# Bind On-Demand Health Plan*

(Administered by Bind Benefits, Inc.)

## Summary Plan Description (SPD)
## For Lumen Retired and Inactive Former Employees

Including:

- CenturyLink Retirees
- Embarq Retirees
- Qwest Post-1990 Management Retirees
- Qwest Post-1990 Occupational Retirees
- Inactives
- COBRA Participants

**Effective January 1, 2021**

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

* The Lumen brand was launched on September 14, 2020. As a result, Lumen, Inc. is referred to as Lumen Technologies, or simply Lumen. The legal name Lumen, Inc. is expected to be formally changed to Lumen Technologies, Inc. upon the completion of all applicable requirements.

Issued Jan. 1, 2021

LUMEN®

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# 1. INTRODUCTION

Lumen Technologies* (hereinafter "Lumen" 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, referred to as "Bind personalized 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 "**Bind Plan**"). The Prescription Drug Benefits are technically provided as a benefit option under the Lumen Health Care Plan*, a separate medical plan from the Bind personalized 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, 2021. 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 Document*s (such as the Summary of Material Modifications (SMMs), the **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 personalized health plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Bind personalized health plan medical 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 healthcare coverage that qualifies as "minimum essential coverage". The Bind Plan does provide 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.

## B. Company's Reserved Rights

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

*The Plan Administrator, the Lumen 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* ***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 23* "**L. Time Deadline to File a Benefit Claim and Time Deadline to File a Benefit-Related Lawsuit**" *and in the* ***General Information SPD*** *for more information about the timing of these deadlines.*

* The Lumen brand was launched on September 14, 2020. As a result, Lumen, Inc. is referred to as Lumen Technologies, or simply Lumen. The legal name Lumen, Inc. is expected to be formally changed to Lumen Technologies, Inc. upon the completion of all applicable requirements.

## 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 personalized 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 **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 **General Information SPD**. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or Lumen.

References to "you" and "your" are references to people who are Participants as the term is defined in the **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 healthcare Provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

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

## E. Bind Personalized Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Bind Plan is to provide for the payment of certain healthcare 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 payable under the Bind 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 Bind 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 healthcare Provider can decide what is the right healthcare decision for you.*** *Decisions by the Claims Administrator or the Plan Administrator are solely decisions with respect to Bind Plan coverage and do not constitute healthcare recommendations or advice.*

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

Lumen 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, Lumen generally takes the position that ERISA preempts such state laws.

# 2. GENERAL PLAN INFORMATION

The Bind personalized health plan benefit option is just one benefit option offered under the Plan. This SPD **must** be read in conjunction with the **General Information SPD** which explains details of your coverage and provides a listing of the other benefit options under the Plan.

*Refer to the **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 Lumen Service Center at 866-935-5011 or 800-729-7526, option 1 and option 1 to request a paper copy of the **General Information SPD** or you can go online at lumen.com/healthandlife 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 the 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 , 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 Bind 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 Lumen Service Center 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, 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 Participants 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* ***General Information SPD*** *as applicable.*

## C. You Must Follow Bind Plan Procedures

**Please** keep in mind that it is very important for you to follow the Bind Plan's procedures, as summarized in this SPD, in order to obtain Bind 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 Bind Plan's procedures. If you do **not** follow the Bind Plan's procedures for claiming a Benefit or resolving an issue involving Bind Plan Benefits, there is no guarantee that the Bind 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 personalized 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.

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|---|---|
| **Bind personalized health plan (Medical) Member Service** | **Phone:**<br>833-576-6519<br>6:00 a.m.-9:00 p.m. (Central)<br>Monday-Friday<br>**Website:** MyBind.com<br>**Mobile App:**<br>Download the MyBind mobile app from the Apple App Store or Google Play Store. |
| **OptumRx (Pharmacy) Member Service** | Refer to Section 20 "PRESCRIPTION DRUGS" |
| **Bind Website and App** | **Once enrolled:**<br>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.<br>**When enrolling:** Lumen.com/ChooseBind<br>**Access Code:** enroll2021 |
| **Bind (Medical Claims Administrator) Mailing Address** | **For Medical Claims:**<br>To file medical Claims, appeal requests and any written inquiries to:<br>Attention: Claims<br>Bind Benefits, Inc.<br>P.O. Box 211758<br>Eagan, MN 55121<br>**For Medical Appeals/Complaints:**<br>To file a medical appeal for Bind, mail the appeal to:<br>Bind Benefits, Inc.<br>Attn: Appeals<br>P.O. Box 211758<br>Eagan, MN 55121<br>For more information on how to appeal a Claim, refer to Section 22 "MEDICAL CLAIMS PROCEDURES" |
| **OptumRx (Pharmacy Claims Administrator) Mailing Address** | **For Prescription Claims:**<br>To file a Prescription Drug appeal, mail the appeal to:<br>UnitedHealthcare Appeals<br>P.O. Box 30432<br>Salt Lake City, UT 84130-0432 |

# 4. BIND PERSONALIZED HEALTH PLAN BENEFIT

## A. Eligibility

### Bind Plan

If you are eligible for medical coverage under the Plan, (*refer to the **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.

### Electing and Activating Conditional Coverages

Once enrolled in the Bind Plan, any Participant is eligible to elect and activate one or more conditional coverages. To elect a conditional coverage into your benefit package you must take the following steps to

activate the coverage – at least three business days in advance of receiving the conditional coverage test, treatment, or therapy unless you expressly and permanently opt-out of the three-business-day waiting period – in order to have coverage for the test, treatment, or therapy:

1. choose the conditional coverage test, treatment, or therapy;
2. choose the Provider and location for the test, treatment, or therapy;
3. attest to the Adverse Health Factor;
4. review the total cost of the test, treatment, or therapy; and
5. click “Activate Coverage” to complete the activation process.*

You can elect and activate coverage yourself on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. If you do not elect and activate the conditional coverage you need so it is effective in advance of you receiving the test, treatment, or therapy, you will not have coverage under the Bind Plan for the test, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period, you may cancel the conditional coverage within the three-business-day waiting period on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. Once the conditional coverage is properly activated and effective, it cannot be cancelled for the duration of the conditional coverage period.

**If the Participant electing and activating conditional coverage is a dependent, the subscriber must complete a sixth step and finally approve the conditional coverage election to fully complete the activation process.*

## B. When Does My Coverage Begin and End: Effective Dates

### Bind Plan

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

### Coverages You Must Elect and Activate

**You must first elect and activate a conditional coverage for it to be effective – or in other words, if you do not first elect and activate conditional coverage, you will not have coverage under the Bind Plan for the conditional coverage test, treatment, or therapy.**

If you are already enrolled in the Bind Plan, coverage for a conditional coverage is effective three business days after you complete the election and activation process, unless you expressly and permanently opt-out of the three-business-day waiting period. To elect a conditional coverage into your benefit package you **must** take the following steps to activate the coverage:

1. choose the conditional coverage test, treatment, or therapy;
2. choose the Provider and location for the test, treatment, or therapy;
3. attest to an Adverse Health Factor;
4. review the total cost of the test, treatment, or therapy; and
5. click “Activate Coverage” to complete the activation process.*

You can elect and activate coverage yourself on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. If you do not elect and activate the conditional coverage you need so it is effective in advance of you receiving the test, treatment, or therapy, you will not have coverage under the Bind Plan for the test, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period, you may cancel the conditional coverage within the three-business-day waiting period on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. Once the conditional coverage is properly activated and effective, it cannot be cancelled for the duration of the conditional coverage period.

If you are enrolled in the Bind Plan (or you have completed Annual Enrollment) but your coverage is not yet effective, you can call Bind Help for assistance in electing and activating conditional coverage to be effective as of the first day of the Plan Year.

**If the Participant electing and activating conditional coverage is a dependent, the subscriber must complete a sixth step and finally approve the conditional coverage election to fully complete the activation process.*

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

### Bind Plan

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

### Coverages You Must Elect and Activate

- Only with respect to conditional coverages: 120 days after the conditional coverage Effective Date, even if the date of the conditional coverage test, treatment, or therapy falls into the subsequent Plan Year so long as you maintain Bind Plan coverage for the subsequent Plan Year.
- If you have activated conditional coverage under the Bind Plan, and have a remaining balance when terminating from Lumen, and elect the Bind Plan under COBRA or Retiree benefits, your remaining balance will be included on your monthly billing statements.

The remainder of this SPD provides more details about the specific Benefits and provisions of the Bind personalized health plan benefit option.

# 5. BIND PERSONALIZED HEALTH PLAN: BIND PLAN FEATURES AND HOW THE BIND PLAN WORKS

The Bind personalized health plan design allows each Participant to make informed choices about their healthcare, cost, and coverage needs. With the MyBind mobile app and the MyBind.com website, Participants can search for available care, cost, and coverage options from anywhere to choose the best option for them. Or Participants can call Bind Help for assistance navigating their coverage options. Eligible Employees and Dependents who properly enroll in the Bind Plan are referred to as “Participants” in this SPD.

## A. Here’s How It Works

When you enroll in the Bind Plan, your coverage automatically includes 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. Your coverage also provides substantial coverage for common and/or Medically Necessary services and treatments, such as maternity care, cancer treatment, and physical therapy.

**Once enrolled in the Bind Plan, Bind coverage also includes the right to elect conditional coverages into your benefit package for 45 less-common tests, treatments, or therapy if you have an Adverse Health Factor – a new or deteriorating medical condition that coincides with the conditional coverage you need. These coverages are conditional because you must first elect and activate the coverage – at least three business days in advance of receiving the test, treatment, or therapy – in order to have coverage for such test, treatment, or therapy under the Bind Plan.**

Conditional coverages include tests, such as Upper GI Endoscopies, and treatments - including, for example, hernia repairs, hysterectomies, lumbar spine fusion, and knee arthroscopies, shoulder arthroscopies, and many other condition-based services. Participants can elect and activate these coverages at any time

during the Plan Year if the Participant experiences an Adverse Health Factor and makes additional premium contributions.

To elect a conditional coverage into your benefit package you must take the following steps to activate the coverage – at least three business days in advance of receiving the conditional coverage test, treatment, or therapy unless you expressly and permanently opt-out of the three-business-day waiting period:

1. choose the conditional coverage test, treatment, or therapy;
2. choose the Provider and location for the test, treatment, or therapy;
3. attest to the Adverse Health Factor;
4. review the total cost of the test, treatment, or therapy; and
5. click "Activate Coverage" to complete the activation process.*

You can elect and activate coverage yourself on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. If you do not elect and activate the conditional coverage you need so it is effective in advance of you receiving the test, treatment, or therapy, you will not have coverage under the Bind Plan for the test, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period, you may cancel the conditional coverage within the three-business-day waiting period on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. Once the conditional coverage is properly activated and effective, it cannot be cancelled for the duration of the conditional coverage period.

