A *Request for Withdrawal Form* is available on the Internet at **www.myuhc.com**. For reimbursement from your HRA, you must include proof of the expenses incurred as indicated on the Request for Withdrawal Form. For HRA Eligible Expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from your group medical plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical plans.

To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare HRA Claims submittal address:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506

See the Health Reimbursement Account SPD for more information.

Note: You cannot be reimbursed for any expense paid under your medical plan, and any expenses for which you are reimbursed from your rollover HRA cannot be included as a deduction or credit on your federal income tax return.

7. PRIOR AUTHORIZATION AND PRE-ADMISSION NOTIFICATION

For Providers that are In-Network, Prior Authorization is required for certain Covered Services in Core. Prior Authorization is not required for Add-In procedures; however, notification of an inpatient stay, also known as Pre-Admission Notification, is required for all inpatient stays. Inpatient stays will be reviewed for Medical Necessity, length of stay and level of care. All acute inpatient rehabilitation (AIR) admissions; long-term acute care (LTAC) admissions; and skilled nursing facility admissions are subject to Medical Necessity review pre-admission. If you have questions about Prior Authorization or Pre-admission Notification, please contact Bind Help.

If you are using an Out-of-Network Provider, you are responsible for ensuring that any necessary Prior Authorizations and Pre-admission Notifications have been obtained or you could be subject to "balance billing" by your Provider. Balance billing occurs when an Out-of-Network Provider bills you for the balance remaining on your bill for services not covered by the Plan.

The Prior Authorization list is subject to change without notice. The most current information can be obtained by having your Provider contact the pre-certification number on your ID card.

Prior Authorization is recommended for certain services including but not limited to:

- All non-emergency inpatient admissions (hospital, skilled nursing, residential programs, etc.)
- Dental and oral surgery services that are accident-related for the treatment of injury to sound and healthy, natural teeth; temporomandibular joint (TMJ) surgical procedures; and orthognathic surgery
- Auditory implants
- Mental health services (inpatient/residential, partial residential, outpatient programs, ABA therapy)
- Bone growth stimulators
- Cancer treatments including radiation and chemotherapy
- Clinical Trials and services considered Investigative or Experimental
- Drugs or procedures that could be construed to be Cosmetic;
- Durable medical equipment (DME), orthotics and prosthesis in Tier 9 and above
- Gender Dysphoria services
- Genetic tests
- Home health care
- Hospice services
- Injectable medications
- Joint replacement and spine surgeries (not included in Add-Ins)
- Neurostimulation
- Non-Emergency air transportation
- Outpatient surgeries and therapies
- Sleep apnea procedures and studies in the lab setting
- Transplant services, except cornea
- Certain Formulary medications (see Section 20. "**PRESCRIPTION DRUGS**" on page 45)

8. BIND CLINICAL PROGRAMS

A. Bind Care Management

Bind Care Management offers support to help you use your benefits, improve your health and achieve an optimal quality of life. At Bind, we believe that people who are more involved in their health care are happier with their decisions and more likely to follow their treatment plans, which leads to better health. We care about your preferences for treatment and about the costs to you.

Our care managers act as an advocate for you and your family by:

- Identifying available treatment options
- Assisting you in making important healthcare decisions
- Coordinating your care with your healthcare Providers
- Researching resources, such as condition-focused programs, support groups and financial assistance
- Offering personalized coaching to help you live better with illness or recover from an acute condition
- Helping you develop self-management skills

Although your care manager will be your primary program contact, you and your Physician will always make the decisions about your treatment. By working closely with your Physician and using the resources available in your community, this program can help you through a difficult time.

It is your choice to participate in Bind Care Management. There are no extra charges for these services, and you can end your participation at any time, for any reason. Participation in this program will not affect your benefits. Contact Bind Help if you think you can use this support.

B. Transplant Centers of Excellence Case Management

For a Solid Organ and Blood/Marrow transplant to be a Covered Service, you must use a facility designated as a Transplant Center of Excellence. Most transplants are expensive and complicated. At Bind, we ensure you are going to a reputable facility that has expertise in the specific type of transplant you need. Contact Bind Help at the number on your ID card for information on who is in the Transplant Center of Excellence network and to get access to their services.

A dedicated nurse case manager who specializes in transplant cases will provide assistance in:

- Selecting the place you will receive your transplant.
- Scheduling your evaluation at the transplant facility.
- Following up with you routinely while on the transplant list.
- Discharge planning, post-transplant support and ongoing help with your care needs.

Organs that are included in the program are: heart, lung, kidney, liver, pancreas, intestine, and bone marrow (blood forming stem cell transplants). While corneal transplant is a solid organ transplant, it is not considered part of the Transplant Centers of Excellence program.

C. Bind Condition-Focused Programs

A Condition-Focused Program (CFP) is a provider contracted with Bind to provide health-related services that prevent, treat, or reverse one or more chronic diseases or conditions. CFP services may include education, decision-support, coaching, nutritional support, caregiver support, meditation, therapeutic movement, and other therapeutic or diagnostic services that would not otherwise be considered medically necessary, or would be excluded benefits, if provided outside of a Bind CFP. CFP services may be provided by digitally-enabled applications (mobile or online) and/or licensed or non-licensed healthcare professionals including but not limited to [lactation consultants, doulas, nutritionists, health coaches, community health workers, and trained peers]. Bind CFPs are credentialed according to the Bind Condition-focused Program Policy and are provided as covered benefits solely at the discretion of the Plan Sponsor.

Diabetes Care Management

Bind offers a personalized virtual diabetes control program focused on nutritional changes, medication changes, biomarker feedback. The program is for Type-II diabetics that meet certain criteria. To find out additional information, visit the MyBind app or call Bind Help.

Chronic Condition Self-Management

This program is a six-week online workshop aimed at empowering chronic condition self-management. Topics covered in the workshops include condition management skills such as making informed treatment decisions and appropriate use of medications and behavioral skills.

Maternity Support Program

Bind offers a maternity support program for access to maternal and pediatric experts. To find out additional information, connect with Bind via web, mobile app, or phone using the information found in the Claims Administrator and Contact Information section.

9. TRANSITION OF CARE AND CONTINUITY OF CARE

Bind offers Transition of Care and Continuity of Care for Core coverage. If you are new to Bind and are actively receiving treatment from a provider who is not in our network, you may be eligible to receive Transition of Care benefits. Transition of Care benefits allows you to see the Out-of-Network Provider at the In-Network copay for a limited time due to a qualifying medical condition until the safe transfer to an In-Network Provider can be arranged. If you are currently covered by Bind, and your health care Provider leaves the network, you have the opportunity to apply for Continuity of Care. Continuity of Care benefits, if approved, allow you to continue to see the Out-of-Network Provider while paying In-Network copays until a safe transition can be made to an In-Network Provider. As Add-In services must be with an In-Network Provider, the Transition of Care benefit does not apply to Add-Ins.

The following criteria must be met for your Transition of Care or Continuity of Care application to be considered:

- You are currently enrolled in Core and actively receiving care for a Covered Service and your Provider is no longer In-Network, or
- You are newly eligible for Bind and currently receiving care for a Covered Service and your current Provider is not In-Network

In addition, you must have at least one of the following conditions:

- **Serious Acute Condition:** A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration such as a heart attack or stroke.
- **Scheduled Surgery/Procedure:** Surgery or another procedure which has been recommended and documented by the Provider and scheduled to take place within 120 days of the enrollee's effective date or Provider termination date and is authorized for continued care by Bind.
- **Pregnancy:** For Covered Persons in their second trimester of pregnancy extending through two months after giving birth, or if the pregnancy is considered high risk at any time.
- **Serious Chronic Condition:** A medical condition due to a disease, illness, or other medical problem or mental health disorder that is serious in nature and that persists without full cure or worsens over time or requires ongoing treatment to maintain remission or prevent deterioration.

- **Terminal Illness:** An incurable or irreversible condition that has a probability of causing death within one year or less. Coverage extends for the duration of the terminal illness.
- **Transplant:** A transplant recipient in need of ongoing care due to complications associated with the transplant.

To request an application for Transition of Care (new members) or Continuity of Care (existing members), call Bind Help at the member number on your Bind ID card. The application must be completed and returned within 30 days of the effective date of coverage for new members or within 30 days of the Provider leaving the network for existing members. After receiving your request, Bind will review and evaluate the information provided and send you a letter to let you know if your request was approved or denied. A denial will include information about how to appeal the determination.

10. CLINICAL TRIALS

Clinical trials are research studies designed to find ways to improve health care or to improve prevention, diagnosis, or treatment of health problems. The purpose of many clinical trials is to find out whether a medicine or treatment is safe and effective for treating a certain condition or disease. Clinical trials compare the effectiveness of this medicine or treatment against standard, accepted treatment, or against a placebo if there is no standard treatment. Participants in clinical trials are typically randomized to different treatment arms and based on that randomization may receive either the study intervention or the control intervention. Services provided in a clinical trial typically include the interventions being evaluated (study agent and control agent) and other clinical services required to evaluate the effectiveness and safety of the interventions being compared.

In compliance with Federal law, your benefits cover routine health care costs for qualifying individuals participating in approved clinical trial.

All participation in clinical trials requires Prior Authorization.

A. Coverage with Evidence Development

Bind implements written “coverage with evidence development” (“CED”) medical policies in order to accelerate the discovery and adoption of healthcare services that generate better clinical outcomes at lower cost. CED medical policies provide coverage for promising new technologies that have not yet been established as effective according to generally accepted professional medical standards, but:

1. **Are not eligible to be covered under the clinical trials policy;**
2. Would otherwise be considered medically necessary;
3. Are safe;
4. Show substantial potential to improve health outcomes and reduce waste and inefficiency in the health care system;
5. Are being evaluated in a high-quality research or clinical study;
6. Can be operationally administered by bind;
7. Do not substantially increase healthcare costs;
8. And meet all of the requirements defined by the bind clinical rationale policy and procedures.

Services covered by a CED policy are covered according to the Core benefit design and do not require Prior Authorization.

11. COVERED BIND ON-DEMAND HEALTH PLAN BENEFITS

The tables below describing the Core and add-in services include copays applicable to the services. Some copays are listed as a range. You may be eligible for reduced copays for certain Benefits and for specific condition-based programs if you use In-Network Providers that Bind has designated as preferred, high-value Providers. **The full range of copays displayed may not be available in all areas or for all services. You can find provider specific copay amounts by utilizing the Search tool on the MyBind app or website, or by calling Bind Help.**

Bind determines which In-Network Providers are preferred, high value Providers by considering, for example, their rates of effectiveness, low risk of complications and the total cost charged by the Provider.

The copays include ranges which will be updated on a quarterly basis. The Bind website and app will demonstrate when a cost for a specific provider will be moving up or down at a future date. Any changes to the specific provider copay will be displayed sixty days in advance. It is important to always connect with Bind (via web, mobile app, or phone) prior to utilizing any services covered under the Plan.

To learn more about the availability of preferred, high-value Providers and the potential for reduced copay amounts please visit **CenturyLink.com/ChooseBind**, or connect with Bind via web, mobile app, or phone using the information found in the Claims Administrator and Contact Information section.

A. Core – Benefit Features

The following chart shows the deductibles and out-of-pocket maximums for Core coverage.

Core	In-Network and Virtual Network	Out-of-Network
Deductible	$0	$0
Out-of-Pocket Maximum		
Individual	$5,000	$10,000
Family	$10,000	$20,000

Notes:

- After you reach the individual out-of-pocket maximum or you and your dependents meet the family out-of-pocket maximum collectively, per Plan Year for copays (Core or Add-In), Core covers the remaining Eligible Charges in-curred. You must pay any amounts greater than the out-of-pocket maximum if any benefit, day, or visit maximums are exceeded. Expenses you pay for any amount in excess of the Usual and Customary amount will not apply towards satisfaction of the out-of-pocket maximum.
- The amount applied to your In-Network, out-of-pocket maximum also applies to your Out-of-Network out-of-pocket maximum not vice versa.