**If the Participant electing and activating conditional coverage is a dependent, the subscriber must complete a sixth step and finally approve the conditional coverage election to fully complete the activation process. The waiting period starts after the subscriber approves the conditional coverage election.*

All Bind coverages are underwritten as one Plan offering. Participants and Plan Sponsors share in the cost of the Bind Plan. Your premium contribution amount depends on the Benefit package you select and the Dependents you choose to enroll.

To summarize, the Bind personalized health plan gives you cost, and coverage options, and allows you to customize and personalize your benefit package during the Plan Year if you experience an Adverse Health Factor.

## B. What Are My Benefits?

Claims for Benefits under the Bind Plan are payable only for Covered Services that are Medically Necessary.

The total cost of Covered Services is shared between you and the Bind Plan. Your share (including for conditional coverages) consists of premium contributions and copayments. The Bind Plan does not have a deductible or co-insurance. Your Bind Plan does have an Out-of-Pocket Maximum which is the maximum amount you will pay each Plan Year for Covered Services.

> Your premium contributions are deducted from your paychecks on a before-tax basis, or in other words, before federal income and Social Security taxes are withheld, and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost of your benefit package. Your premium contributions are subject to review and the Plan Administrator reserves the right to change your premium contribution amount from time to time. Your conditional coverage costs are on an after-tax basis.

Your copayments for Covered Services are listed in Section 11 "**A. Copayments**", Section 20 "**PRESCRIPTION DRUGS**", and Section 18 "**A. Conditional Coverage Copayments**" – and also on the MyBind mobile app and MyBind.com website.

The Bind Plan pays for the remainder of the amount billed by your Network Provider for Covered Services after any discounts are applied.

Discounts are negotiated with Network Providers. If you use Network Providers, you will pay lower Copayments and the Provider will not charge you any additional fees. If you use an out-of-network Provider, you will pay (in addition to your Copayment) all amounts that exceed the Usual and Customary amount. Copayments for Bind coverage, Prescription Drugs, and conditional coverage can be found in the following sections:

- Bind coverage: Section 11.B
- Prescription Drugs: Section 20
- Conditional coverages: Section 18.A

Conditional coverage tests, treatments, and therapies must be received from Network Providers.

Once your total Copayments (including those for conditional coverages) reach your applicable Out-of-Pocket Maximum, the Bind Plan pays 100% of Eligible Charges for the remainder of the Plan Year, except for amounts you pay for out-of-network Covered Services in excess of the Usual and Customary amount – these amounts are NOT counted towards your 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. Under ERISA participants have a right to obtain a paper copy of network provider listing. And we are required by ERISA to explain this. So, please add a statement here.

### In-Network Benefits

As a Participant in the Bind 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 the Bind Plan when you receive care from Network Providers; in most instances, your out-of-pocket expenses will be far less. The Bind Plan features a large Network of Providers.

These Providers will:

1. File Claims for Benefits for you; and
2. Accept payment based on the discounted rate previously negotiated.

Network Providers may take care of Prior Authorization, Pre-Admission Notification, pre-admission 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 Network Provider information, refer to Lumen.com/ChooseBind or connect with Bind via web, mobile app, or phone using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

You must show your insurance identification "ID" card every time you request healthcare services from a Network Provider which can be found on the MyBind mobile app. If you do not show your ID card, Network Providers have no way of knowing that you are enrolled under the Bind 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 healthcare services outside the Network, the Bind Plan generally pays Claims for Benefits at a lower level. As a result, you will be responsible for the difference between the amount billed

by the out-of-network facility-based Physician and the amount we determine to be the Eligible Charge for reimbursement. 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 will 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 Claims for 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 or out-of-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 service you receive and the Provider, you may have access to a discount through the Network partner's Shared Savings Program for non-Network Providers. As part of this program, some Providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these Providers, the Copayment 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. These discounts are not always known until the service is rendered and cannot be determined in advance. Refer to Section 28 "**A. Medical Glossary**" for details about how the Shared Savings Program applies.

Conditional coverage is 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 Bind Plan will still pay Benefits for you and your covered Dependents at In-Network levels. This "Virtual Network" is designed to help Retirees 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 Bind Plan for reimbursement.

Covered services will be subject to "Eligible Expenses" as described in the Medical Glossary. You will automatically be enrolled in the Virtual Network if this is applicable (otherwise this is not available to you) your ID card 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 healthcare 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 far less. Therefore, in most instances, your out-of-pocket expenses will be far 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 Lumen 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 a 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 healthcare 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 do not 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 Benefit level.

# 6. HEALTH REIMBURSEMENT ACCOUNT (HRA) AND BIND

If you elect the Bind personalized health plan and have a prior CDHP Health Reimbursement Account (HRA) balance from your prior coverage these dollars will follow you. Your prior account HRA dollars will not be available until after the run-out period (for Claims to clear under the CDHP Plan benefit option HRA). This typically takes 90 days. Under the Bind personalized health 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 if you retire and elect one of these Plan benefit options under the Lumen Retiree and Inactive Health Plan.

Ninety (90) days after you commence coverage in the Bind Plan, you will have access to your HRA account balance. You can then use the money to pay yourself back for eligible Bind healthcare 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 Retiree Health Reimbursement Account SPD for more information.*

If you are enrolled in the Bind personalized health plan and experience a Qualified Life Event (QLE) which may allow you to change your benefit options and you elect to change your medical option during the year to elect the HDHP, any remaining HRA account dollars will be automatically moved to a Post-Deductible HRA after a 90-day Claims run-out period.

A post deductible HRA is an account that reimburses Claims once the annual deductible has been met under a qualified HDHP for the Plan Year. The Post Deductible HRA funds will be used to reimburse medical and pharmacy expenses. These Claims will automatically roll over to your Post Deductible HRA. IRS regulations prevent Participants enrolled in a HDHP with a Health Savings Account (HSA) to have other first dollar coverage.

# 7. PRIOR AUTHORIZATION AND PRE-ADMISSION NOTIFICATION

Select services require Prior Authorization or notification. Prior Authorization is required if the services are rendered by both Network and out-of-network Providers.

Network Providers are responsible for obtaining Prior Authorization for select Covered Services and are responsible for Pre-Admission Notification for planned inpatient admissions and post-admission notification within 24 hours of admission for Emergency inpatient admissions. Prior Authorization is not required for conditional coverages; however, if the procedure is being performed in an inpatient setting, the Provider is responsible for Pre-Admission Notification within 24 hours of admission. 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 the services may not be covered by the Bind Plan. Contact Bind Help prior to obtaining services to determine whether Prior Authorization is required or ask your Provider to contact the pre-certification number on your ID card.

The most current information can be obtained by having your Provider contact the pre-certification number on your ID card or by calling Bind Help.

**Prior Authorization may be required for but not limited to the following services:**

- Acute care hospitalizations (planned)
- Acute inpatient rehabilitation
- Skilled Nursing Facilities
- Long-term acute care
- Residential treatment facilities
- Partial hospitalization
- Advance behavioral analysis
- Non-Emergency air transportation
- Bariatric surgery
- Bone growth stimulators
- Clinical Trials
- Select cardiovascular procedures
- Select chemotherapy
- Cochlear implant surgery
- Potentially Cosmetic and Reconstructive surgery
- Select Durable Medical Equipment, orthotics, and prosthetics
- Gender reassignment surgery
- BRCA testing
- Select genetic and molecular tests
- Intensity-modulated radiation therapy
- Select injectable medications
- MR-guided focused ultrasound
- Organ transplants
- Orthognathic surgery
- Proton beam therapy
- Sleep apnea procedures
- Sleep studies
- Select spinal surgeries
- Vein procedures
- Ventricular assist devices

## A. Pre-Service and Urgent Care Request for Benefits

A pre-service Claim is a type of Claim that requires Prior Authorization but is not urgent. 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 as

soon as possible, taking into account the medical exigencies, but no more than 72 hours after we receive your Claim. Urgent care Claims filed improperly, or missing information may be denied.

If your pre-service or urgent care Claim is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). Please refer to Section 23 "**WHAT DO I DO IF MY CLAIM IS MEDICAL DENIED?**" for the process for filing an appeal and the timing of appeal determinations.

### B. Concurrent Care Request for Benefits

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.

If an on-going 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 on-going 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.

If your concurrent care Claim is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). Please refer to Section 23 "**WHAT DO I DO IF MY CLAIM IS MEDICAL DENIED?**" for the process for filing an appeal and the timing of appeal determinations.

## 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 healthcare 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 Care Model Innovations (see below), 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 Resource Services

For a Solid Organ and Blood/Marrow transplant to be a Covered Service, you must be enrolled in Transplant Resource Services and 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 more information on Transplant Resources Services and access to the Transplant Center of Excellence.

Once you are enrolled in Transplant Resource 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, heart/lung, lung, kidney, kidney/pancreas, liver, liver/intestine, 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 Care Model Innovations

A Care Model Innovations (CMI) program is a Provider contracted with Bind to provide health-related services that prevent, treat, or reverse one or more chronic diseases or conditions. CMI 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 CMI.

CMI 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, nutritionists, health coaches, community health workers, and trained peers. Bind CMIs are credentialed according to the Bind Care Model Innovations 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, and biomarker feedback. The program is for Type-II diabetics that meet certain criteria. To find out additional information, visit Bind via web, mobile app, or phone using the information found in Section 3 “**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**”.

### 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. To find out additional information, connect with Bind via web, mobile app, or phone using the information found in Section 3 “**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**”.

### Maternity Support Program

Bind offers a maternity support program with around-the-clock access to maternity nurses, lactation consultants, and early childhood experts. To find out additional information, connect with Bind via web,

mobile app, or phone using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

Bind may offer additional or varying Care Model Innovations throughout the year. To find out additional information, connect with Bind via web, mobile app, or phone using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

# 9. TRANSITION OF CARE AND CONTINUITY OF CARE

Bind offers Transition of Care and Continuity of Care. 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 allow you the option to request coverage from your current out-of-network Provider at the in-network Copayments for a limited time due to a qualifying medical condition until the safe transfer to a Network Provider can be arranged. If you are currently covered by Bind, and your healthcare Provider leaves the Network, you have the opportunity to apply for Continuity of Care. Continuity of Care Benefits, if approved, allow you the option to request extended care from the out-of-network Provider while paying in-network Copayments until a safe transition can be made to a Network Provider.

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

- You are currently enrolled in the Bind Plan and actively receiving care for a Covered Services by an in-network Provider and the Provider leaves the network and becomes an out-of-network Provider, or
- You are newly eligible for Bind and currently receiving care for a Covered Service by an in-network Provider and your Provider is no longer in-network under the Bind Plan.

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

- **Inpatient and Residential Care:** If you are actively receiving inpatient or residential care at a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits to cover the duration of the inpatient or residential care stay.
- **Scheduled Surgery/Procedure:** If you have a scheduled procedure with a Network Provider who becomes out-of-network, you may quality for Transition of Care or Continuity of Care Benefits if the procedure is 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:** If you are in your second trimester of Pregnancy or are earlier in your pregnancy but considered high-risk and are receiving care from a Provider who was in-network and becomes out-of-network, you may quality for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically extend through two months after giving birth.
- **Serious Chronic Condition:** If you are actively being treated for a serious chronic medical condition which may persist or worsen if care is delayed and are receiving care from a Provider who was in-network and becomes out-of-network, you may quality for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically are covered for 120 days of the Participant's Effective Date or Provider termination date.
- **Terminal Illness:** If you have an incurable or irreversible condition that has a probability of causing death within one year or less and are receiving care from a Provider who was in-network and becomes out-of-network, you may quality for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically are covered for 120 days of the Participant's Effective Date or Provider termination date.
- **Transplant:** If you are the recipient of an organ transplant and in need of ongoing care due to complications associated with the transplant and are receiving care from a Provider who was in-network and becomes out-of-network, you may quality for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically are covered for 120 days of the Participant's Effective Date or Provider termination date.

To request an application for Transition of Care (new Participants) or Continuity of Care (existing Participants), 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 Participants or within 30 days of the Provider leaving the Network for existing Participants. 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 healthcare 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 medicines or treatments 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 healthcare costs for qualifying individuals participating in approved Clinical Trial. For more information call Bind Help.

Clinical Trial services may require Prior Authorization and Medical Necessity review.

## 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 healthcare 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 Bind Plan Benefit design.

# 11. COVERED BIND PERSONALIZED HEALTH PLAN BENEFITS

## A. Copayments

The table below describes how your coverage works and includes Copayments and any premium contributions applicable to the healthcare service you choose. Some Copayments are listed as a range based on Bind’s analysis of treatment outcomes and cost information that identifies doctors, clinics, and Hospitals that provide cost-efficient care. You may be eligible for reduced Copayments for certain Benefits and for specific Care Model Innovations programs if you use Network Providers that Bind has designated as preferred, high-

value Providers. Copayments within the ranges may be updated from time to time, but never higher than the maximum Copayment.

**The full range of Copayments displayed may not be available in all areas or for all services. You can find Provider specific Copayment amounts by utilizing the 'Search tool' on the MyBind mobile app or MyBind.com website, or by calling Bind Help.**

To learn more about the availability of preferred, high-value Providers and the potential for reduced Copayment amounts please visit Lumen.com/ChooseBind, or connect with Bind via web, mobile app, or phone using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

The following chart shows the deductibles and Out-of-Pocket Maximums (maximum) for the Bind Plan.

## B. Benefit Features

| The Bind Plan | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Deductible** | $0 | $0 |
| **Out-of-Pocket Maximum** | | |
| **Individual** | $5,000 | $10,000 |
| **Retiree (EE) + Spouse/Retiree (EE) + Child** | $7,500 | $15,000 |
| **Family** | $10,000 | $20,000 |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Once you meet the individual Out-of-Pocket Maximum, Benefits are payable at 100% of the Eligible Charge during the rest of that year.
- If you have other family members enrolled in the Bind Plan, they have to meet their own, individual Out-of-Pocket Maximum until the overall family Out-of-Pocket Maximum has been met. 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. The amount applied to your out-of-network Out-of-Pocket Maximum does not apply to your in-network Out-of-Pocket Maximum.

## C. Covered Services

| Ambulance Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | $600 Copayment/transport | $600 Copayment/transport |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Ground or air ambulance, as the Claims Administrator determines appropriate.
- Emergency ambulance services and transportation provided by a licensed ambulance service to the 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, the Claims 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: the Bind 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 an out-of-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.
- Non-Emergency ground and air ambulance services may require Prior Authorization and will be reviewed for Medical Necessity.

| Behavioral Health: Mental Health and Substance Use Disorder Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit** | $20 Copayment / visit | $130 Copayment / visit |
| **Mental Health Telemedicine Visit** | $20 Copayment / visit | $130 Copayment / visit |
| **Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder Visit** | $20 Copayment / visit | $130 Copayment / visit |
| **Cognitive, Occupational, Physical, and Speech Therapy** | $10 Copayment / visit | $40 Copayment / visit |
| **Electroconvulsive Therapy (ECT)** | $250 Copayment / visit | $500 Copayment / visit |
| **Intensive Outpatient Treatment Program (IOP)** | $125 Copayment / visit | $250 Copayment / visit |
| **Partial Hospitalization (PHP)/Day Treatment** | $175 Copayment / visit | $350 Copayment / visit |
| **Subacute Detoxification Care** | $125 Copayment / visit | $250 Copayment / visit |
| **Substance Use Disorder Medication Therapy** | $10 Copayment / visit | $20 Copayment / visit |
| **Transcranial Magnetic Stimulation (TMS) Therapy** | $45 Copayment / visit | $90 Copayment / visit |
| **All Other Outpatient Hospital Services (Visit)** | $750 Copayment / visit | $1,500 Copayment / visit |
| **Residential Treatment Facility Care** | $1,300 Copayment / stay | $2,800 Copayment / stay |
| **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Benefits include:
  - Diagnostic evaluation assessment and treatment planning
  - Other treatments and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management services
  - Crisis intervention
  - Intensive Outpatient Treatment program (IOP) (a structured outpatient Mental Health or Substance Use treatment program at a freestanding or Hospital-based facility and provides services for at least three hours per day, two or more days per week)
  - Residential treatment
  - Partial Hospitalization (PHP)/Day treatment (a structured ambulatory program that may be freestanding or Hospital-based and provides services for at least 20 hours per week)
  - Other Outpatient treatment
- Coverage is available for both face-to-face and Telehealth services.
- The Bind Plan pays forcovers behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies (IBT) 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.
- An Intensive Behavioral Therapy (IBT) is outpatient behavioral care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age appropriate skills in Participants with Autism Spectrum Disorder.
  - 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.
  - Visit limits do not apply to therapies provided for a mental health condition, such as autism disorders.
- Applied Behavioral Analysis for Autism Spectrum Disorder Services are reviewed for Medical Necessity. Have your Provider request may require Prior Authorization and Medical Necessity review.
- Refer to the MyBind app to determine what Copayment has been assigned to your procedure/service.
- See “Hospital Services” section for other coverage notes.

| Cancer Chemotherapy | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | $1,100 Copayment / visit | $2,200 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The Bind 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.
- Benefits include Physician services and facility charges.
- 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.
- Select Cancer Chemotherapy services may require Prior Authorization and Medical Necessity review.

| Colonoscopy Non-Screening | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | $300 to $750 Copayment / visit | $1,500 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- When this procedure is performed to diagnose disease symptoms, a Copayment applies.
- Coverage is available for a diagnostic colonoscopy received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office. Benefits include Physician services and facility charges.
- Services for preventive screenings are provided under the Preventive Care Services for coverage notes.
- The Copayments may vary based on Provider and location.

| Complex Imaging | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | $150 to $575 Copayment / visit | $1,150 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- 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, refer to "Preventive Care Services" section for coverage notes.
- The Copayments may vary based on Provider and location. Benefits include Physician and facility charges. If imaging occurs on multiple areas of the body, such as the lumbar spine and the cervical spine, more than one Copayment may apply.

| Dental Services: Accidental and Medical | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| **All Other Services** | | |
| • **Oral Surgery (removal of impacted teeth)** | $140 Copayment / visit | $280 Copayment / visit |
| • **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |
| • **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The Bind Plan 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.
- 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 a 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.
- The Bind Plan 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 Participant 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.
- Accidental Dental Services may require Prior Authorization and Medical Necessity review.

| Dialysis Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |
| **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The Bind 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.
- The Copayments for the office visit may vary based on Provider and location.

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

**Notes:**

The Bind Plan covers Durable Medical Equipment, prosthetics, orthotics, and supplies subject to the limitations listed below:

- Refer to the MyBind mobile app for additional coverage information.
- Coverage includes rental or purchase of DME if Medically Necessary, ordered or provided by a Physician for outpatient use primarily in a home setting, serves a medical purpose for the treatment of an illness or Injury, and not of use to a Participant in the absence of a disease or disability.
- Visit Lumen.com/ChooseBind, MyBind.com website, the MyBind mobile app or call Bind Help to learn what DME items are in which tier.
- This list is subject to periodic review and modification (generally quarterly, but no more than six times per Calendar Year).
- 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 Participant per Calendar Year up to a maximum of $350 for Network and out-of-network Providers combined.
- The Bind Plan covers the purchase of one standard breast pump, either manual or electric, for pregnancy or postpartum participants per pregnancy. Participant may have to pay a surcharge to the provider if they purchase enhanced models.
- Cranial orthoses such as head shaping helmets and head reconstruction are a set of orthotic devices and services to reshape the head. They may be medically indicated for plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- 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.
- Enteral Nutrition and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. The formula or product must be administered under the direction of a Physician or registered dietitian. (example conditions include, but not limited to, metabolic disease such as phenylketonuria (PKU) and maple syrup urine disease severe food allergies, and impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract)
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Orthotics are limited to up to $350 per Participant per Calendar Year for foot orthotics for Network and out-of-network Providers combined.
- Coverage is provided for eligible Durable Medical Equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Select Durable Medical Equipment (DME) may require Prior Authorization and Medical Necessity review.

| Emergency Room Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Emergency Room Visit** | $500 Copayment / visit | $500 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayment 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 Room Services Copayment will be waived, and you will be responsible for the Inpatient Hospital Services Copayment.
- If you are admitted to observation directly from the Emergency Room for the same condition, the Emergency Room Services Copayment will be waived, and you will be responsible for the Outpatient Hospital Services Copayment.