B. Core

Acupuncture Services	In-Network and Virtual Network	Out-of-Network
Office Visit	$10 - $70 copa y / visit	$130 copay / visit
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit

Notes:

- Limited to 60 visits or services per Covered Person per Plan Year for In-Network and Out-of-Network Providers combined.

Ambulance Services	In-Network and Virtual Network	Out-of-Network
	$400 copay / trip	$400 copay / trip

Notes:

- Ground or air ambulance, as the Plan Administrator determines appropriate.
- Emergency ambulance services and transportation provided by a licensed ambulance service to nearest hospital that offers emergency health services.
- Ambulance service by air is covered in an emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, Plan Administrator may pay benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services.
- Ambulance Services for non-emergency: this Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as Bind determines appropriate) between facilities when the transport is:
- From a non-network hospital to a network hospital
- To a hospital that provides a higher level of care that was not available at the original hospital
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.
- Air ambulance services will be reviewed for Medical Necessity.

Autism Spectrum Disorder Services	In-Network and Virtual Network	Out-of-Network
Mental Health Office Visit	$35 copay / visit	$130 copay / visit
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hospital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- Core pays for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.
- These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Service for which Benefits are available under the applicable medical Covered Services categories as described in this section.
- Autism Spectrum Disorder Services are reviewed for Medical Necessity. Have your Provider request a Prior Authorization.
- Benefits include:
  - Diagnostic evaluation assessment and treatment planning
  - Treatment and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management services
  - Crisis intervention
  - Residential treatment
  - Partial hospitalization/Day treatment
  - Outpatient treatment
- See Hospital Services for other coverage notes.

Chemotherapy	In-Network and Virtual Network	Out-of-Network
Office Visit	$10 - $70 copa y / visit	$130 copay / visit
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hospital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- The Plan pays Benefits for therapeutic treatments received in an office, outpatient hospital or alternate facility, including intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.
- Covered Health Services include medical education services that are provided in an office, outpatient hospital or alternate facility by appropriately licensed or registered healthcare professionals.
- See Hospital Services for other coverage notes.

Chiropractic Services	In-Network and Virtual Network	Out-of-Network
Office Visit	$35 copay / visit	$130 copay / visit
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit

Notes:

- Limited to 60 visits or services per Covered Person per Plan Year for In-Network and Out-of-Network Providers combined.
- Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.

Colonoscopy Non-Screening	In-Network and Virtual Network	Out-of-Network
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit

Notes:

- When this procedure is performed to diagnose disease symptoms, a copay applies.
- The copays may vary based on Provider location.

Complex Drug Administration	In-Network and Virtual Network	Out-of-Network
Office Visit / Home	$225 copay / visit	$450 copay / visit
Outpatient Hostpital Visit	$900 copay / visit	$1,800 copay / visit

Notes:

- This copay applies to specific drugs that must be administered in a medical setting or under medical supervision. Call Bind Help to learn which infusions and injections are subject to these copays.
- Subject to Prior Authorization for Medical Necessity review.
- See Hospital Services for other coverage notes.
- See Chemotherapy section for coverage notes related to chemotherapy administration.

Complex Imaging	In-Network and Virtual Network	Out-of-Network
Office Visit or **Outpatient Hostpital Visit**	$150 - $575 copay / visit	$1,150 copay / visit

Notes:

- Coverage includes MRI (Magnetic Resonance Imaging), MRA (Magnetic Resonance Angiography), CT (Computed Tomography), PET (Positron Emission Tomography), and Nuclear Medicine.
- If your physician suggests a low-dose CT Scan (LDCT) for lung cancer screening, this will require a Prior Authorization. The copays may vary based on Provider location.
- See Hospital Services for other coverage notes.

Dental Services	In-Network and Virtual Network	Out-of-Network
Specialist Office Visit	$65 copay / visit	$130 copay / visit
Orthognathic Surgery, Jaw Surgery **Outpatient Hostpital Visit**	$900 copay / visit	$1,800 copay / visit

Orthognathic Surgery, Jaw Surgery **Inpatient Hostpital**	$1,100 copay / stay	$2,200 copay / stay

Notes:

- Bind covers dental services to treat and restore damage done to a sound, natural tooth as a result of an accidental injury. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss. Treatment and repair for services required due to an accidental injury must be started within six months and completed within twelve months of the date of the injury.
- Bind also covers dental services, limited to dental services required for treatment, of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.
- Eligible Charges for hospitalizations are those incurred by a Covered Person who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a physician, dentist, or dental Specialist.
- Orthognathic surgery is subject to Medical Necessity review and requires Prior Authorization.
- See Hospital Services for other coverage notes.

Additional Notes on Dental Services:

- Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary and Appropriate: Oral surgery and anesthesia for removal of impacted teeth, removal of a tooth root without removal of the whole tooth, and root canal therapy.
- Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures.
- Facility provider and anesthesia Services rendered in a Facility provider setting in conjunction with non-covered dental procedures when determined by the Claims Administrator to be Medically Necessary and Appropriate due to your age and/or medical condition.
- Accident-related dental Services from Physician or dentist for the Treatment of an injury to sound natural teeth if the Treatment begins within 6 months of the injury.
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth.

Dialysis Services	In-Network and Virtual Network	Out-of-Network
Office Visit	$10 - $70 copay / visit	$130 copay / visit
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hospital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- The Plan pays Benefits for therapeutic treatments received in an office, home, outpatient hospital or alternate facility. Benefit includes services and supplies for renal dialysis, including both hemodialysis and peritoneal dialysis. Benefit also includes training of the patient.
- See Hospital Services for other coverage notes.

Durable Medical Equipment (DME)	In-Network and Virtual Network	Out-of-Network
Tier 1	$0 copay	$20 copay
Tier 2	$20 copay	$40 copay
Tier 3	$40 copay	$80 copay
Tier 4	$60 copay	$120 copay
Tier 5	$80 copay	$160 copay
Tier 6	$100 copay	$200 copay
Tier 7	$150 copay	$300 copay
Tier 8	$200 copay	$400 copay
Tier 9	$250 copay	$500 copay
Tier 10	$350 copay	$700 copay
Tier 11	$500 copay	$1,000 copay
Tier 12	$1,000 copay	$2,000 copay

Notes:

- Coverage includes rental or purchase of DME.
- Visit **CenturyLink.com/ChooseBind**, **MyBind.com**, the MyBind App or call Bind Help to learn what DME items are in which tier.
- Hearing aids are limited to one hearing aid per ear every 36 months.
- Scalp/cranial hair prostheses (wigs) are a Covered Service for scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy and limited to one wig per person per calendar year up to a maximum of $350 for In-Network Benefits and Out-of-Network Benefits combined.
- Cataract surgery or aphakia is limited to one frame and one pair of lenses or one pair of contact lenses or one year supply of disposable contact lenses.
- DME in Tiers 9 through 12 will be subject to Prior Authorization to ensure Medical Necessity.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.

Emergency Services	In-Network and Virtual Network	Out-of-Network
Emergency Room Visit	$300 copay / visit	$300 copay / visit

Notes:

- Copay applies to Emergency Room facility and professional expenses and includes related expenses.
- If you are admitted as an inpatient directly from the Emergency Room for the same condition, the Emergency Services copay will be waived and you will be responsible for Inpatient Hospital Services copay.

Gender Dysphoria Services	In-Network and Virtual Network	Out-of-Network
Office Visit	$35 copay / visit	$130 copay / visit
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hospital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- The following services are covered for gender dysphoria:
- Gender reassignment surgery including genital reconstruction, clitoriplasty, vaginoplasty, scrotoplasty
- Mastectomy
- **Gender Dysphoria:** A disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:
- **Diagnostic criteria for adults and adolescents:** A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- **Diagnostic criteria for children:** A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- These services are subject to Prior Authorization and Medical Necessity review.

Genetic Testing	In-Network and Virtual Network	Out-of-Network
Office Visit	$130 copay / visit	$260 copay / visit
Home Health Services	**In-Network and Virtual Network**	**Out-of-Network**
Home Health Care Visit	$35 copay / visit	$130 copay / visit

Notes:

- Limited to 120 visits per Covered Person per Plan Year for in- and Out-of-Network combined.

Hospice Care	In-Network and Virtual Network	Out-of-Network
Home Hospice Visit	$35 copay / visit	$130 copay / visit
Inpatient Hostpital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.
- Hospice care requires a Prior Authorization.
- See Hospital Services for other coverage notes.

Hospital Services	In-Network and Virtual Network	Out-of-Network
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hostpital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- The copays above apply unless a benefit is specified in another section of this SPD.
- Outpatient Hospital Visit copay will apply for an Observation Stay.
- Inpatient Hospitalization/Stay Benefits include:
  - Physician and Non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a Semi-private Room (a room with two or more beds).
  - Physician services for lab tests, radiologists, anesthesiologists, pathologists, and Emergency room Physicians.
  - The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the emergency department or from observation, the emergency room copay or observation copay will be waived.
- All inpatient services require Pre-admission Notification if planned, and notification within 24 hours of admission if emergent.

Infertility Diagnosis	In-Network and Virtual Network	Out-of-Network
Office Visit	$10 - $70 copay / visit	$130 copay / visit
Infertility Treatment	**In-Network and Virtual Network**	**Out-of-Network**
Artificial insemination	$200 copay / visit	Not Covered
Egg Retrieval	$1,500 copay / visit	Not Covered
Embryo Implantation	$1,500 copay / visit	Not Covered
Cryopreservation	$1,000 copay / visit	Not Covered
Storage	$500 copay / visit	Not Covered
Thawing	$1,000 copay / visit	Not Covered
Genetic Testing (PGT)	$1,000 copay / visit	Not Covered

Notes:

- Covered Person must meet the following clinical criteria to be eligible for specific infertility services:
  - Inability to achieve pregnancy after 12 months of unprotected heterosexual intercourse or
  - Inability to achieve pregnancy after 6 months of unprotected heterosexual intercourse in women age 35 or older or
  - Women with documented FSH levels less than or equal to 19 mIU/ml on day 3 of the menstrual cycle or
  - Women who have not met time criteria for failure to conceive, but who have a documented anatomic variant resulting in the inability to achieve pregnancy (e.g., severe pelvic inflammatory disease, endometriosis, or ectopic pregnancy requiring surgical removal of both fallopian tubes) or
  - Males with anatomical variants such as aspermia or varicocele resulting in an inability to reproduce
- Core coverage pays Benefits for infertility services and associated expenses including:
  - Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician;
  - Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);
  - Ovulation stimulation;
  - Cryopreservation, also known as Embryo freezing, and storage (up to 24 months) for embryos produced from one (1) cycle for a member who will undergo cancer treatment that is expected to render them infertile; and
  - Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).

- There is a lifetime maximum of $10,000 for covered infertility treatments and prescription medications. This lifetime maximum is combined across all health plans sponsored by Plan Administrator.
- If member is bypassing the IVF reversal and requesting the direct infertility treatment (IVF) even though they had a previous sterilization it would be covered. Benefits include implanting only one embryo per cycle. A cycle is defined as one partial or complete fertilization attempt extending through the implantation phase only.
- **Dependent Child's Pregnancy:** Direct or indirect expenses incurred for a Dependent Child's pregnancy are not covered. Please Note: This exclusion does not apply to prenatal services for which Benefits are provided under the Preventive Care Services benefit, including certain items and services under the United States Preventive Services Task Force requirements or the Health Resources and Services Administration (HRSA) requirement or care to save the life of the mother. If you reside in the State of Massachusetts, the benefit coverage for a Dependent Child's pregnancy is different and the Plan covers additional benefits. If you have questions on which prenatal services for a Dependent Child's pregnancy are covered, please contact the Claims Administrator.
- Infertility Treatments require Prior Authorization.

Maternity Delivery Care	In-Network and Virtual Network	Out-of-Network
Routine Pre- and Post-Natal Office Visits, including Labs and Tests	$0 copay	$100 copay / visit
Inpatient Delivery	$400 - $1,100 copay / stay	$2,200 copay / stay

Notes:

- If a baby stays in the hospital longer than the baby's mother, then another copay will apply to the baby's services.
- Coverage is limited to a 48-hour hospital stay following normal vaginal delivery and 96 hours for a normal cesarean section.
- Home visit limited to 1 visit immediately following discharge of mother and newborn.
- The copays for inpatient delivery may vary based on Provider location.
- **Dependent Child's Pregnancy:** Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury for certain Covered Persons. However, direct or indirect expenses incurred for a Dependent Child's pregnancy are not covered. **Please Note:** This exclusion does **not** apply to prenatal services for which Benefits are provided under the Preventive Care Services benefit, including certain items and services under the United States Preventive Services Task Force requirements or the Health Resources and Services Administration (HRSA) requirement or care to save the life of the mother. If you reside in the State of Massachusetts, the benefit coverage for a Dependent Child's pregnancy is different and the Plan covers additional benefits. If you have questions on which prenatal services for a Dependent Child's pregnancy are covered, please contact the Claims Administrator.
- See Hospital Services for other coverage notes.

Mental Health and Substance Use Disorder Services	In-Network and Virtual Network	Out-of-Network
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hospital	$1,100 copay / stay	$2,200 copay / stay
Resident Treatment Stay	$1,100 copay / stay	$2,200 copay / stay
Partial Hospitilization/Day Treatment	$750 copay / visit	$1,500 copay / visit

Notes:

- Benefits include:
  - Diagnostic evaluations, assessment and treatment planning
  - Treatment and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management services
  - Crisis intervention
  - Residential treatment
  - Partial hospitalization/Day treatment
  - Outpatient treatment
- All inpatient services require Pre-admission Notification if planned and notification within 24 hours of admission if emergent.
- Substance Abuse Inpatient Residential and partial hospitalization services require Prior Authorization and are subject to Medical Necessity review.
- See Hospital Services for other coverage notes.

Occupational Therapy	In-Network and Virtual Network	Out-of-Network
Occupational Therapy Visit	$15 - $120 copay / visit	$240 copay / visit

Notes:

- Limited to 60 visits for occupational therapy per Covered Person per Plan Year for In-Network and Out-of-Network Providers combined. The copays may vary based on Provider location.
- Occupational therapy for mental health condition such as autism disorder will follow mental health office visit copay.
- See Hospital Services for other coverage notes.

Office Visit and Diagnostic Visit	In-Network and Virtual Network	Out-of-Network
Office Visit - Primary Care / Specialist Visit	$10 - $70 copay / visit	$130 copay / visit
Mental Health Office Visit	$35 copay / visit	$130 copay / visit
E-Visit and Telephone Visit with Physician	$35 copay / visit	Not Covered
Convenience Care/Retail Visit	$15 copay / visit	Not Covered
Lab / X-Ray	$0 copay / visit	$0 copay / visit
Allergy Injection Visit	$0 copay / visit	$130 copay / visit
Allergy Testing and Treatment	$65 copay / visit	$130 copay / visit

Complex Office Visit: **Vein Ablation, Chemodenervation, Implantation of Drug Delivery Device, Eye Cryotherapy, Photocoagulation**	$165 copay / visit	$330 copay / visit
Naturopathic Professional Visits	$35 copay / visit	$130 copay / visit

Notes:

- See Virtual Visit section for virtual visit details.
- Vision Therapy is covered as an office visit.
- Naturopathic Professional Services - up to 20 visits per Covered Person per calendar year for Network and Out-of-Network Benefits combined

Pallative Care	In-Network and Virtual Network	Out-of-Network
Office Visit / Home	$35 copay / visit	$130 copay / visit
Inpatient	$1,100 copay / stay	$2,200 copay / stay

Notes:

- Core covers palliative care for members with a new or established diagnosis of progressive debilitating illness. The services must be within the scope of the Provider's license to be covered. Palliative care does not include hospice or respite care.
- See Hospital Services for other coverage notes.

Physical Therapy	In-Network and Virtual Network	Out-of-Network
Physical Therapy Visit	$15 - $120 copay / visit	$240 copay / visit

Notes:

- Limited to 60 visits per Covered Person per Plan Year for In-Network and Out-of-Network Providers combined. The copays may vary based on Provider location.
- Physical therapy for mental health condition such as autism disorder will follow mental health office visit copay.
- See Hospital Services section for other coverage notes.

Prescription Drugs	In-Network and Virtual Network	Out-of-Network
	See Prescription Drugs section for details	Not Covered
Preventive Care	**In-Network and Virtual Network**	**Out-of-Network**
Office Visit	$0 copay / visit	$100 copay / visit

Notes:

- Services include evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration and Advisory Committee on Immunization Practices.
- Examples include:
  - Pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations, up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.
  - Routine physical exams.
  - Routine screenings for certain cancers and other conditions.
  - Routine immunizations.
  - Routine lab tests, pathology and radiology.
  - Hearing and vision screening limited to one exam per calendar year for children up to age of 21.
  - Hearing aid exams limited to one every 3 years per ear.
  - Routine pre-natal and postpartum care services.
  - One routine postnatal care exam that includes a health exam, assessment, education and counseling provided during the period immediately after childbirth.

Preventive Contraceptive Methods and Counseling for Women	In-Network and Virtual Network	Out-of-Network
Office Visits	$0	$100 copay / visit

Notes:

- For Prescription Drug Coverage see Prescription Drugs section.
- Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.

Radiation Therapy	In-Network and Virtual Network	Out-of-Network
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit

Notes:

- See Hospital Services for other coverage notes.

Reconstructive Surgery	In-Network and Virtual Network	Out-of-Network
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hostpital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.
- Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.
- Benefits for Reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Services. You can contact Bind Help at the number on your ID card for more information about Benefits for mastectomy-related services.
- There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic procedure. This Plan does not provide benefits for Cosmetic services or procedures.
- The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as Reconstructive procedures.
- Reconstructive Surgery is subject to Medical Necessity review and Prior Authorization should be obtained.
- See Hospital Services for other coverage notes.

Skilled Nursing Facility Services	In-Network and Virtual Network	Out-of-Network
Skilled Nursing Facility	$1,100 copay / stay	$2,200 copay / stay

Notes:

- Limited to 120 days per Covered Person per Plan Year for In-Network and Out-of-Network Providers combined.
- Benefits include:
  - Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility are covered by Core and require Prior Authorization.
  - Supplies and non-physician services received during the inpatient stay.
  - Room and board in a semi-private room (a room with two or more beds).

    - Physician services for radiologists, anesthesiologists, and pathologists.
    - Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.
- Benefits are available only if both of the following are true:
    - The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost- effective alternative to an inpatient stay in a hospital.
    - You will receive skilled care services that are not primarily Custodial Care.
- Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
    - It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
    - It is ordered by a Physician.
    - It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
    - It requires clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in the Glossary.
- All Skilled Nursing Facility admissions require a Prior Authorization.
- See Hospital Services for other coverage notes.

Speech Therapy	In-Network and Virtual Network	Out-of-Network
Speech Therapy Visit	$15 - $120 copay / visit	$240 copay / visit

Notes:

- Limited to [60] visits for speech therapy per Covered Person per Plan Year for In-Network and Out-of-Network Providers combined. The copays may vary based on Provider location.
- Speech therapy for mental health condition such as autism disorder will follow mental health office visit copay.
- See Hospital Services for other coverage notes.

Temporomandibular Joint (TMJ) Service	In-Network and Virtual Network	Out-of-Network
Specialist Office Visit	$65 copay / visit	$130 copay / visit
Outpatient Hostpital Visit	$750 copay / visit	$1,500 copay / visit
Inpatient Hospital	$1,100 copay / stay	$2,200 copay / stay

Notes:

- Includes orthodontic services and supplies and surgical and non-surgical options for the treatment of TMJ.
- These services require Prior Authorization and Medical Necessity review.
- See Hospital Services for other coverage notes.

Transplant Services	In-Network and Virtual Network	Out-of-Network
Office Visit	$65 copay / visit	Not Covered
Outpatient Hostpital Visit	$750 copay / visit	Not Covered
Inpatient Hospital	$1,100 copay / stay	Not Covered

Notes:

- Transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/intestine, pancreas, intestine and cornea. Transplant Services, except for corneal transplant, require Prior Authorization. Bind has identified quality Providers for Transplant Services referred to as the Transplant Center of Excellence (See Section 9. Bind Clinical Programs for additional information). Transplant Services must be received at a location specified as a Center of Excellence.
- Benefits are available to the donor and the recipient when the recipient is covered under Core. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's Core coverage.
- Bind has specific guidelines regarding Benefits for transplant services. Contact Bind Help at the number on your ID card for information about these guidelines.
- Core covers expenses for travel and lodging for the patient, and a companion as follows:
  - Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by an In-Network Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
  - The eligible expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
  - If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
  - Travel and lodging expenses are only available if the patient resides more than 50 miles from the In-Network Provider.
  - Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Covered Person if the reimbursement exceeds the per diem rate.
- The Claim Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

  Lodging

  - A per diem rate, up to $50 per day, for the patient (when not in the Hospital) or the caregiver.
  - Per diem is limited to $100 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

  Travel

  - Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the In-Network Provider
  - Taxi fares (not including limos or car services)
  - Economy or coach airfare
  - Parking
  - Trains
  - Boat
  - Bus
  - Tolls

Examples of items that are not covered:

- Groceries
- Alcoholic beverages
- Personal or cleaning supplies
- Meals
- Over-the-counter dressings or medical supplies
- Deposits
- Utilities and furniture rental, when billed separate from the rent payment
- Phone calls, newspapers, or movie rentals

- All Transplant Services with the exception of Corneal transplant require Prior Authorization.
- See Hospital Services for other coverage notes.

Urgent Care	In-Network and Virtual Network	Out-of-Network
Urgent Care Visit	$125 copay / visit	$250 copay / visit
Virtual Visits	**In-Network and Virtual Network**	**Out-of-Network**
Virtual Visit (Designated Provider)	$0 copay / visit	Not Covered

Notes:

- Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).
- Benefits are available only when services are delivered through a designated virtual network Provider.
- No virtual visit coverage for out of network.
- Please visit CenturyLink.com/ChooseBind, MyBind.com, the MyBind App or call Bind Help to locate a designated virtual visit Provider.

12. 2ND.MD

See the *Retiree General Information SPD* for more Information.

13. NURSELINE

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that CenturyLink has available that may help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.

- How to take prescription drug products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine℠ gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

14. COR MEDICAL

See the *Retiree General Information SPD* for more Information.

15. CANCER RESOURCE SERVICES

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in the Glossary.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Well Connected Nurse;
- call Member Services at the phone number on the back of your ID card; or
- visit **www.myoptumhealthcomplexmedical.com**

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Hospital — Inpatient Stay
- Physician Fees for Surgical and Medical Services
- Physician's Office Services
- Scopic Procedures — Outpatient Diagnostic and Therapeutic
- Surgery — Outpatient
- Therapeutic Treatments — Outpatient

Cancer clinical trials and related treatment and services are covered by the Plan. Such treatment and services must be recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

Note: *The services described under Travel and Lodging are Covered Health Services only in connection with cancer-related services received at a Designated Facility.*

To receive Benefits under the CRS program, **you must obtain Prior Authorization from** Well Connected **PRIOR** to obtaining Covered Health Services. The Plan will only **pay Benefits** under the CRS program **if** Well Connected provides the proper Prior Authorization to the Designated Facility provider performing the services ***(even if you self-refer to a provider in that Network). Call the phone number on the back of your ID card.***

16. DOCTOR ON DEMAND

Virtual Visits let you skip the waiting room. It's a cheaper, faster option suited for a wide range of common, non-emergent health issues. Access care anytime from anywhere. Talk with real, board-certified doctors via phone, chat or video conference and obtain a diagnosis and treatment.