| Gender Dysphoria Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit** | $20 Copayment / visit | $130 Copayment / visit |
| **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |
| **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Benefits for the treatment of Gender Dysphoria provided or under the direction of a Physician include:
- 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 Mental Disorders by the American Psychiatric Association*:
- **Diagnostic criteria for adults and adolescents:** A marked incongruence between one's experienced/expressed gender and assigned gender at birth, 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 at birth).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender at birth).
  - 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 at birth).
  - 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 at birth, 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 at birth).
  - In boys (assigned gender at birth), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender at birth), 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 at birth), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender at birth), 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.
- Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.

| Genetic Testing | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | $250 Copayment / visit | $500 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
  - The following categories of services are covered:
  - Genetic tests for cancer susceptibility
  - Genetic tests for hereditary diseases
  - Unspecified molecular pathology
  - Fetal aneuploidy testing
- Select Genetic Testing services may require Prior Authorization and Medical Necessity review.

| Home Health Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Home Health Care Visit** | $25 Copayment / visit | $170 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Limited to 120 visits per Participant per Plan Year for Network and out-of-network Providers combined.
- Services received from a Home Health Agency (an organization authorized by law to provide healthcare services in the home) or independent Provider that are the following:
  - Ordered by a Physician;
  - Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
  - Provided on a part-time, intermittent care schedule; and
  - Provided when Skilled Care is required.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Care Agency, will apply toward the Home Health Services visit limits.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, not from a Home Health Agency will apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.

| Hospice Care | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Home Hospice Visit** | $25 Copayment / visit | $170 Copayment / visit |
| **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- 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 Participant is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.
- Inpatient Hospice Care may require Prior Authorization and Medical Necessity review.

| Hospital Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |
| **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The Copayments above apply unless a Benefit is specified in another section of this SPD.
- Multiple Copayments may apply if more than one planned procedure is performed during a visit/stay.
- Outpatient Hospital visit Copayment 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 Bind 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 Copayment or observation Copayment will be waived.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

| Infertility Diagnosis and Treatment | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Artificial insemination** | $200 Copayment / service | $400 Copayment / service |
| **Egg Retrieval** | $1,500 Copayment / service | $3,000 Copayment / service |
| **Embryo Implantation** | $1,500 Copayment / service | $3,000 Copayment / service |
| **Cryopreservation** | $1,000 Copayment / attempt | $2,000 Copayment / attempt |
| **Storage** | $500 Copayment / year | $1,000 Copayment / year |
| **Thawing** | $1,000 Copayment / service | $2,000 Copayment / service |
| **Genetic Testing (PGT)** | $1,000 Copayment / visit | $2,000 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- To be eligible for Benefits, the Participant:
  - Must be under age 44, if female and using own eggs/oocytes; or
  - Must be under age 55, if female using donor eggs/oocytes.
  - For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.
- Participant must meet the one of the following clinical criteria to be eligible for specific infertility services:
  - Failure to achieve or maintain a pregnancy due to impotence/sexual dysfunction;
  - Infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization;
  - Diagnosis of a males factor causing infertility (e.g., with anatomical variants such as aspermia or varicocele resulting in an inability to reproduce, or treatment of sperm abnormalities, including the surgical recovery of sperm);
  - 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).
- The Bind Plan 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 intrafallopian transfer (GIFT), Pronuclear stage tubal transfer (PROST), and zygote intrafallopian transfer (ZIFT);
  - Ovulation induction and controlled ovarian stimulation;
  - Cryopreservation, also known as embryo freezing, and storage (up to 24 months) for embryos produced from one (1) cycle for a Participant who will undergo cancer treatment that is expected to render them infertile; and
  - Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
  - Preimplantation Genetic Testing (PGT) is a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. (e.g., PGT-M for monogenic disorder (formerly Chromosomal PGD) and PGT-MR for structural rearrangements (formerly chromosomal PDG)).
  - Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm;
  - There is a lifetime maximum of $10,000 per Participant for covered infertility treatments and prescription medications. This lifetime maximum is combined across all health Plans sponsored by the Plan Administrator.
- If a Participant 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.
- Multiple Copayments may apply if more than one service is performed during a visit.
- **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 Bind Plan covers additional Benefits. If you have questions on which prenatal services for a Dependent Child's Pregnancy are covered, please contact Bind Help.

| Laboratory Services, X-Rays, and Diagnostic Tests - Outpatient | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Diagnostic Laboratory Services / X-Rays / Ultrasounds** | $35 to $240 Copayment / visit | $130 to $480 Copayment / visit |
| **Routine Laboratory Services / X-Ray / Ultrasounds** | $0 Copayment / visit | $0 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Services for illness and Injury related diagnostic purposes, received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office include:
  - Non-routine diagnostic testing including, but not limited to:
    - Echocardiogram Exercise Stress Test;
    - Transthoracic Echocardiogram (TTE);
    - EKG Exercise Stress Test;
    - Electroencephalogram (EEG);
    - Electromyography (EMG) and Nerve Conduction Studies (NCS);
    - Sleep Study.
  - Routine diagnostic testing such as:
    - Clinical laboratory or pathology tests and interpretation charges, such as blood tests, analysis of tissues, liquids, or wastes from the body;
    - Radiology/X-ray, such as fluoroscopic tests and their interpretation, imaging studies that are recorded as a permanent picture such as film.
    - Authorized direct-to-consumer/home-based test kits are eligible for Benefit consideration when all of the following conditions are met:
      - Prescribed or ordered by a Provider, pharmacist or designated virtual visit Provider due to:
        - Have, or may have, been exposed to the virus that causes COVID-19 based on current signs and symptoms (e.g., cough, fever, difficulty breathing)
        - Have been in close contact with an individual confirmed or suspected of having COVID-19.
        - Have recently traveled to or live in a place where transmission of COVID-19 is known to occur.
        - Use a COVID-19 diagnostic testing laboratory authorized to perform the test by the FDA under the **emergency use authorization act.**
        - The home-collection kit is FDA-approved or FDA-authorized under the **emergency use authorization act**.
- For clarity, an Upper GI Endoscopy or non-Screening Colonoscopy are not considered Diagnostic Tests.
- The Copayments for diagnostic laboratory services/x-ray/ultrasounds may vary based on Provider and location. Refer to the MyBind app to determine what Copayment has been assigned to your procedure/service.
- Select Laboratory services and Diagnostic Testing may require Prior Authorization and Medical Necessity review.

| Maternity Care and Delivery | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Routine Pre-natal and Post-Natal Office Visits, including Labs and Tests** | $0 Copayment / visit | $130 Copayment / visit |
| **Inpatient Delivery** | $500 to $2,000 Copayment / stay | $4,000 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Routine pre-natal and post-natal maternity 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 and Health Resources and Services Administration.
- Home visit limited to 1 (one) visit immediately following discharge of mother and newborn.
- Hospital visits or admits that do not result in delivery, including false labor and tests or services not considered "routine" will follow the inpatient or outpatient Hospital services Benefit.
- The Copayments for inpatient delivery may vary based on Provider and location, this includes a birthing center.
- One Copayment for all Covered Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another Copayment will apply to the baby's services. See "Hospital Services" section for Benefits.
- Inpatient deliveries do not require Prior Authorization or notification unless the mother is hospitalized more than 48-hours following a normal vaginal delivery and 96-hours for a normal cesarean section delivery. Stays beyond these time periods may require Prior Authorization and Medical Necessity review.
- **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 Participants. However, direct, or indirect expenses incurred for a Dependent Child's Pregnancy are not covered. **Please Note:** This exclusion does **not** apply to pre-natal 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 Bind Plan covers additional Benefits. If you have questions on which pre-natal services for a Dependent Child's Pregnancy are covered, please contact Bind Help.

| Medical Infusions and Injectables | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Office Home – Tier 1** | $425 Copayment / visit | $850 Copayment / visit |
| **Outpatient Hospital Visit – Tier 1** | $675 Copayment / visit | $1,350 Copayment / visit |
| **Office Home – Tier 2** | $850 Copayment / visit | $1,700 Copayment / visit |
| **Outpatient Hospital Visit – Tier 2** | $1,350 Copayment / visit | $2,700 Copayment / visit |

**Notes:**

Benefits are available for certain medical infusions and injectables administered on an outpatient basis in a Hospital, Alternate Facility, Physicians office, or in your home.

- Refer to the MyBind mobile app for additional coverage information.
- This Copayment 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 Copayments.
- See “Cancer Chemotherapy” section for coverage notes related to chemotherapy administration.
- Select injectable drugs that can be safely self-administered may not be covered under the medical Benefit. These drugs or equivalent drugs are covered under the pharmacy Benefits. See Section 20 “Prescription Drugs”.
- Refer to the MyBind app to determine what Copayment has been assigned to your procedure/service.
- Select Medical Infusions and Injectables may require Prior Authorization and Medical Necessity review.

| Office Visit and Diagnostic Visit | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Office Visit — Primary Care / Specialist Visit** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| **Office Visit - Telemedicine** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| **Provider House Call (Home Visit)** | $55 Copayment / visit | Not Covered |
| **Mental Health Office Visit** | $20 Copayment / visit | $130 Copayment / visit |
| **Mental Health Office Visit - Telemedicine** | $20 Copayment / visit | $130 Copayment / visit |
| **E-Visit and Telephone Consult with Your Physician after an Emergency Room Visit** | $35 Copayment / visit | Not Covered |
| **Virtual Visit – other than Designated Provider (see “Virtual Visits”*)** | Not Covered | Not Covered |
| **Virtual Visit – Doctor on Demand*** | $0 Copayment / visit | Not Applicable |
| **Convenience Care / Retail visit** | $20 Copayment / visit | Not Covered |
| **Allergy Injection Visit** | $0 Copayment / visit | $130 Copayment / visit |
| **Allergy Testing and Treatment** | $85 Copayment / visit | $170 Copayment / visit |
| **Naturopathic Professional Visits** | $35 Copayment / visit | $130 Copayment / visit |

**Notes:**

The Bind Plan covers services provided in an office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician’s office is freestanding, located in a clinic, or located in a Hospital.