A. Services Offered

- Allergies
- Bites and stings
- Bladder infections
- Cold and cough
- Digestive issues
- Ear infection
- Flu
- Pink eye
- Sinus infection
- Skin conditions
- And more

To request an appointment, visit **https://patient.doctorondemand.com/**.

If this is your first visit, have your insurance information handy. You'll need it when you register for an account.

17. WELL CONNECTED RESOURCES TO HELP YOU STAY HEALTHY

The Well Connected Program is a voluntary incentive wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease (including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others).

Participation is Voluntary. If you choose to participate in the Well Connected Program, you will be asked to complete a voluntary Health Survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for LDL cholesterol, Fasting blood sugar or A1C. You are not required to complete the Health Survey or to participate in the biometric screening test or other medical examinations.

Health Survey. You and your Spouse/Domestic Partner must be enrolled in a CenturyLink medical plan are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

To find the health survey, log in to **www.centurylink.com/iamwellconnected**. If you need any assistance with the online survey, please call the number on the back of your ID card.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way. CenturyLink does not receive the results or data from your survey

Alternatives to Succeed. If you are unable to complete an activity, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Wellness Support Team at 877-818-5826.

What's the Health Survey for? The information obtained through your Health Survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Well Connected Program, such as Personal online or Telephonic Coaching You also are encouraged to share your results or concerns with your own doctor.

Condition Management program. If you have been diagnosed with certain chronic medical conditions: heart failure coronary artery disease, diabetes, asthma and/or Chronic Obstructive Pulmonary Disease (COPD), you may be eligible to participate in a disease management program at no additional cost to you. The programs are designed to support you. This means that you will receive free educational information through the mail and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition.

Examples of support topics include:

- Education about the specific disease and condition.
- Medication management and compliance.
- Reinforcement of on-line behavior modification program goals.
- Preparation and support for upcoming Physician visits.
- Review of psychosocial services and community resources.
- Caregiver status and in-home safety.
- Use of mail-order pharmacy and Network providers.
- Participation is completely voluntary and without extra charge.

Note: If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

Personal /Telephonic Coaching

- Wellness Coaching provides a blended model of personal coaching, self-paced online learning and digital support to help you meet your personal health goals. You have access to:
- Online and telephonic coaching options

- Access to online courses, 24/7, guided discussion, live chat or secure message with a Wellness Coach
- Personalized action plan
- Choose the goals you want to focus on:
- Eating better
- Reducing Stress
- Quit Tobacco
- And more

For information and to get started call 800-478-1057.

A. Protections from Disclosure of Medical Information

The Program Administrator is required by law to maintain the privacy and security of your personally identifiable health information. Although the Well Connected Program and CenturyLink may use aggregated and depersonalized information it collects to design a program based on identified health risks in the workplace, The Well Connected Program will never disclose any of your personal information either publicly or to CenturyLink, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Well Connected Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Well Connected Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Well Connected Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Well Connected Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Well Connected Program will abide by the same confidentiality requirements. Your health information may be shared with wellness coaches, nurses, and doctors, whom are involved in administering the Well Connected Program and health plan and may also be shared with vendors and subcontractors in accordance with applicable laws, including HIPAA, as necessary to administer the Well Connected Program or health plan. Anyone who receives your information for purposes of providing you services as part of the Well Connected program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the Well Connected Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Well Connected Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and the event of a data breach involving information you provide in connection with the Well Connected Program, the Plan Administrator will notify you within the time periods required by applicable laws, including HIPPA.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Well Connected Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Integrity Line at 800-333-8938 or email at **IntegrityLine@CenturyLink.com**.

The Plan believes in giving you the tools you need to be an educated health care consumer. To that end, it has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your covered dependents;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

18. ADD-INS

For an additional premium, Covered Persons may enroll in Add-Ins. Add-In coverage includes select, planned procedures that often have treatment and location options. Service(s) must be provided within the time frame shown in the Add-In coverage period column below. Add-In coverage is only available for In-Network Providers and the procedure must be Medically Necessary.

ADD-IN COVERAGE MUST BE PURCHASED THREE BUSINESS DAYS PRIOR TO RECEIVING SERVICES RELATED TO THE ADD-IN COVERAGE. Add-In coverage is effective three business days after it is purchased, and all services related to the Add-In must be complete within 120 days of its effective date. Failure to purchase Add-In Coverage prior to receiving the services may result in an adverse benefit determination (e.g., denial of claim, reduction of benefits, etc.). If you need any of these procedures because it directly relates to an Emergency, trauma event or cancer-related procedure, treatment, or surgery, you do not need to purchase an Add-In as these situations are covered in Core.

The copays listed for Add-In coverage are maximum copays for each Add-In. You may be eligible for reduced copays if you use In-Network Providers that Bind has designated as preferred, high-value Providers. Bind determines which In-Network Providers are preferred, high value Providers by considering, for example, their rates of effectiveness, low risk of complications and the total cost charged by the Provider.

Add-In coverage is for **In-Network** only. Some add-ins may be covered under Core if you or your dependent meet certain age requirements. Please call Bind Help for additional information.

A. Add-In Copays

Add-In	Copay Maximum	Coverage Period
Ankle Arthroscopy and Ligament Repair	$2,300	120 Days
Bariatric Surgery	$2,200	120 Days
Sling Surgery for Female Urinary Incontinence	$2,200	120 Days
Breast Reduction Surgery	$2,300	120 Days
Bunionectomy and Hammertoe Surgery	$2,200	120 Days
Carotid Endarterectomy and Stents	$2,300	120 Days
Carpal Tunnel Surgery	$2,300	120 Days
Cervical Spine Disc Decompression	$2,400	120 Days
Cervical Spine Fusion	$2,300	120 Days
Coronary Catheterization and Percutaneous Coronary Interventions	$2,300	120 Days
Coronary Artery Bypass Graft Surgery	$2,500	120 Days

Add-In	Copay Maximum	Coverage Period
Ear Tubes	$2,200	120 Days
Ankle and Foot Bone Fusion	$2,300	120 Days
Ganglion Cyst Surgery	$2,200	120 Days
Hernia Repair	$2,300	120 Days
Hip Arthroscopy and Repair	$2,300	120 Days
Hip Replacement and Revision	$2,300	120 Days
Hysterectomy	$2,200	120 Days
Hysteroscopy and Endometrial Ablation	$2,100	120 Days
Knee Arthroscopy and Repair	$2,300	120 Days
Knee Replacement and Revision	$2,300	120 Days
Lumbar Spine Disc Decompression	$2,400	120 Days
Lumbar Spine Fusion	$2,400	120 Days
Morton's Neuroma Surgery	$2,000	120 Days
Reflux and Hiatal Hernia Surgery	$2,300	120 Days
Plantar Fasciitis Surgery	$2,100	120 Days
Sinus and Nasal Septum Surgery	$2,400	120 Days
Shoulder Arthroscopy and Repair	$2,300	120 Days
Shoulder Replacement and Revision	$2,300	120 Days
Tonsillectomy / Adenoidectomy	$2,100	120 Days
Upper GI Endoscopy	$2,300	120 Days

Add-Ins provide coverage on the same date of the surgery or during the same hospital admission, for the following associated health care services:

- Anesthesia
- Facility charges
- Labs
- Medications administered by a Provider
- Pathology
- Provider services
- Radiology
- Supplies

B. Exclusions to Add-Ins

- For Add-In procedures performed in a clinic or outpatient facility: health care services provided prior to and after the date of the Add-In procedure, unless such services are directly related to the same or similar Add-In body part. Core coverage may be available.
- For Add-In procedures performed in an inpatient facility: health care services provided prior to an admission and after a discharge from an inpatient facility, unless such services are directly related to the same or similar Add-In body. Core coverage may be available.

- Care that is not Medically Necessary.
- Items listed in Exclusions to Add-Ins section.

19. EXCLUSIONS: PLAN BENEFITS NOT COVERED

Core does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition unless specifically described or listed in Section 12.B.

A. Add-Ins

1. Health care services listed as an Add-In in Section 19.A, are not covered in Core except for Emergency, trauma or cancer-related services.

B. Alternative Treatments

2. Health care services ordered or rendered by Providers or para-professionals unlicensed by the appropriate regulatory agency.
3. Aromatherapy.
4. Hypnotism.
5. Massage therapy that is not Physical Therapy or prescribed by a licensed provider as a component of a multi-modality rehabilitation treatment plan.
6. Rolfing.
7. Vocational therapy.
8. Homeopathic medicine, including dietary supplements.
9. Holistic medicine and services, including dietary supplements.
10. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

C. Dental

11. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care required for the direct treatment of a medical condition.
12. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
13. Endodontics, periodontal surgery and restorative treatment are excluded.
14. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums.
15. Dental implants, bone grafts, and other implant-related procedures.
16. Dental braces (orthodontics).
17. Treatment of congenitally missing, malposition or supernumerary (extra) teeth, even if part of a congenital anomaly.

D. Devices, Appliances, Supplies and Prosthetics

18. Devices used specifically as safety items or to affect performance in sports-related activities.
19. Orthotic appliances and devices that straighten or re-shape a body part. Examples of excluded orthotic appliances and devices include but are not limited to some types of braces, arch supports, and include orthotic braces available over-the-counter.
20. Shoe inserts and orthotics except as prescribed by a Provider.
21. Shoes.
22. Cranial banding.
23. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
24. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
25. Devices and computers to assist in communication and speech.
26. Oral appliances for snoring.
27. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits.
28. Over-the-counter medical equipment or supplies such as saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a prescription even if a prescription has been ordered.
29. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, diapers, incontinence supplies.
30. Supplies, equipment and similar incidentals for personal comfort. Examples include air conditioners, air purifiers, humidifiers, recliners, exercise equipment, Jacuzzis, and vehicle modifications such as van lifts.
31. Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
32. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.
33. Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts and car carrier.

E. Drugs

34. See “**EXCLUSIONS: PRESCRIPTION DRUG PLAN BENEFITS NOT COVERED**” on page 53.

F. Experimental or Investigational or Unproven Services

35. Services that are considered Experimental or Investigational as determined by Bind are excluded. The fact that an Experimental or Investigational treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational in the treatment of that particular condition.

G. Foot Care

36. Routine foot care (except for standard diabetic foot care), examples include the cutting or removal of corns and calluses.
37. Hygienic and preventive maintenance foot care.

H. Gender Dysphoria Cosmetic Procedures

38. Cosmetic procedures related to a diagnosis of Gender Dysphoria including:
    a. Abdominoplasty
    b. Blepharoplasty
    c. Body contouring, such as lipoplasty or liposuction
    d. Brow lift, face lift, forehead lift, or neck tightening
    e. Calf implants
    f. Cheek, chin, and nose implants
    g. Chondrolaryngoplasty
    h. Injection of fillers or neurotoxins
    i. Head width reduction
    j. Hair removal and transplantation
    k. Lip reduction and augmentation
    l. Mastopexy
    m. Skin resurfacing
    n. Voice modification surgery
    o. Voice lessons and voice therapy

I. Mental Health/Substance Abuse

39. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual Of Mental Disorders by the American Psychiatric Association.
40. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including IEIBT Intense Early Intervention Using Behavioral Therapy and Lovaas.
41. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
42. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
43. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
44. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
45. Outside of initial assessment, unspecified disorders for which the Provider is not obligated

to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

46. Transitional living services.
47. Inpatient or intermediate or outpatient care services that were not pre-authorized.
48. Investigative therapies for treatment of autism.
49. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.

J. Nutrition

50. Nutritional or Cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
51. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).

K. Physical Appearance

52. Cosmetic Procedures such as:
    a. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple
    b. Pharmacological regimens, nutritional procedures or treatments
    c. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
    d. Hair removal or replacement by any means
    e. Treatments for skin wrinkles or any treatment to improve the appearance of the skin
    f. Treatment for spider veins
    g. Skin abrasion procedures performed as a treatment for acne
    h. Treatments for hair loss
    i. Varicose vein treatment of the lower extremities, when it is considered Cosmetic
53. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
54. Reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed Reconstructive surgery offers minimal improvement in your appearance. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
55. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.
56. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.
57. Wigs (scalp/cranial hair prostheses) except for members with scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy.

L. Procedures and Treatment

58. Treatment of benign gynecomastia (abnormal breast enlargement in males).
59. Biofeedback.
60. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
61. Rehabilitation services and manipulative treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
62. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
63. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
64. Psychosurgery (e.g. lobotomy).
65. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care Providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
66. Chelation therapy, except to treat heavy metal poisoning.
67. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
68. Breast reduction surgery that is determined to be a Cosmetic procedure except as required by the Women's Health and Cancer Rights Act of 1998.
69. Elective abortion, except in situations where the life of Covered Person would be endangered if the fetus is carried to full term.

M. Providers

70. Services performed by a Provider who is a family member by birth or marriage, including your spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.
71. Services performed by a Provider with your same legal residence.
72. Services ordered or delivered by a Christian Science practitioner.
73. Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.

N. Reproduction

74. The following infertility treatment-related services:
    a. Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
    b. Donor services and nonmedical costs of oocyte (egg) or sperm donation (e.g., donor agency fees).
    c. Embryo or oocyte accumulation defined as a fresh oocyte (egg) retrieval prior to the

depletion of previously banked frozen embryos or oocytes (eggs).

d. Embryo transport.
e. Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
f. All costs associated with surrogate motherhood; nonmedical costs associated with gestational carrier.
g. Ovulation predictor kits.
h. Surrogate parenting, donor oocytes (eggs), donor sperm and host uterus.
i. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
j. Reversal of voluntary sterilization.

O. Services Provided Under Another Plan

75. Services for which coverage is available:
    a. Under another medical plan, except for eligible expenses payable as described in this SPD.
    b. Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.
    c. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
    d. While on active military duty.
    e. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

P. Transplants

76. Health services for transplants involving permanent mechanical or animal organs.
77. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Medical coverage.)

Q. Travel

78. Health services provided in a foreign country, unless determined to be an Emergency.
79. Travel or transportation expenses, even if ordered by a Physician, except as identified under Ambulance and Transplant in Section 12.B.

R. Types of Care

80. Custodial Care.
81. Domiciliary Care.
82. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
83. Private Duty Nursing.
84. Respite care except as defined under Hospice Care in Section 12.B.
85. Rest cures.

86. Services of personal care attendants.
87. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision, Hearing and Voice

88. Implantable lenses used only to correct a refractive error, radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
89. Eye exams (including refraction), eyeglasses, contact lenses and any fittings associated with them.
90. Refractive surgery (e.g. Lasik) for ophthalmic conditions that are correctable by contacts or glasses.
91. Bone anchored hearing aids except when either of the following applies:
    a. For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    b. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
    c. Bind will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in Bind. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.
92. Eye exercise.
93. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
94. Any type of communicator, voice enhancement, voice prosthesis, electronic voice producing machine, or any other language assistive devices.

T. All Other Exclusions

95. Health care services that Bind determines are not Medically Necessary.
96. Autopsies and other coroner services and transportation services for a corpse.
97. Charges for:
    a. Missed appointments.
    b. Room or facility reservations.
    c. Completion of Claim forms.

20. PRESCRIPTION DRUGS

Core includes coverage for prescription drugs dispensed at In-Network pharmacies with the copays listed below. There is no coverage for Out-of-Network pharmacies. A Formulary is used to determine which prescription drugs are covered. The Formulary is subject to regular review and modification. You can find In-Network pharmacies and Formulary medications by connecting with Bind via web, mobile app, or phone using the information found in Section 3. Claims Administrator and Contact

Information, Formulary medications, drug tiers and Specialty Drugs.

If your copay is higher than the retail price, you pay the lower amount.

Use the MyBind app, visit **CenturyLink.com/ChooseBind**, **MyBind.com** or call Bind Help to determine the tier of your drug or to learn more about Preventive medications.

	30-Day Supply		90-Day Supply	
	In-Network Pharmacies	**Out-of-Network Pharmacies**	**In-Network Pharmacies and Mail Order Pharmacy**	**Out-of-Network Pharmacies**
Preventive	$0 copay	Not Covered	$0 copay	Not Covered
Tier 1	$10 copay	Not Covered	$25 copay	Not Covered
Tier 2	$60 copay	Not Covered	$150 copay	Not Covered
Tier 3	$90 copay	Not Covered	$225 copay	Not Covered

A. Specialty Drug Tiers

If your copay is higher than the retail price, you pay the lower amount.

Specialty Pharamacy	
	30-Day Supply
Tier 1	$200 copay
Tier 2	$225 copay
Tier 3	$300 copay

> ***Note:*** The Coordination of Benefits provision described in Section 25. Coordination of Benefits (COB) does not apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

B. Identification Card (ID Card) — Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don’t show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

C. Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

Copay for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Copay for a Prescription Drug at a Non- Network Pharmacy is a percentage of the Predominant Reimbursement Rate.

For Prescription Drugs at a retail Network Pharmacy, you are responsible for paying the lower of:

- the applicable copay;
- the Network Pharmacy’s Usual and Customary Charge for the Prescription Drug; or

- the Prescription Drug Charge that the Claims Administrator agreed to pay the Network Pharmacy.

For Prescription Drugs from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the applicable copay; or
- the Prescription Drug Charge for that particular Prescription Drug.

D. Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting the Claims Administrator at the toll-free number on your ID card or by logging onto **MyBind.com**.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the copay. However, some drugs require prior approval before the prescription can be obtained, as described later in Section 21. J. Prior Authorization/Medical Necessity Requirements. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed;
- for a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copay for each cycle supplied.
- Oral and self-injectable infertility prescription drugs apply to the medical/prescription drug lifetime benefit maximum of $10,000 in and out-of-network combined.

Note: *Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services.*

Otherwise, you are responsible for paying 100% of the cost.

E. Mail Order

You may (but are not required to) use OptumRx Mail Service pharmacy for most maintenance medications. Through OptumRx Mail Service Pharmacy, you receive convenient, safe and reliable service, including:

- Delivery of up to a 3-month supply of your medication right to your mailbox
- Flexible delivery anywhere in the U.S. with no charge to you for standard shipping
- Educational information about your prescriptions with each shipment
- Access to pharmacists 24 hours a day, seven days a week to answer your medication questions

In addition, some drugs require prior approval before the prescription can be obtained, as described later in the Prior Authorization/Medical Necessity Requirements section.

Getting Started

Option 1: Call OptumRx at 1-800-791-7658.

Member Services is available 24 hours a day, seven days a week to help you start using mail service. Please have your medication name and doctor's telephone number ready when you call.

Option 2: Talk to your doctor before your prescriptions must be switched to OptumRx.

Tell your physician you want to use OptumRx for home delivery of your maintenance medications. Be sure to ask for a new prescription written for up to a 3-month supply with three refills to maximize your plan benefits. Then you can either:

Mail in your written prescriptions along with a completed order form.

Ask your doctor to call 1-800-791-7658 with your prescriptions or to fax them to 1-800-491-7997.

***Option 3: Log on to* www.optumrx.com**

You can get started by

- Clicking on "Manage My Prescriptions" and selecting "Transfer Prescriptions"
- Select the medications you would like to transfer
- Print out the pre-populated form and bring this to your doctor
- Ask your doctor to call or fax in the prescriptions with the order form

Once OptumRx receives your complete order for a new prescription, your medications should arrive within ten business days - completed refill orders should arrive in about seven business days. If you need your medication right away, ask your doctor for a 1-month supply that can be immediately filled at a participating retail pharmacy. You can avoid this step by allowing sufficient time for your prescriptions to be moved to OptumRx.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drugs.

Note: *To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.*

F. Designated Pharmacy

If you require certain Prescription Drugs, the Claims Administrator may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please refer to the "**Prescription Drug Glossary**" on page 88 of this SPD for the definition of Designated Pharmacy.

G. Specialty Prescription Drugs

You may fill a prescription for Specialty Prescription Drugs up to two times at any Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please refer to the "**Prescription Drug Glossary**" on page 88 for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the tables at the beginning of this section for details on Specialty Prescription Drug supply limits.

Note: To lower your out-of-pocket Prescription Drug costs:
Consider Tier 1 Prescription Drugs, if you and your Physician decide they are appropriate.

H. Assigning Prescription Drugs to the PDL

The Claims Administrator Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors.

Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are most cost effective for specific indications as compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

This means you should carefully review with your prescribing physician whether a Prescription Drug is covered and if so, at what tier. You can also call the number on the back of your ID card to obtain this information.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

I. Prior Authorization/Medical Necessity Requirements

Due to the high cost and specific condition treatment requirements that may be associated with medications, Prior Authorization/Medical Necessity Review may be applied to ensure these medications are being used appropriately and at the right time for a specific condition.

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Provider, your pharmacist or you to notify the Claims Administrator for Prior Authorization or Medical Necessity approval. The Claims Administrator will determine if the Prescription Drug, is in accordance with approved guidelines:

- A Covered Health Service as defined by the Plan.
- Medically Necessary and meets clinical guidelines, as defined under Prior Authorization in Section 29.B. Prescription Drug Glossary.
- Not Experimental or Investigational or Unproven, as defined in Section 29.B. Prescription Drug Glossary. If approved, the prior authorization will need to be reviewed every 12 months

The Plan may also require you to notify the medical Claims Administrator so they can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

J. Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator.

K. Out-of-Network Pharmacy Notification

When Prescription Drugs are dispensed at a Out-of-Network Pharmacy, you or your Physician are responsible for notifying the Claims Administrator as required.

If the Claims Administrator is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at an Out-of-Network Pharmacy. If the Claims Administrator is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug. See “**CLAIMS PROCEDURES**” on page 54 for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a Out-of-Network Pharmacy), less the required Copayment and/or Copay any Deductible that applies.

To determine if a Prescription Drug requires notification, either visit **MyBind.com** or call the toll-free number on your ID card.

The Prescription Drugs requiring notification are subject to the Claims Administrator's periodic review and modification. Benefits may not be available for the Prescription Drug after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

L. Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to the "**CLAIMS PROCEDURES**" on page 54.

M. Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

N. Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **MyBind.com** or call the phone number on the back of your ID card. Whether or not a Prescription Drug has a supply limit is subject to the Claims Administrator 's periodic review and modification.

Note: *Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.*

O. If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug is assigned.

P. Special Programs

CenturyLink and the Claims Administrator may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by calling the number on the back of your ID card.

Q. Smoking Cessation Products

Coverage for prescription smoking cessation products (including Chantix, Bupropion, Nicotrol, and Zyban) are covered at 100% by the Plan for up to 90 days per calendar year. You must be enrolled in the Quit For Life® program to be eligible for these products as a covered Benefit. See "**WELL CONNECTED RESOURCES TO HELP YOU STAY HEALTHY**" on page 34 for more information.

R. Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription

Drug was prescribed by a specialist physician. You may access information on which Prescription Drugs are subject to Benefit enhancement, reduction or no Benefit by calling the telephone number on your ID card.