- Refer to the MyBind mobile app for additional coverage information.
- Coverage is available for both face-to-face and Telehealth services.
- Vision therapy is covered as an office visit.
- *See “Virtual Visits” section for virtual visit details.
- Convenience Care / Retail Clinics are walk-in clinics in retail stores, supermarkets, and pharmacies that treat uncomplicated minor illness, Injury, and preventive care services.
- Naturopathic Professional Services limited to 20 visits per Participant per Plan Year for Network and out-of-network Providers combined.
- If your Provider refers you for a test or service within a Hospital or other facility, the outpatient Hospital Copayment may apply.
- The Copayments for the office visit may vary based on Provider and location. Refer to the MyBind app to determine what Copayment has been assigned for procedure/service.

| Orthognathic Surgery and Temporomandibular (TMU) Joint Disorder | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| **Orthognathic (Jaw) Surgery** | $1,750 Copayment / visit | $3,500 Copayment / visit |
| **Temporomandibular Joint Dysfunction (TMJ) Surgery** | $900 Copayment / visit | $1,800 Copayment / visit |
| **All other services:** | | |
| **Office Visit** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |
| **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

The Bind Plan covers services for the evaluation and treatment of TMJ and associated muscles.

- Refer to the MyBind mobile app for additional coverage information.
- Includes orthodontic services and supplies, and surgical and non-surgical options for the treatment of TMJ. Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.
- The Copayments for the office visit may vary based on Provider and location. Refer to the MyBind app to determine what Copayment has been assigned for Procedure/service.
- Orthognathic surgery and select services for TMJ Disorder may require Prior Authorization and Medical Necessity review.

| Palliative Care | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| **Home Care** | $25 Copayment / visit | $170 Copayment / visit |
| **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The Bind Plan covers palliative care for Participants 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.
- Includes services for pain management received as part of a palliative care treatment plan.
- The Copayments for the office visit may vary based on Provider and location.
- See "Hospital Services" notes for services related to Hospice.

| Prescription Drugs | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | See Section 20 "PRESCRIPTION DRUGS" for details | Not Covered |

| Preventive Care Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | $0 Copayment / visit | $130 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- 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 care 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 age 6.
  - Routine physical exams.
  - Routine screenings for certain cancers and other conditions.
  - Routine screening colonoscopy is covered as preventive with diagnosis of family history.
  - 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.
  - 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.
    - Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.
    - For Prescription Drug coverage see Section 20 “PRESCRIPTION DRUGS” for details.
- Low-dose CT Scan (LDCT) for lung cancer screening may require Prior Authorization and Medical Necessity review.

| Radiation Therapy and Other High Intensity Therapy | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| | $250 to $725 Copayment / visit | $500 to $1,450 Copayment / visit |

**Notes:**

The Bind Plan covers services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician’s office. Benefits include Physician services and facility charges.

- Refer to the MyBind mobile app for additional coverage information.
- Services such as, but not limited to:
  - Brachytherapy
  - Conventional External Beam Radiation Therapy (EBRT)
  - Proton Therapy
  - Radiation Therapy Simulation and Planning
  - Stereotactic Radiation Therapy
- The Copayments may vary based on Provider and location. Refer to the MyBind app to determine what Copayment has been assigned to your procedure/service.
- Select Radiation Therapy may require Prior Authorization and Medical Necessity Review.

| Reconstructive Surgery | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $20 to $90 Copayment / visit | $180 Copayment / stay |
| **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |
| **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- 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 Bind 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. An 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. The Bind Plan does not provide Benefits for Cosmetic services or procedures.
- The fact that a Participant 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.
- The Copayments for the office visit may vary based on Provider and location.
- Reconstructive surgery may require Prior Authorization and Medical Necessity review.

| Rehabilitative/Habilitative Services and Other Low Intensity Therapy | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Acupuncture Visit** | $20 Copayment / visit | $40 Copayment / visit |
| **Aural Therapy – Post Cochlear Implant** | $10 to $30 Copayment / visit | $75 Copayment / visit |
| **Cardiac Rehabilitation Therapy** | $30 Copayment / visit | $60 Copayment / visit |
| **Chiropractic Visit** | $20 Copayment / visit | $40 Copayment / visit |
| **Cognitive, Occupational, Physical, and Speech Therapy** | $10 to $30 Copayment / visit | $75 Copayment / visit |
| **Pulmonary Rehabilitation Therapy** | $30 Copayment / visit | $60 Copayment / visit |

**Notes:**

Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Benefits includes services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Services provided in your home are provided as described under the "Home Health Care Visit" section.

- Refer to the MyBind mobile app for additional coverage information.
- The Copayments for aural, cognitive, occupational, physical, and speech therapy may vary based on Provider and location.
- Acupuncture is limited to 60 visits or services per Participant per Plan Year for Network and out-of-network Providers combined.
- Aural Therapy does not have visit limits.
- Cardiac rehab does not have any visit limits.
- Chiropractic Visit is limited to 60 visits or services per Participant per Plan Year for 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.
- Occupational and Cognitive therapy is limited to 60 visits per Participant per Plan Year for Network and out-of-network Providers combined.
  - Cognitive rehabilitation therapy following traumatic brain Injury or cerebral vascular accident is covered when Medically Necessary.
- Physical therapy is limited to 60 visits per Participant per Plan Year for Network and out-of-network Providers combined.
- Pulmonary rehab does not have any visit limits.
- Speech therapy is limited to 60 visits per Participant per Plan Year for Network and out-of-network Providers combined.
- Therapies provided in the home will follow the home healthcare visit Copayment. See "Home Health Services" section for coverage notes.
- Therapies related to the treatment of a mental health condition, such as autism disorder, are provided under "Behavioral Health: Mental Health and Substance Use Disorder Services" section and do not apply to limits in this section.
- The Copayments for services, procedures or treatments may vary based on Provider and location. Refer to the MyBind app to determine what Copayment has been assigned for procedure/service.

| Skilled Nursing Facility Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Skilled Nursing Facility** | $1,300 Copayment / stay | $3,900 Copayment / stay |
| **Inpatient Rehabilitation Facility** | $1,300 Copayment / stay | $3,900 Copayment / stay |

**Notes:**

The Bind Plan covers services provided during an inpatient stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility

- Refer to the MyBind mobile app for additional coverage information.
- Limited to 120 days for Skilled Nursing Facility stays per Participant per Plan Year for Network and out-of-network Providers combined.
- All Inpatient Rehabilitation Facility, such as a long-term acute rehabilitation center, a Hospital, or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility, that provides occupational therapy, physical therapy, and/or speech therapy as authorized by law.
- Benefits include:
  - Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Bind Plan.
  - 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; and
  - It is ordered by a Physician; and
  - 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; and
  - 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 Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Bind Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 28 “A. Medical Glossary”.
- All Skilled Nursing Facility and Inpatient Rehabilitation Facility admissions require a Prior Authorization and Medical Necessity review.
- See “Hospital Services” section for other coverage notes.

| Transplant Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Bone Marrow and Solid Organ Transplant** | $2,450 Copayment / visit | Not Covered |
| **Corneal Transplant** | $1,050 Copayment / visit | Not Covered |
| **Cellular and Gene Therapy** | | |
| • **Outpatient Hospital Visit** | $750 Copayment / visit | Not Covered |
| • **Inpatient Hospital** | $1,400 Copayment / stay | Not Covered |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/intestine, pancreas, intestine and cornea.
- Benefits are also available for Cellular and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility.
- All Participants undergoing Transplant Services, except for corneal transplant, must enroll in Transplant Resource Services which is a care coordination program for patients undergoing Transplants.
- Bind has identified quality Providers for transplant services, except for corneal transplant, referred to as the Transplant Center of Excellence (See Section 8 “BIND CLINICAL PROGRAMS” for additional information). Transplant services, except for corneal transplant, 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 the Bind Plan. 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 healthcare 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.
- The Bind Plan 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 a 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 Network Provider.
  - Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Participant if the reimbursement exceeds the per diem rate.
- The Claims Administrator must receive valid receipts for such charges before you will be reimbursed.
- Transplant Services may be subject to Prior Authorization and Medical Necessity Review.

**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 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

| Treatment/Procedures/Services | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Tier 1** typically minor procedures performed in an outpatient office setting (e.g., eye cryotherapy, capsule endoscopy) | $55 to $365 Copayment / visit | $110 to $730 Copayment / visit |
| **Tier 2** typically minor surgeries, procedures, or treatments performed in an outpatient Hospital setting. (e.g., bronchoscopy, needle biopsy and aspiration) | $250 to $950 Copayment / visit | $950 to $1,900 Copayment / visit |
| **Tier 3** typically major surgeries, procedures, or treatments performed in an outpatient or inpatient hospital setting. (e.g., thyroid surgery, parathyroid surgery) | $600 to $1,700 Copayment / visit | $3,400 Copayment / visit |
| **Tier 4** typically major surgeries, procedures, or treatments performed in an inpatient or outpatient setting. (e.g., colon surgery, cochlear implant surgery) | $800 to $2,450 Copayment / visit | $3,500 to $4,500 Copayment / visit |
| **All other services** | | |
| • **Office Visits** | $20 to $90 Copayment / visit | $180 Copayment / visit |
| • **Outpatient Hospital Visit** | $750 Copayment / visit | $1,500 Copayment / visit |
| • **Inpatient Hospital** | $1,400 Copayment / stay | $2,800 Copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The Copayments above apply unless a Benefit is specified in another section of this SPD.
- Multiple Copayments may apply if more than one planned procedure is performed during a visit/stay.
- The Copayments for Procedures in Tier 1 - Tier 4 may vary based on Provider and location. Refer to the MyBind app to determine what Copayment has been assigned to specific Treatments / Procedures / Services.
  - Tier 1 is a category of minor procedures typically performed in an outpatient office setting.
  - Tier 2 is a category of minor surgeries, procedures, or treatments typically performed in an outpatient Hospital setting.
  - Tier 3 is a category of major surgeries, procedures, or treatments typically performed in an outpatient Hospital setting.
  - Tier 4 is a category of major surgeries, procedures, or treatments typically performed in an inpatient Hospital setting.
- Outpatient Hospital Visit copayment 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 Bind 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 Copayment or observation Copayment will be waived.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Select office-based and outpatient procedures may require Prior Authorization and Medical Necessity review.

| Urgent Care | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Urgent Care Visit** | $65 Copayment / visit | $130 Copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Visits at a walk-in Urgent Care center that treats Injury or illness requiring immediate care, but not serious enough to require an Emergency department visit.

| Virtual Visits | In-Network and Virtual Network | Out-of-Network |
|---|---|---|
| **Virtual Visit (Designated Provider)** | $10 Copayment / visit | Not Applicable |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical and mental health conditions for Participants, 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 healthcare 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.
  - Please note that not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.
- No virtual visit coverage for out-of-network Providers.
- This Benefit does not apply in the event you receive care through your primary care or Specialty Provider via online or virtual methods. Please see “Office Visit and Diagnostic Visit” section for applicable Copayments with your primary care or Specialty Provider.
- Services for email, standard telephone calls or Telehealth visits that occur within medical facilities (CMS defined originating facilities) are provided under Office Visit and Diagnostic Visit Benefits.
- Please visit Lumen.com/ChooseBind, MyBind.com, the MyBind mobile app, or call Bind Help to locate a designated virtual visit Provider.

# 12. 2ND.MD

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

# 13. NURSELINE[SM]

NurseLine[SM]

Benefits for NurseLine[SM] services described below (including any references to the program elsewhere in this document) are administered by NurseLineSM, independent of the Bind personalized health plan. NurseLineSM, and is responsible for the accuracy of the information.

NurseLine[SM] 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 healthcare decisions. When you call, a registered nurse may refer you to any additional resources that Lumen 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[SM] 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[SM] is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto www.optum.com where you may access the link to initiate an online chat with a registered nurse who can help answer your general

health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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

# 14. COR MEDICAL

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

# 15. CANCER RESOURCE SERVICES

The Bind Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in the Medical 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 Bind case manager;
- 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 Bind Plan pays Benefits as described under Section 11 "**COVERED BIND PERSONALIZED HEALTH PLAN BENEFITS**":

Cancer Clinical Trials (see Section 10 "**CLINICAL TRIALS**") and related treatment and services are covered by the Bind 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 Bind 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 is 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
- Therapy services – Mental Health
- And more

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

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

# 17. WELL CONNECTED INCENTIVE PROGRAM AND RESOURCES TO HELP YOU STAY HEALTHY

The Well Connected Program is a voluntary wellness program available to all Retirees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve Retiree 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 Company medical plan and 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.lumen.com/healthandlife. 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. The Company 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 is 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.

## 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 Lumen 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 Lumen, 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@Lumen.com.

The Plan Administrator believes in giving you the tools you need to be an educated healthcare 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 healthcare system.

## B. Weight Watchers Program

Weight Watchers offers a scientifically proven program for weight loss and wellness, with Digital, Studio and Personal coaching solutions to help meet your goals. For more than 55 years, Weight Watchers has helped millions lose weight with the latest nutritional and behavior change science.

Their easy-to-use app puts it all in the palm of your hand: quick food and activity tracking, 24/7 Live Coaching, goal-setting, 8,000+ recipes, a barcode scanner, a supportive network of members, and more. If you would like additional information regarding the Weight Watchers Program visit weightwatchers.com/us/

Retirees and Spouses/Domestic Partners who are enrolled in a UHC medical plan will be eligible to receive up to $55/month for participating in the Weight Watchers Program. A prescription from your health care Provider

is required advising of a weight management related medical condition or illness (e.g., heart disease, obesity, hypertension) to be eligible for reimbursement per IRS Code Section 213(d), along with a receipt and a Weight Watchers Reimbursement Form which can be found on the Company Intranet. lumenbenefits.com

# 18. CONDITIONAL COVERAGES

Once enrolled in the Bind Plan, any Participant is eligible to elect and activate conditional coverages. Conditional coverage includes select, planned tests, treatments, or therapies that often have varying Provider and location options. Service(s) must be provided within the time frame shown in the conditional coverage period column below. Conditional coverage services must be Medically Necessary.

Conditional coverage is effective three business days after it is elected, and all services related to the conditional coverage must be complete within 120 days of its Effective Date.

- **Emergency - If you need any of these tests, treatments, or therapies because it directly relates to an Emergency, trauma event, or cancer-related treatments (i.e., post-diagnosis) including surgery, you do not need to elect and activate conditional coverage as these situations are already covered in your Bind Plan.**

The conditional coverage Copayments listed below are maximum Copayments. You may be eligible for reduced Copayments if you use Network Providers that Bind has designated as preferred, high-value Providers. Bind determines which 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.

Some conditional coverages may be covered under the Bind Plan, without requiring you to elect and activate a conditional coverage, if you or your Dependent meet certain age requirements (e.g., knee replacement or lumbar spine fusion - member must elect and activate conditional coverage if 18 or older). Please call Bind Help for additional information.

To elect a conditional coverage as your benefit coverage you must take the following steps to activate the coverage – at least three business days in advance of receiving the conditional coverage test, treatment, or therapy, unless you expressly and permanently opt-out of the three-business-day waiting period – in order to have coverage for the test, treatment, or therapy:

1. choose the conditional coverage test, treatment, or therapy;
2. choose the Provider and location for the test, treatment, or therapy;
3. attest to the Adverse Health Factor;
4. review the total cost of the test, treatment, or therapy; and
5. click “Activate Coverage” to complete the activation process.*

You can elect and activate coverage yourself on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. If you do not elect and activate the conditional coverage you need so it is effective in advance of you receiving the test, treatment, or therapy, you will not have coverage under the Bind Plan for the test, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period, you may cancel the conditional coverage within the three-business-day waiting period on the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance. Once the conditional coverage is properly activated and effective, it cannot be cancelled for the duration of the coverage period.

**If the Participant electing and activating conditional coverage is a Dependent, the subscriber must complete a sixth step and finally approve the conditional coverage election to fully complete the activation process.*

# A. Conditional Coverage Copayments

| Conditional Coverages | In-Network Copayment Maxiumum | Out-of-Network Copayment | Coverage Period |
|---|---|---|---|
| Ankle and Foot Bone Fusion | $2,500 | $3,000 | 120 days |
| Ankle Arthroscopy and Ligament Repair | $2,500 | $3,000 | 120 days |
| Ankle Replacement and Revision | $2,500 | $3,000 | 120 days |
| Back Surgery, Cervical Spine Disc Decompression | $2,500 | $3,000 | 120 days |
| Back Surgery, Cervical Spine Fusion | $2,500 | $3,000 | 120 days |
| Back Surgery, Lumbar Spine Disc Decompression | $2,500 | $3,000 | 120 days |
| Back Surgery, Lumbar Spine Fusion | $2,500 | $3,000 | 120 days |
| Bariatric Surgery | $2,500 | $3,000 | 120 days |
| Breast Reduction Surgery* | $2,500 | $3,000 | 120 days |
| Bunionectomy and Hammertoe Surgery | $1,950 | $2,350 | 120 days |
| Cardiac Ablation | $2,500 | $3,000 | 120 days |
| Carotid Endarterectomy and Stents | $2,500 | $3,000 | 120 days |
| Carpal Tunnel Surgery | $1,300 | $1,400 | 120 days |
| Cataract Surgery | $1,100 | $1,100 | 120 days |
| Coronary Artery Bypass Graft Surgery | $2,500 | $3,000 | 120 days |
| Coronary Catheterization and Percutaneous Coronary Intervention | $2,500 | $3,000 | 120 days |
| Ear Tubes | $1,250 | $1,350 | 120 days |
| Elbow Arthroscopy and Tenotomy | $1,550 | $1,800 | 120 days |
| Elbow Replacement and Revision | $2,500 | $3,000 | 120 days |
| Fibroid Removal (Myomectomy) | $2,500 | $3,000 | 120 days |
| Gallbladder Removal Surgery (Cholecystectomy) | $2,200 | $2,650 | 120 days |
| Ganglion Cyst Surgery | $1,300 | $1,450 | 120 days |
| Hernia Repair | $2,100 | $2,500 | 120 days |
| Hip Arthroscopy and Repair | $2,500 | $3,000 | 120 days |
| Hip Replacement and Revision | $2,500 | $3,000 | 120 days |
| Hysterectomy* | $2,500 | $3,000 | 120 days |
| Hysteroscopy and Endometrial Ablation | $1,550 | $1,800 | 120 days |
| Kidney Stone Ablation and Removal (Lithotripsy) | $1,900 | $2,300 | 120 days |
| Knee Arthroscopy and Repair | $2,000 | $2,400 | 120 days |
| Knee Replacement and Revision | $2,500 | $3,000 | 120 days |
| Morton's Neuroma Surgery | $1,550 | $1,750 | 120 days |
| Pacemakers and Defibrillators | $2,500 | $3,000 | 120 days |
| Plantar Fasciitis Surgery | $1,550 | $1,800 | 120 days |
| Prostate Removal Surgery | $2,000 | $2,400 | 120 days |
| Reflux and Hiatal Hernia Surgery | $2,500 | $3,000 | 120 days |
| Shoulder Arthroscopy and Repair | $2,500 | $3,000 | 120 days |
| Shoulder Replacement and Revision | $2,500 | $3,000 | 120 days |
| Sinus and Nasal Septum Surgery | $2,200 | $2,650 | 120 days |
| Sling Surgery for Female Urinary Incontinence | $2,500 | $3,000 | 120 days |
| Spinal Cord Stimulators | $1,150 | $1,200 | 120 days |
| Tonsillectomy and Adenoidectomy | $1,450 | $1,600 | 120 days |
| Upper GI Endoscopy | $1,100 | $1,150 | 120 days |
| Valve Replacement | $2,500 | $3,000 | 120 days |
| Wrist and Hand Joint Replacement | $1,900 | $2,300 | 120 days |
| Wrist Arthroscopy and Repair | $1,650 | $1,950 | 120 days |

*Hysterectomy procedure and Breast reduction surgery for the treatment of Gender Dysphoria are covered under the Bind Plan and require Prior Authorization.

Conditional coverage provides coverage on the same date of the surgery or during the same Hospital admission, for the following associated healthcare services:

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

### B. Exclusions to Conditional Coverages

- For conditional coverages procedures performed in a clinic or outpatient facility: healthcare services provided prior to and after the date of the test, treatment, or therapy even if such services are directly related to the same or similar conditional coverage body part. The Bind Plan coverage may already be available for such services under the Bind Plan.
- For conditional coverages performed in an inpatient facility: healthcare services provided prior to an admission and after a discharge from an inpatient facility even if such services are directly related to the same or similar conditional coverage body part. The Bind Plan coverage may already be available for such services under the Bind Plan.
- Health care services that are not Medically Necessary.
- Items listed in the Exclusions: Bind Plan Benefits Not Covered.