S. Step Therapy

Certain Prescription Drugs for which Benefits are described in this section or pharmaceutical products for which Benefits are described under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drugs and/or pharmaceutical products you are required to use a different Prescription Drug(s) or pharmaceutical products(s) first.

You may determine whether a particular Prescription Drug or pharmaceutical product is subject to step therapy requirements by calling the number on the back of your ID card.

T. My ScriptRewards

Provides members select medications to treat HIV infection at $0 cost share. The $0 cost share medications include: Cimduo, Cimduo plus Isentress, Isentress HD, Dovato, Symfi, Symfi Lo OR Cimduo plus Tivicay. In addition, members who fill the $0 cost hare combination products will be eligible for up to $500 in prepaid debit cards to offset medical expenses. HIV is the first medication category to be part of the My ScriptRewards program.

Benefits:

- Guides the member to the most cost effective, guideline recommended regimen.
- Lowest out of pocket cost for the member.

Members can call 833-854-6523 for more information and to join the program.

U. Rebates and Other Discounts

The Claims Administrator and CenturyLink may, at times, receive rebates for certain drugs on the PDL. The Claims Administrator does not pass these rebates and other discounts on to you. Nor does the Claims Administrator apply rebates or other discounts towards your Annual Deductible or Copays.

The Claims Administrator and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this section. The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

V. Coupons, Incentives and Other Communications

The Claims Administrator may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition. It is important to note that if you use a manufacturer coupon or copay card for Specialty Medications, the amount paid by the manufacturer on your behalf will not apply to your deductible or out of pocket maximums. Only your true out of pocket costs will apply to your deductible or out of pocket maximums.

21. EXCLUSIONS: PRESCRIPTION DRUG PLAN BENEFITS NOT COVERED

The exclusions listed below apply to the Prescription Drugs section. In addition, exclusions from coverage listed in the Exceptions: Prescription Drug Plan Benefits Not Covered also apply to this section.

When an exclusion applies to only certain Prescription Drugs, contact the Claims Administrator for information on which Prescription Drugs are excluded. This listing is subject to change and is updated from time to time and over time.

Medications that are:

1. for any condition, Injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or benefits are received;
2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or Benefits are received, except as otherwise provided by law;
3. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;
4. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;
5. dispensed outside of the United States, except in an Emergency;
6. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
7. for smoking cessation unless enrolled in the Quit Tobacco® program. Supply limits apply;
8. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition);
9. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
10. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
11. certain Prescription Drugs that have not been prescribed by a specialist physician;
12. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
13. prescribed, dispensed or intended for use during an Inpatient Stay;

14. weight loss drugs excluded except those covered by the plan and prescribed by a qualified provider ;
15. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare determines do not meet the definition of a Covered Health Service;
16. Prescription Drugs that contain an approved biosimilar or a biosimilar and Therapeutically Equivalent (having essentially the same efficacy and adverse effect profile) to another covered Prescription Drug;
17. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;
18. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
19. in a particular Therapeutic Class;
20. unit dose packaging of Prescription Drugs;
21. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless the Claims Administrator and CenturyLink have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in the Glossary;
22. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed. However, Replacement Prescription Drugs are automatically available for catastrophes and natural disasters, such as floods and earthquakes. (Note: You have the option to appeal if an excluded drug is prescribed for a specific medical condition. Please reference the "**CLAIMS PROCEDURES**" on page 54 for more information.);
23. used for cosmetic purposes; and
24. vitamins, except for the following which require a prescription: prenatal vitamins;
25. vitamins with fluoride; and single entity vitamins

22. CLAIMS PROCEDURES

When you use In-Network services, the Provider will generally collect your copay from you at the time of your treatment and send a Claim to the Plan for payment. Sometimes Out-of-Network Providers will do the same. Other times, Out-of-Network Providers may bill you for the total cost of your treatment, and you will need to submit the Claim to the Plan to be paid. Whether you pay out-of-pocket or your Provider bills the Plan directly, you are still entitled to the same benefits.

If you receive a bill from your Provider (whether in- or Out-of-Network) for the Plan's portion of the costs, or you pay for your medical care out of pocket and need to be reimbursed, you must submit a Claim to the Plan. This section summarizes the procedures you must follow to submit a Claim for payment, and the procedures the Plan will use to determine whether and how much to pay for that Claim.

If you would like more details about Claims procedures and your rights and responsibilities, contact Bind Help.

A. Regular Post-Service Claims

Post-service Claims are non-urgent Claims after you have received treatment. (Urgent care and

concurrent care Claims have different timelines and requirements; see below.) Generally, you do not need to file a Claim for services from In-Network Providers—the Provider, will handle the filing of the Claim. For Out-of-Network Providers that do not file insurance Claims or if you receive emergency care outside the United States and are seeking reimbursement from the Plan, you can submit a Claim using this procedure.

You can submit a post-service Claim by mail to the address on your ID card. You will need to provide several pieces of information for Bind to be able to process your Claim and determine the appropriate Plan benefits:

- The name and birthdate of the Covered Person who received the care
- The member ID listed on the Bind ID card
- An itemized bill from your Provider, which should include:
  - The Provider's name, address, tax identification number, NPI number, and license number (if available)
  - The date(s) the Covered Person received care
  - The diagnosis and procedure codes for each service provided
  - The charges for each service provided
- Information about any other health coverage the Covered Person has
- Proof of payment may be requested to substantiate your Claim but is not required upon initial submission to Bind

B. Other General Claims Procedures

Your medical Claim must be submitted within one year from the date you received the healthcare services. If you are not capable of submitting a claim within one year, you must submit the Claim as soon as reasonably possible. If your Claim relates to an inpatient stay, the date you were discharged counts as the date you received the healthcare service for Claims purposes.

Within 30 days of submitting your Claim, you'll receive a decision. If we need more information on a Claim, we will reach out to you to provide that additional information, but we will still make a decision on your Claim within 30 days. If you are able to submit the requested additional information after a decision has been made, we may adjust our decision and reprocess your Claim accordingly.

Claims for medical (non-pharmacy) benefits will be reviewed by Bind. If more time is needed to decide your Claim, we may request a one-time extension of not more than 15 days.

If your Claim is ultimately denied, you'll receive an explanation of why it was denied and how you can appeal.

C. Urgent Care Claims

An urgent care Claim is a special type of Prior Authorization that occurs when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. Because your Provider is the one who initiates Prior Authorization, it will usually be your Provider who will request expedited processing. Urgent care Claims will be decided within 72 hours after submission. Urgent care Claims filed improperly or missing information may be denied.

If your urgent care Claim is denied, you'll receive an explanation of why it was denied and how you can appeal (including how to request expedited review).

D. Concurrent Care Claims

In some cases you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you will want to extend that course of treatment. This is called a concurrent care Claim.

If your extension request is not "urgent" (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent you may request expedited processing.

23. WHAT DO I DO IF MY CLAIM IS DENIED?

A. If Your Claim is Denied

If a Claim for Benefits is denied in part or in whole, you may call Bind Help before requesting a formal appeal. If they cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

To submit an appeal:

1. Contact Bind Help to request an Appeal Filing Form or refer to the Appeal Filling Form included with your Explanation of Benefits
2. Complete the Appeal Filing Form
3. Submit the Appeal Filing Form and your denial notice to:

   Bind Benefits, Inc.
   PO Box 211758
   Eagan, MN 55121

B. Review of an Appeal

Bind will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Bind upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal within 60 days from receipt of the first level appeal determination.

C. Access to Relevant Documents

Upon written request and free of charge, any Covered Persons may examine their Claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal Claims review process. Bind will review all Claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the Claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

D. Timing of Appeals Determinations

Separate schedules apply to the timing of Claims appeals, depending on the type of Claim. There are three types of Claims:

- **Urgent Care Request for Benefits:** A request for Benefits provided in connection with urgent care services.
- **Pre-Service Request for Benefits:** A request for Benefits which the Plan must approve or in which you must notify Bind before non-urgent care is provided.
- **Post-Service Request for Benefits:** A Claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Plan Administrator's decision letter to you.

The tables below describe the time frames which You and Bind are required to follow.

E. Urgent Care Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, Bind must notify you within:	**24 hours**
You must then provide completed request for Benefits to Bind within:	**48 hours** after receiving notice of additional information required
Bind must notify you of the benefit determination within:	**72 hours**
If Bind denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Bind must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*Follow the procedure for an Expedited Appeal provided in your denial of coverage letter.

F. Pre-Service Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, Bind must notify you within:	**5 days**
If your request for Benefits is incomplete, Bind must notify you within:	**15 days**
You must then provide completed request for Benefits information to Bind within:	**45 days**
Bind must notify you of the benefit determination:	
If the initial request for Benefits is complete, within:	**15 days**
After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**

Type of Request for Benefits or Appeal	Timing
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Bind must notify you of the first level appeal decision within:	**15 days** after receiving a complete first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Bind must notify you of the second level appeal decision within:	**15 days** after receiving a complete second level appeal

*Bind may require a one-time extension for the initial Claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

G. Post-Service Claims

Type of Claim or Appeal	Timing
If your Claim is incomplete, Bind must notify you within:	**30 days**
You must then provide completed Claim information to Bind within:	**45 days**
Bind must notify you of the benefit determination:	
If the initial Claim is complete, within:	**30 days**
After receiving the completed Claim (if the initial Claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Bind must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Bind must notify You of the second level appeal decision within:	**30 days** after receiving the second level appeal

H. Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Bind, or if Bind fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Bind's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling Bind Help or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Bind's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Bind has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

I. Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, Bind will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that Bind may process the request.

After Bind completes the preliminary review, they will issue a notification in writing to you. If the request is eligible for external review, Bind will assign an IRO to conduct such review. Bind will assign requests by either rotating assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

Bind will provide to the assigned IRO the documents and information considered in making the determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Plan Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and Bind will include it with the

documents forwarded to the IRO.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Bind. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and Bind, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Bind's determination, the Plan will immediately provide coverage or payment for the benefit Claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

J. Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a Claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and You have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Bind will determine whether the individual meets both of the following:

- **I**s or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that Bind may process the request.

After Bind completes the review, Bind will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Bind will assign an IRO in the same manner Bind utilizes to assign standard external reviews to IROs. Bind will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or

conclusions reached by Bind. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Bind.

You may contact Bind Help for more information regarding external review rights, or if making a verbal request for an expedited external review.

K. Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Bind will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an ongoing course of treatment 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 request and decided according to post-service or pre-service timeframes, whichever applies.

L. Limitation of Action

You cannot bring any legal action against the Plan Administrator or Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your Claim have been completed. If you want to bring a legal action against the Plan Administrator or Claim Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan Administrator or Claim Administrator.

M. Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post- service claim if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented, and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits. Contact the pharmacy Claims Administrator for information on how to submit a claim.

N. Time Deadline to File a Benefit Claim and Time Deadline to File a Benefit-Related Lawsuit

The Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Plan or any person acting with respect to the Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Adjustment is the earlier of:

1. Within 180 days of an adverse decision by the Plan Administrator, or

2. The earlier of:
    a. Within 180 days of the effective date of an election that is later claimed to be erroneous, or
    b. By the last day of the Plan Year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

24. COORDINATION OF BENEFITS (COB)

Refer to the Retiree General Information SPD for more information and other important information.

25. SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to “you” or “your” in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation — Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver’s insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement — Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy — including no—fault Benefits, PIP Benefits and/or medical payment Benefits — other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sick-

ness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the [participant][employee], deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan

What Happens to Settlements, Refunds, Rebates, Reversions to the Plan. For purposes of this Plan, any and all reversions, settlements, rebates, dividends, refunds or similar amounts or forms of distribution, of any type whatsoever, paid, provided or in any way attributable to the maintenance of a benefit program under this Plan, including but not limited to any outstanding benefit payments or

reimbursements that revert to the Company after remaining uncashed or unclaimed for a period of 12 months, shall be the sole property of the Company, and no portion of these amounts shall constitute "assets" of the Plan, unless and to the extent otherwise required by applicable law.