## 19. EXCLUSIONS: BIND PLAN BENEFITS NOT COVERED

The Bind Plan 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 11 "**COVERED BIND PERSONALIZED HEALTH PLAN BENEFITS**".

### A. Alternative Treatments

1. Health care services ordered or rendered by Providers or para-professionals unlicensed by the appropriate regulatory agency.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy that is not physical therapy or prescribed by a licensed Provider as a component of a multi-modality rehabilitation treatment plan.
5. Rolfing.
6. Vocational therapy.
7. Homeopathic medicine, including dietary supplements.
8. Holistic medicine and services, including dietary supplements.
9. 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.

## B. Conditional Coverage

10. Health care services listed as a conditional coverage in Section 18 "**CONDITIONAL COVERAGES**", are not covered by the Bind Plan unless you elect and activate the coverage, except for Emergency, trauma, or cancer-related services.

## 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 tooth decay or cavities 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 for a Participant with diabetic foot disease.
21. Shoes, except as prescribed by a Provider for a Participant with diabetic foot disease.
22. Cranial banding, except when Medically Necessary for the treatment of plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
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, but not limited to, bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, diapers, and 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. SeeSection 21 “EXCLUSIONS: BIND PLAN BENEFITS NOT COVERED”.

## F. Experimental or Investigational or Unproven Services

35. Biofeedback that is Experimental or Investigational or Unproven.
36. Intracellular micronutrient testing.
37. 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. To find out additional information call Bind Help.

## G. Foot Care

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

## H. Gender Dysphoria Cosmetic Procedures

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

## I. Mental Health/Substance Abuse

41. 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*.
42. Unproven intensive behavioral therapy treatment programs for the treatment of Autism Spectrum Disorders, including Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas.
43. Non-medical 24-hour withdrawal management which is an organized residential service, including those defined in the American Society of Addiction Medicine (ASAM) criteria providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdraw, using peer and social support rather than medical and nursing care.
44. 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 Mental Disorders by the American Psychiatric Association*.
45. 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.
46. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction, and learning.
47. 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.
48. 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 Mental Disorders by the American Psychiatric Association*.
49. Transitional living services.
50. Inpatient or intermediate or outpatient care services that were not pre-authorized.
51. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.
52. Wilderness therapy, nature camps, and similar arrangements.

## J. Nutrition

53. 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).
54. 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

55. 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.
56. 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 of the lower extremities when it is considered Cosmetic.

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.

57. Excision or removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
58. Treatment of benign gynecomastia (abnormal breast enlargement in males).
59. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic procedure.
60. 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.
61. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments. and diversion or general motivation.
62. Medical and surgical treatment of excessive sweating (hyperhidrosis).
63. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.
64. Wigs (scalp/cranial hair prostheses) except for Participants with scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy.

## L. Procedures and Treatment

65. Helicobacter pylori (H. pylori) serologic testing.
66. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
67. 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.
68. Outpatient cognitive rehabilitation and post cochlear implant aural therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
69. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include healthcare 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.
70. Chelation therapy, except to treat heavy metal toxicity and overload conditions.
71. 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.
72. 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.
73. Home Births.
74. Elective abortion, except in situations where the life of the mother would be endangered if the fetus is carried to full term.

## M. Providers

75. Services performed by a Provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent, Child, or Domestic Partner. This includes any service the Provider may perform on himself or herself.
76. Services performed by a Provider with your same legal residence.

77. Services ordered or delivered by a Christian Science practitioner.
78. Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.

## N. Reproduction

79. The following infertility treatment-related services:
    a. Cryopreservation and storage unless it is embryo freezing and storage (up to 12 months) for embryos produced from one (1) cycle for a Participant who will undergo cancer treatment that is expected to render them infertile.
    b. Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
    c. Donor services and nonmedical costs of oocyte (egg) or sperm donation (e.g., donor agency fees).
    d. Embryo or oocyte accumulation defined as a fresh oocyte (egg) retrieval prior to the depletion of previously banked frozen embryos or oocytes (eggs).
    e. Multi-embryo implantation.
    f. Cloning.
    g. Embryo transport.
    h. Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
    i. All costs associated with surrogate motherhood; nonmedical costs associated with gestational carrier (a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person).
    j. Services for partners, Spouses, and the maternity expenses of gestational carriers not covered by the Bind Plan.
    k. Ovulation predictor kits.
    l. Surrogate parenting, donor oocytes (eggs), donor sperm, and host uterus.
    m. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
    n. Reversal of voluntary sterilization.

## O. Services Provided Under Another Plan

80. 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

81. Health services for transplants involving permanent mechanical or animal organs.
82. 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

83. Health services provided in a foreign country, unless determined to be an Emergency.
84. Travel or transportation expenses, even if ordered by a Physician, except as identified under Ambulance and Transplant in Section 11 "**B. Benefit Features**".

## R. Types of Care

85. Custodial Care.
86. Domiciliary Care.
87. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
88. Private Duty Nursing.
89. Respite care except as defined under Hospice Care in Section 11 "**B. Benefit Features**".
90. Rest cures.
91. Services of personal care attendants.
92. 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

93. Implantable lenses used only to correct a refractive error, radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
94. Routine eye exams (including refraction), eyeglasses, contact lenses and any fittings associated with them, except as identified in Section 11 "**B. Benefit Features**".
95. Refractive surgery (e.g. Lasik) for ophthalmic conditions that are correctable by contacts or glasses.
96. Bone anchored hearing aids except when either of the following applies:
    a. For Participants with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    b. For Participants with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
    c. The Bind Plan will not pay for more than one bone anchored hearing aid per Participant who meets the above coverage criteria during the entire period of time the Participant is enrolled in the Bind Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Participants who meet the above coverage are not covered, other than for malfunctions.
97. Eye exercise.
98. 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.
99. Any type of communicator, voice enhancement, voice prosthesis, electronic voice producing machine, or any other language assistive devices.

## T. All Other Exclusions

100. Health care services that Bind determines are not Medically Necessary.
101. Autopsies and other coroner services and transportation services for a corpse.
102. Charges for:
    a. Missed appointments.

b. Room or facility reservations.
c. Completion of Claim forms.
d. Record processing.

103. Charges prohibited by federal anti-kickback or self-referral statutes.
104. Over-the-counter self-administered home diagnostic tests (except direct-to-consumer/home-based tests), including but not limited to HIV, ovulation, and Pregnancy tests.
105. Direct to consumer retail genetic tests.
106. Expenses for health services and supplies.
    a. That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
    b. Illness or Injury during illegal acts.
    c. That are received after the date the Participants coverage ends, including health services for medical conditions which began before the date the Participants coverage ends.
    d. For which the Participant has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Bind Plan.
    e. That exceed Eligible Expenses for any specified limitation in this SPD.
107. Foreign language and sign language services.
108. Long term (more than 30 days) storage of blood, umbilical cord, or material (e.g., cryopreservation of tissue, blood, and blood products.
109. Physical, psychiatric, or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:
    a. Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage, adoption, or as a result of incarceration.
    b. Conducted for purposes of medical research.
    c. Related to judicial or administrative proceedings or orders unless determined to be Medically Necessary.
    d. Required to obtain or maintain a license of any type.
110. In the event of an out-of-network Provider waives, does not pursue, or fails to collect copayments or other amounts owed for a particular healthcare service, no Benefits are provided for the healthcare service.

# 20. PRESCRIPTION DRUGS

The Plan includes coverage for Prescription Drugs dispensed at Network pharmacies with the Copayments 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 Network pharmacies and Formulary medications by connecting with www.optumrx.com or phone using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

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

| | 30-Day Supply | | 90-Day Supply | |
|---|---|---|---|---|
| | **In-Network Pharmicies** | **Out of Network Pharmacies** | **In-Network Pharmicies and Mail Order Pharmacy** | **Out of Network Pharmacies** |
| **Preventive** | $0 Copayment | Not Covered | $0 Copayment | Not Covered |
| **Tier 1** | $10 Copayment | Not Covered | $25 Copayment | Not Covered |
| **Tier 2** | $70 Copayment | Not Covered | $175 Copayment | Not Covered |
| **Tier 3** | $100 Copayment | Not Covered | $250 Copayment | Not Covered |

## A. Specialty Drug Tiers

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

| Specialty Pharmacy | |
|---|---|
| | **30-Day Supply** |
| **Tier 1** | $200 Copayment |
| **Tier 2** | $225 Copayment |
| **Tier 3** | $300 Copayment |

**Note:** The Coordination of Benefits provision described in Section 24 "**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 do not 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.

Copayment for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Copayment 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 Copayment;
- 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 Copayment; or
- the Prescription Drug Charge for that particular Prescription Drug.

## D. Retail

The Pharmacy 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 www.optumrx.com.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copayment. However, some drugs require prior approval before the prescription can be obtained, as described later in Section 20 "**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 Copayment 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 Copayment for each cycle supplied.
- Oral and self-injectable infertility Prescription Drugs apply to the medical/Prescription Drug lifetime Benefit maximum of $10,000.

**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; and
- 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 Section 20 "**Prior Authorization/Medical Necessity Requirements**".

## F. 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 are 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.; or
- 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 Copayment 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.*

## G. 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 Section 28 "**B. Prescription Drug Glossary**" for the definition of Designated Pharmacy.

## H. 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 Section 28 "**B. Prescription Drug Glossary**" for the definition 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.

## I. Assigning Prescription Drugs to the PDL

The Pharmacy 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 Participants as a general population. Whether a particular Prescription Drug is appropriate for an individual Participant is a determination that is made by the Participant 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 Section 28 "**B. Prescription Drug Glossary**".

**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.

## J. 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 Pharmacy Claims Administrator for Prior Authorization or Medical Necessity approval. The Pharmacy 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 the Prescription Drug Glossary.
- Not Experimental or Investigational or Unproven, as defined in the 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.

## K. Network Pharmacy Notification

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

## L. Out-of-Network Pharmacy Notification

When Prescription Drugs are dispensed at an out-of-network Pharmacy, you or your Physician are responsible for notifying the Pharmacy Claims Administrator as required.

If the Pharmacy 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 Pharmacy Claims Administrator is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug. See Section 20 "**M. Prescription Drug Benefit Claims**" for information on how to file a Pharmacy Claim.

When you submit a Pharmacy Claim on this basis, you may pay more because you did not notify the Pharmacy 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 an out-of-network Pharmacy), less the required Copayment that applies.