See the Retiree General Information SPD for more details regarding the Plan's right of recovery or Subrogation.

A. Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.
- Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

26. GENERAL ADMINISTRATIVE PROVISIONS

A. Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official *Plan Document,* the *Plan Document shall govern.*

B. Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator may need information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Plan including eligibility and Benefits. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator has the

right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the enrollment form.

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required by law or regulation.

For complete listings of your medical records or billing statements, we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we and the Claims Administrator will designate other persons or entities to request records or information from or related to you, and will release those records as necessary. Our designees have the same rights to this information as we have.

During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

C. Interpretation of Plan

The Plan Administrator, and to the extent it has delegated to the Claims Administrator, have sole and exclusive authority and discretion in:

- Interpreting Benefits under the Plan
- Interpreting the other terms, conditions, limitations, and exclusions set out in the Plan, including this SPD
- Determining the eligibility, rights, and status of all persons under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan.

The Plan Administrator and to the extent it has delegated to the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator, or its authorized delegate, may, in its sole discretion, offer Benefits for services that would not otherwise be Covered Health Services.

The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

D. Right to Amend and Right to Adopt Rules of Administration

The Plan Administrator, the CenturyLink Employee Benefits Committee, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plans. The Company, in its separate and distinct role as the Plan Sponsor has the right, within its

sole discretion and authority, at any time to amend, modify, or eliminate any benefit or provision of the Plans or to not amend the Plans at all, to change contribution levels and/or to terminate the Plans, subject to all applicable laws. The Company has delegated this discretion and authority to amend, modify or terminate the Plan to the CenturyLink Plan Design Committee.

E. Clerical Error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature, involving claims processing, and recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded, and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as practicable. Interest shall not be payable with respect to a Benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan Documents.

F. What Happens to Settlements, Refunds, Rebates, Reversions to the Plan

For purposes of this Plan, any and all reversions, settlements, rebates, dividends, refunds or similar amounts or forms of distribution, of any type whatsoever, paid, provided or in any way attributable to the maintenance of a benefit program under this Plan, including but not limited to any outstanding benefit payments or reimbursements that revert to the Company after remaining uncashed or unclaimed for a period of 12 months, shall be the sole property of the Company, and no portion of these amounts shall constitute “assets” of the Plan, unless and to the extent otherwise required by applicable law.

27. CLAIM FOR PREMIUM ADJUSTMENT AND THE DEADLINES

There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits.

If the appeal is not filed by this deadline it shall be deemed untimely and denied on that basis.

A. The Required Forum for Legal Disputes

After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Participant wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

B. Administrative Services

The Plan may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

C. Examination of Covered Persons

In the event of a question or dispute regarding Benefits, the Plan may require that a Physician of the Plan's choice examine you at our expense.

D. Workers' Compensation Not Affected

Benefits provided under the Health Plan do not substitute for and do not affect any requirements for coverage by Worker's Compensation insurance.

E. Conformity with Statutes

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law benefit mandates.

F. Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-network entity. The decision about whether or not to participate is yours alone but CenturyLink recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 8. Bind Clinical Programs.

G. Incentives to Providers

The Plan and the Claims Administrator do not provide health care services or supplies, nor does CenturyLink or the Plan Administrator practice medicine.

Rather, the Claims Administrator arranges for Providers to participate in a Network. Network Providers are independent practitioners; they are not CenturyLink Employees or Employees of the Claims Administrator, nor is there any other relationship with Network Providers such as principal-agent or joint venture. Each party is an independent contractor.

- The Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Plan or the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to health care. Examples of financial incentives for Network Providers are:
    - Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness
    - Capitation is when a group of Network Providers receives a monthly payment for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the health care is less than or more than the payment
    - Risk-sharing payments. The Network provider is paid a specific amount for a particular

unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per Covered Person or an amount per service with targeted outcome. If the amount paid is more than the cost of providing or arranging a Covered Person's health services, the Network provider may keep some of the excess. If the amount paid is less than the cost of providing or arranging a Covered Person's health service, the Network provider may bear some of the shortfall

- Various payment methods to pay specific Network Providers are used. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also contact the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

H. Refund of Benefit Overpayments

If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person
- All or some of the payment we made exceeded the cost of Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including issuing you a Form 1099 for the amount of the overpayment as gross income.

Additionally, if the Covered Person was determined not to be eligible for the Benefits under the Plan, that individual must refund the amount of the excess Benefit payment and the Plan may undertake collection actions, subject to the requirements of applicable law.

I. Your Relationship with the Claims Administrator and the Plan

In order to make choices about your health care coverage and treatment, the Plan believes that it is important for you to understand how the Claims Administrator interacts with the Plan Sponsor's benefit Plan and how it may affect you. The Claims Administrator helps administer the Plan Sponsor's benefit plan in which you are enrolled. The Claims Administrator does not provide medical services or make treatment decisions. This means:

- the Plan and the Claims Administrator do not decide what care you need or will receive. You and your Physician make those decisions;
- the Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD; and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Plan and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Plan and the Claims Administrator will use de-identified data for commercial purposes including research.

J. Relationship with Providers

The relationships between the Plan, the Claims Administrator and Network providers are solely contractual relationships between independent contractors. Network providers are not CenturyLink's agents or employees, nor are they agents or employees of the Claims Administrator. CenturyLink and any of its employees are not agents or employees of Network providers, nor are the Claims Administrator and any of its employees, agents or employees of Network providers.

The Plan and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, The Plan and the Claims Administrator arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided. They are not CenturyLink's employees nor are they employees of the Claims Administrator. The Plan and the Claims Administrator do not have any other relationship with Network providers such as principal-agent or joint venture. The Plan and the Claims Administrator are not liable for any act or omission of any provider.

The Claims Administrator is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Plan Administrator is responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

K. Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Copay, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non- Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

It is possible that you might not be able to obtain services from a particular Network provider. The

Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Contact the Claims Administrator for assistance.

L. Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with the Claim Administrator's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, Bind may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, CenturyLink reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes CenturyLink (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to Refund of Overpayments in the Coordination of Benefits section.

Bind will pay Benefits to you unless:

- The provider submits a claim form to Bind that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.
- Bind will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

M. Rebates and Other Payments

The Plan and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. The Plan and the Claims Administrator do not pass these rebates on to you nor are they applied to your Out of Pocket Maximum or taken into account in determining your Copays.

N. Review and Determine Benefits in Accordance with Bind Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), The Claims Administrator's reimbursement policies are applied to provider billings. The Claims Administrator shares it's reimbursement policies with Physicians and other providers in The Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of the Claims Administrator's reimbursement policies for yourself or to share with your non-Network Physician or provider by calling the telephone number on your ID card.

28. GLOSSARY

A. Medical Glossary

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan. ***In addition to this Glossary, and throughout this document, there are also terms defined in the Retiree General Information SPD.***

Add-In(s): The coverages that a Covered Person may enroll in in addition to the Core Benefits.

Adverse Health Factor: A new or deteriorating health or medical condition that coincides with the treatment(s) described in a specific Add-In (see "**ADD-INS**" on page 37), and to which you must self-attest that you have as part of the process to purchase Add-In benefits.

Addendum: Any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility: A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment: Any attached written description of additional or alternative provisions to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Enrollment: The period of time, determined by CenturyLink, during which eligible Employees

may enroll themselves and their eligible Dependents under the Plan. CenturyLink determines the period of time that is the Annual Enrollment period.

Applied Behavior Analysis (ABA): A type of intensive behavioral treatment for Autism Spectrum Disorder. ABA treatment is generally focused on the treatment of core deficits of Autism Spectrum Disorder, such as maladaptive and stereotypic behaviors that are posing danger to self, others or property, and impairment in daily functioning.

Autism Spectrum Disorders: A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early development period that cause clinically significant impairment in social, occupational, or other important areas of functioning and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Benefits: The health care services covered under Core and/or Add-In approved by the Plan Administrator as Covered Services, as explained in this SPD and any amendments.

Body Mass Index (BMI): A calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI: See Body Mass Index (BMI).

CHD: See Congenital Heart Disease (CHD).

Claim: A request for Benefits made by a Covered Person or his/her authorized representative in accordance with the procedures described in this SPD. It includes Prior Authorization requests.

Claims Administrator: Also known as a third party administrator, or TPA, provides administrative services to the Plan Administrator in connection with the operation of the Plan, including processing of Claims, as may be delegated to it.

Clinical Trial: A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA: See Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Copay: The percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section5. Bind On-Demand Health Coverage Plan: Plan Features and How the Plan Works.

Company: CenturyLink, Inc.

Complications of Pregnancy: A condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

Congenital Anomaly: A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD): Any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic

substances during her Pregnancy; or

- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): A federal law that requires employers to offer continued health insurance coverage to certain Employees/Retirees and their covered dependents whose group health insurance has been terminated. ***Refer to the Retiree General Information SPD for more information.***

Continuity of Care: The option for existing members to request continued care from their current health care professional if he or she is no longer working with their health plan and is now considered Out-of-Network.

Core: The Core benefits that all Covered Persons have under the Bind Plan.

Cosmetic: Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not Medically Necessary.

Cost-Effective: the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services: Health care services that are provided by your Provider or clinic and are covered by Core or Add-Ins subject to all of the terms, conditions, limitations and exclusions.

Covered Person: The person who is enrolled in Core, and eligible for Add-Ins, under the eligibility rules. This could include either the eligible Employee or an enrolled eligible Dependent as defined by the Plan and only while such person(s) is enrolled and eligible for Benefits under the Plan. References to “you” and “your” throughout this SPD are references to a Covered Person. ***See the Retiree General Information SPD for more details.***

CRS: See Cancer Resource Services (CRS).

Custodial Care: Services to assist in activities of daily living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, bathing and feeding.

Definitive Drug Test: Test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent: An individual who meets the eligibility requirements specified in the Plan, as described in the **Retiree General Information SPD**. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Facility: A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility, including but not limited to Centers of Excellence (COE), may or may not be located within your geographic area.

To be considered a Designated Facility or Centers of Excellence, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME: See Durable Medical Equipment (DME).

Domestic Partner: An individual of the same or opposite sex with whom you have established a domestic partnership as described in the Retiree General Information SPD.

Domiciliary Care: Living arrangements designed to meet the needs of people who cannot live

independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME): Medical equipment that is all of the following:

used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;

- not disposable, other than the diabetic supplies and inhaler spacers specifically stated as covered;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

E-Visit and Telephone Visit with Physician: Care provided by designated participating Providers performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of health care services that leads to a treatment plan provided by a participating Provider who is a licensed physician or a participating Provider who is a qualified licensed health care professional.

Effective Date: The date your coverage under this SPD is effective, which depends on the date that you timely complete all applicable enrollment requirements imposed by the Plan Administrator.

Eligible Charge: A charge for health care services, subject to all of the terms, conditions, limitations and exclusions of Core and Add-Ins for which Bind or Covered Person will pay.

Eligible Expenses: Charges for Covered Health Services that are provided while the Plan is in effect and determined by the Claim's Administrator.

Eligible Expenses are determined solely in accordance with the Claims Administrator 's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator 's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

For Services Provided by a/n:	Eligible Expenses are Based On:
Network Provider	Contracted rates with the provider

For Services Provided by a/n:	Eligible Expenses are Based On:
Out-of-Network Provider	Negotiated rates agreed to by the Non- Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator. If rates have not been negotiated, then one of the following amounts: • for Covered Health Services other than those services further specified below, Eligible Expenses are determined based on competitive fees in that geographic area. If no fee information is available for a Covered Health Service, the Eligible Expense is based on 50% of billed charges, except that certain Eligible Expenses for Mental Health Services and Substance Use Disorder Services are based on 80% of the billed charge; • for Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor; • for Covered Health Services that are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group. **Note:** Out-of-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described above.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of Copay.

Eligible Expenses are subject to the Claims Administrator 's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Emergency: The sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:

1. Placing the Covered Person's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Health Services: Health care services and supplies necessary for the treatment of an Emergency that are within the capabilities of the staff and facilities available at the Hospital.

Employee: Meets the eligibility requirements specified in the Plan, as described in the Eligibility section. An Employee must live and/or work in the United States. The determination of whether an individual who performs services for the Company is an Employee of the Company or an independent contractor and the determination of whether an Employee of the Company was classified as a member of any classification of Employees shall be made in accordance with the classifications used by the Company, in its sole discretion, and not the treatment of the individual for any purposes under

the Code, common law, or any other law.

Employee Retirement Income Security Act of 1974 (ERISA): The federal law that regulates retirement and employee welfare benefit plans maintained by employers.

Employer: CenturyLink, Inc.

EOB: See Explanation of Benefits (EOB).

ERISA: See Employee Retirement Income Security Act of 1974 (ERISA).

Explanation of Benefits (EOB): The EOB provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Covered Person's responsibility. The EOB is not a bill. a statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Copay;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria: A disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of

which must be criterion as shown in the first bullet below):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of ones' sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Health Statement(s): A single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency: A program or organization authorized by law to provide health care services in the home.

Hospital: An institution, operated as required by law, which:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury: Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility: A long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay: An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment: A structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care: Skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Investigative/Experimental Treatment: A procedure, study, test, drug or equipment will be considered Experimental and/or Investigational if it is not subject to a Bind Coverage with Evidence Development Policy and any of the following criteria/guidelines is met:

- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities/providers/etc. studying substantially the same drug, device, medical treatment or procedure refer to it as Experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).
- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
- It is the subject of an ongoing Clinical Trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
- It is being used for off-label therapies for a non-indicated condition – even if FDA approve for another condition.

Long-term Acute Care Facility (LTAC): A facility or hospital that provides care to people with complex medical needs requiring long-term hospital stay in an acute or critical setting.

Medicaid: A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary/Medical Necessity: A health care service is deemed Medically Necessary when it is delivered or supervised by a licensed healthcare provider according to the current standard of care, and is generally considered safe and effective for the prevention, diagnosis, or treatment of a covered health condition, as indicated by it being:

- Supported by two or more high-quality clinical trials published in peer-reviewed journals

- Consistent with clinical guidelines generally accepted in practice
- Clinically appropriate – type, frequency, extent and duration of service must be appropriate for you as an individual
- Cost effective – services must not be more costly than alternative services that are at least as likely to produce equivalent therapeutic and diagnostic results
- Or subject to a Bind Coverage with Evidence Development Policy
- Bind ensures Medical Necessity through Utilization Management processes.
- Review against our glossary → simultaneous with SME/legal/plan design review
- Health care services that are all of the following as determined by the Claims Administrator or its

Medicare: Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services: Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator: The organization or individual designated by CenturyLink who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness: Those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service

Network: When used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator ‘s affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator’s ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits: Description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5.C.”**Network and Out-of-Network Benefits and Providers (for those residing in a Network area)**” on page 9 for details about how Network Benefits apply.

New Pharmaceutical Product: A Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year

Out-of-Network Benefits: Description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to Section 5.C."**Network and Out-of-Network Benefits and Providers (for those residing in a Network area)**" on page 9 for details about how Out-of-Network Benefits apply.

Out-of-Pocket Maximum: The maximum amount you pay every calendar year. Refer to Section 11.A. "**Core – Benefit Features**" on page 16 for the Out-of-Pocket Maximum amount. See Section 5.B. "**What Are My Benefits?**" on page 8 for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment: A structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Payroll Deductions: Premiums for Core and Add-In benefits are paid by reducing the covered person's pay, typically on a pre-tax basis, as allowed by the IRS guidelines.

Pharmaceutical Product(s): *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Pharmacy Benefit Manager: A Third Party Administrator of prescription drug programs for commercial health plans and self-insured employer plans. Navitus is the PBM for Bind.

Physician: Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, naturopath or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan: The CenturyLink Health Care Plan.

Plan Administrator: The entity, as defined under Section (3)(16) of ERISA, that has the exclusive, final and binding discretionary authority to administer the Plan, to make factual determinations, to construe and interpret the terms of the SPD, Plan, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of Benefits. The Plan Administrator may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing Claims and performing other Plan-connected administrative services, CenturyLink Employee Benefits Committee and its designees.

Plan Sponsor: The entity that establishes and maintains the Plan, has the authority to amend and/or terminate the Plan and is responsible for providing funds for the payment of Benefits. CenturyLink, Inc.

Plan Year: The period following the Effective Date of the plan and each subsequent period (generally 12 months) this plan remains in force.

Pre-Admission Notification: Process whereby the Provider or you inform the Plan that you will be admitted to the inpatient hospital, skilled nursing facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization or residential treatment facility. This notice is required in advance of being admitted for inpatient care for any type of non-emergency admission and for partial hospitalization. All contracted facilities are required to provide preadmission notification.

Physician: Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law. Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the health plan.

Pregnancy: Includes prenatal care, postnatal care, childbirth, and any complications associated with what is listed.

Primary Physician: A Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician.

Prior Authorization: Pre-service benefit coverage decision for a service, procedure or test that has been subject to an evidence-based review resulting in a Medical Necessity determination.

Advanced approval to receive health care services deemed medically necessary by the Claim's Administrator. These are healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, including surgically implanted medical devices that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare'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 Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms;
- if you and/or a covered dependent have had services including medical devices approved in the past by UnitedHealthcare and have had a recent medical condition change which results in an increase of pain, device malfunction (including battery replacement) and/or deteriorating medical condition, the services must be reviewed to determine if they are covered under the plan in order for the device to be repaired or replaced. Recent and sufficient clinical data must be provided in order for coverage to be determined
- Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

- If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.
- UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on myuhc.com or by calling the phone number on the back of your ID card, and to Physicians and other health care professionals on UnitedHealthcare Online.

Private Duty Nursing: Nursing care that is provided to a patient on a one-to- one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure: A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility: A facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room: A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi- private Room is not available.

Shared Savings Program: A program in which the network partner may obtain a discount to a Non-Network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the Non-Network Provider. When this happens, you may experience lower out-of-pocket amounts. Plan copays would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the network partner. In this case the Non-Network Provider may bill you for the difference between the billed amount and the rate determined by the network partner. If this happens you should call the number on your medical ID Card. Shared Savings Program providers are not Network Providers and are not credentialed by the network partner

Short-term Acute Care Facility: A facility or hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.

Sickness: Physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance use disorder, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Care: Skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility: A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed and a transitional care unit) that provides skilled care.

Specialist Physician: A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Specialty Drugs: Injectable and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics:

- Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes;
- Intensive patient training and compliance assistance are required to facilitate therapeutic goals;
- There is limited or exclusive product availability and/or distribution;
- There are specialized product handling and/or administration requirements; or

- Are produced by living organisms or their products. Injectable and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics:
- Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes;
- Intensive patient training and compliance assistance are required to facilitate therapeutic goals;
- There is limited or exclusive product availability and/or distribution;
- There are specialized product handling and/or administration requirements; or
- Are produced by living organisms or their products.

Spinal Treatment: The therapeutic application of chiropractic and/or spinal treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Spouse: An individual to whom you are legally married, or a Domestic Partner as defined in the Retiree General Information SPD.

Sub-Acute Facility: A facility that provides intermediate care on a short-term or long-term basis.

Substance Use Disorder Services – Substance-Related and Addictive Disorders Services: Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service

Summary Plan Description (SPD): The document describing, among other things, the Benefits offered under the Bind On-Demand Health Plan and your rights and obligations under such benefit option as required by ERISA.

Transitional Care: Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services: Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or

cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **myuhc.com**

Please Note:

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The Claims Administrator may, in its discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

- If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved.
- It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Covered Person must consent to the procedure acknowledging that the Claims Administrator does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow the Claims Administrator to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.
- The decision about whether such a service can be deemed a Covered Health Service is solely at the Claims Administrator ’s discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care: Treatment of an unexpected Sickness or Injury that is not life- threatening but requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person’s life. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center: A facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;

- are at a location, distinct from a hospital emergency department, an office or a clinic;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

Usual and Customary: The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The Usual and Customary amount is used to determine the amount that may be charged by a Provider for the benefits.

Utilization Management: Utilization Management processes are conducted by Bind to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, and pharmacy policy management, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review (review of claims to ensure services were medically necessary).

Well Connected: Programs that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Well Connected Nurse: The primary nurse (Personal Health Nurse) that the Claims Administrator may assign to you if you have a chronic or complex health condition. If a Well Connected Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

B. Prescription Drug Glossary

Brand-Name: A Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by the Pharmacy Claims Administrator (UHC) as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

Note: You should know that all products identified as “brand name” by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Pharmacy Claims Administrator (UHC).

Designated Pharmacy: A pharmacy that has entered into an agreement with the Claims Administrator (UHC) or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic: A Prescription Drug that is either:

chemically equivalent to a Brand-name drug; or identified by the Claims Administrator (UHC) as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as a “generic” by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Pharmacy Prescription Claims Administrator (UHC).

Network Pharmacy: A retail or mail order pharmacy that has:

- entered into an agreement with the Pharmacy Claims Administrator (UHC) to dispense Prescription Drugs to Covered Persons;

- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Pharmacy Claims Administrator (UHC) as a Network Pharmacy.

PDL: See Prescription Drug List (PDL).

PDL Management Committee: See Prescription Drug List (PDL) Management Committee of the Pharmacy Claims Administrator (UHC).

Predominant Reimbursement Rate: The amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Out-of-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a Out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Pharmacy Claims Administrator (UHC) calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

Prescription Drug: A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies: insulin syringes with needles; blood testing strips - glucose; urine testing strips - glucose; ketone testing strips and tablets; lancets and lancet devices; insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and glucose monitors.

Prescription Drug Charge: The rate the Pharmacy Claims Administrator (UHC) has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL): A list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting the Pharmacy Claims Administrator (UHC) at the phone number on the back of your ID card or by logging onto **myuhc.com**.

Prescription Drug List (PDL) Management Committee: The committee that the Pharmacy Claims Administrator (UHC) designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Prior Authorization/Medical Necessity: Some non-life threatening prescription drugs require prior approval through the Pharmacy Claims Administrator (UHC) to determine if the drug meets certain criteria or conditions before the drug can be prescribed. Such criteria may include but are not limited to the medication; dose and duration; lab results; severity of illness, past use of non-drug treatment options; other clinical evidence, and availability of lower cost options. Generally, your physician or pharmacy will initiate this approval.

Specialty Prescription Drug: Prescription Drug that is generally high cost, self- injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutic Class: A group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent: When Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge: The usual fee that a pharmacy charges individual for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

C. HRA Glossary

Many of the terms used throughout this section may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. The HRA Glossary defines terms used throughout this section, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this section have the meaning set forth in your medical plan SPD.

HRA: Health Reimbursement Account or HRA. It is an IRS Section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA Eligible Expense: An expense that you incur specific to health care on or after the date you are enrolled in the HRA Plan and include the following: (i) an eligible medical expense as defined in Section 213(d); (ii) an Eligible Expense as defined in your medical plan SPD, including Prescription Drugs ; (iii) a medical expense not paid for under your active medical Plan as it represents your portion of responsibility for the cost of health care such as Annual Deductible and Copayments; and (iv) a medical expense not reimbursable through any other plan covering health benefits, other insurance, or any other accident or health plan.