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

The Prescription Drugs requiring notification are subject to the Pharmacy Claims Administrator's periodic review and modification. Benefits may not be available for the Prescription Drug after the Pharmacy 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.

## M. Prescription Drug Benefit Claims

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

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Pharmacy Claims Administrator should have paid for it; or
- you pay a Copayment and you believe that the amount of the Copayment 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. Limitation on Selection of Pharmacies

If the Pharmacy 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 do not make a selection within 31 days of the date the Plan Administrator notifies you, the Pharmacy Claims Administrator will select a single Network Pharmacy for you.

## O. 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 www.optumrx.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 Pharmacy 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 Pharmacy 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.*

## P. 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 Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug is assigned.

## Q. Special Programs

Lumen and the Pharmacy 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.

## R. 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.

## S. 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.

## T. 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.

## U. My ScriptRewards

Provides Participants 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, Participants who fill the $0 cost share 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 Participant to the most cost effective, guideline recommended regimen.
- Lowest out-o- pocket cost for the Participant.

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

## V. Rebates and Other Discounts

The Pharmacy Claims Administrator and Lumen may, at times, receive rebates for certain drugs on the PDL. The Pharmacy Claims Administrator **does not** pass these rebates and other discounts on to you. Nor does the Pharmacy Claims Administrator apply rebates or other discounts towards your Copayments.

The Pharmacy 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 Pharmacy Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

## W. Coupons, Incentives and Other Communications

The Pharmacy 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 Out of Pocket Maximums.

# 21. EXCLUSIONS: PRESCRIPTION DRUG PLAN BENEFITS NOT COVERED

The exclusions listed below apply to Section 20 “**PRESCRIPTION DRUGS**”. In addition, exclusions from coverage listed in Section 19 “**Drugs**” also apply to this section.

When an exclusion applies to only certain Prescription Drugs, contact the Pharmacy 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 or other Company approved programs (e.g. Quit for Life, Smokefree.gov, America Lung Association, hospital/physician-based programs). 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 Pharmacy Claims Administrator and Lumen have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in the Prescription Drug 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.;*
23. used for Cosmetic purposes; and
24. vitamins, except for the following which require a prescription: prenatal vitamins; vitamins with fluoride; and single entity vitamins.

# 22. MEDICAL CLAIMS PROCEDURES

Refer to Section 21 "**M. Prescription Drug Benefit Claims**".

When you receive In-Network services, the Provider will generally collect your Copayment from you at the time of your treatment and send a Claim to the Bind 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 Bind Plan to be paid. Whether you pay out-of-pocket or your Provider bills the Bind Plan directly, you are still entitled to the same Benefits.

If you receive a bill from your Provider (whether In-Network or out-of-network) for the Bind Plans' 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 Bind Plan. This section summarizes the procedures you must follow to submit a Claim for payment, and the procedures the Bind 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 Medical Claims

Post-service Claims are non-urgent Claims after you have received treatment. Pre-service and Urgent Care Request for Benefits are described under Section 7 "**PRIOR AUTHORIZATION AND PRE-ADMISSION NOTIFICATION**". (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 Bind 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 Bind Plan Benefits:

- The name and birthdate of the Participant who received the care
- The Participant 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 Participant received care
  - The diagnosis and procedure codes for each service provided
  - The charges for each service provided
- Information about any other health coverage the Participant 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 will 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 will receive an explanation of why it was denied and how you can appeal.

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

## A. If Your Medical Claim is Denied

If a medical Claim for Benefits is denied in part or in whole, you should 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 medical appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial Benefit determination.
- A healthcare 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.

Bind will review your appeal and will notify you of its decision within 30 days.

## C. Access to Relevant Documents

Upon written request and free of charge, any Participants may examine their Claim and/or appeals file(s). Participants 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 Participant 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 Bind Plan in connection with the Claim; and, (ii) a reasonable opportunity for any Participant 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 Bind 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 Bind 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 decision letter from Bind.

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

## E. Urgent Care Request for Benefits*

| Type of Request for Benefit or Appeal | Timing |
|---|---|
| If your request for Benefits is incomplete, Bind must notify you within: | **24 hours** |
| You must then provide a completed request for Benefits to Bind within: | **48 hours**<br>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**<br>after receiving the adverse Benefit determination |
| Bind must notify you of the appeal decision within: | **72 hours**<br>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 Benefit 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 a 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** |
| You must appeal an adverse Benefit determination no later than: | **180 days**<br>after receiving the adverse Benefit determination |
| Bind must notify you of the first level appeal decision within: | **15 days**<br>after receiving a complete first level appeal |
| You must appeal the first level appeal (file a second level appeal) within: | **60 days**<br>after receiving the first level appeal decision |
| Bind must notify you of the second level appeal decision within: | **15 days**<br>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 Bind 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**<br>**after receiving the adverse Benefit determination** |
| Bind must notify you of the first level appeal decision within: | **30 days**<br>after receiving the first level appeal |
| You must appeal the first level appeal (file a second level appeal) within: | **60 days**<br>after receiving the first level appeal decision |
| Bind must notify you of the second level appeal decision within: | **30 days**<br>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 the determination made by Bind. 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 the decision letter from Bind.

An external review request should include all of the following:

- A specific request for an external review.
- The Participant'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 Bind of the request.

- A referral of the request Bind 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 Bind Plan at the time the healthcare 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 Bind.
- 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 the determination made by Bind, the Bind Plan will immediately provide coverage or payment for the Benefit Claim at issue in accordance with the terms and conditions of the Bind Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Bind Plan will not be obligated to provide Benefits for the healthcare 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 healthcare 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:

- Is or was covered under the Bind Plan at the time the healthcare 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. 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.

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

The Bind health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Bind health Plan or any person acting with respect to the Bind health 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 payroll 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.

**Agent for Service of Legal Process:**
Associate General Counsel
931 14th Street, 9th Floor
Denver, CO 80202

**Legal process may also be served on:**
The Corporation Company (a.k.a. CT Corp)
1675 Broadway, Suite 1200
Denver, Colorado 80202

**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 Bind 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 Bind Plan or (2) the date on which an adverse Benefit determination on appeal was issued to you with respect to your Bind Plan Benefit Claim.

This means that you cannot bring any legal action against the Bind 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 Bind Plan or the Claims Administrator.

# 24. COORDINATION OF BENEFITS (COB)

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

# 25. RIGHT OF FULL RESTITUTION (SUBROGATION) AND REIMBURSEMENT

The Bind Plan does not provide Benefits for any accident, Injury or Sickness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). This includes, but is not limited to, any claim for damages or entitlement to recover from your or another party's:

- Underinsured and uninsured motorist coverage
- No fault and medical payments coverage
- Other medical coverage
- Worker's compensation
- Short term and long term disability coverage
- Personal injury coverage
- Homeowner's coverage
- Other insurance coverage available

No-fault insurance benefits and auto medical payments coverage should always be selected as the primary coverage if given a choice when purchasing automobile insurance coverage as the Benefits available under Bind Plan are secondary to automobile no-fault and medical payments coverage.

In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents when expenses arise from an accident, Injury or Sickness, subject to the terms of the Bind Plan, the Bind Plan may conditionally advance the payment of the Benefits. **If the Bind Plan advances payment of Benefits, the terms of this entire subrogation and reimbursement provision shall apply, and the Bind Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Individual (which is defined to include Participants and their Eligible Dependents) identifies the medical benefits the Bind Plan advanced. The Bind Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or alleged**

**comparative fault or contributory negligence in causing the Injury(ies) or accident for which the Plan advanced medical benefits.**

**Example:**

Mr. Jones is a participant in the Bind Plan and is involved in a motor vehicle accident where another party is at fault. Mr. Jones is admitted to the hospital, using his Bind Plan ID card. His claims are paid by his Claims Administrator under the Bind Plan. Once these claims are paid by the Bind Plan, they are electronically sent to HMS, the recovery services administrator. The recovery services administrator contacts Mr. Jones to ask about his treatment at the hospital and is advised of the motor vehicle accident by Mr. Jones, as required by the Bind Plan. The recovery services administrator obtains all the information regarding the accident (auto carrier/attorney/ etc.) and contacts the involved parties putting them on notice of the Bind Plan's interest. The recovery services administrator follows the case until a settlement is made between Mr. Jones and the at fault auto carrier and/or any uninsured/underinsured auto insurance. The Bind Plan is reimbursed for Mr. Jones' hospital claims. This process ensures those claims which are paid by the Plan as the result of a liable third party are captured and returned to the Bind Plan.

## Benefits Conditional Upon Cooperation

By participating in the Bind Plan, you and your eligible Dependents acknowledge and agree to the terms of the Bind Plan's equitable or other rights to full restitution, reimbursement or any other available remedy. You will take no action to prejudice the Plan's rights to restitution, reimbursement or any other available remedy. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution, reimbursement or any other available remedy.

## Other Party Liability

If you or your Eligible Dependent is injured or becomes ill due to the act or omission of another person (an "other party"), the Plan Administrator shall, with respect to Services required as a result of that Injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement, subrogation or any other available remedy to recover the amounts the Plan Administrator paid for Services provided to you or your Eligible Dependent from any recovery (defined below) obtained by or on behalf of you or your Eligible Dependent, from or on behalf of the third party responsible for the Injury Illness or Sickness or from your coverage, including but not limited to uninsured/underinsured motorist coverage, other medical coverage, no-fault coverage, workers' compensation, short term or long term disability (often referred to as STD and LTD) coverage, personal injury coverage, homeowner's coverage and any other insurance coverage available.

The Plan Administrator's right to restitution, reimbursement or any other available remedy, is against any recovery you or your Eligible Dependent receives as a result of the Injury or Illness or Sickness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage or other coverages listed above, related to the Illness, Sickness or Injury (the "Recovery"), without regard to whether the you or your Eligible Dependent has been "made whole" by the Recovery and without reduction for any attorney fees and costs paid or owed by or on your behalf by you or your Eligible Dependent. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution, reimbursement or any other available remedy.

## You or your Eligible Dependent is required to:

1. Notify the Plan Administrator or to its delegated recovery vendor, in writing of any actual or potential claim or legal action which such you or your Eligible Dependent expects to bring or has brought against the third party arising from the alleged acts or omissions causing the Injury or Illness or Sickness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with the Plan Administrator, or its delegated recovery vendor, to execute any forms or documents needed to enable the Plan Administrator to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree to assign to the Bind Plan the right to subrogate and recover Benefits directly from any third party or other insurer. A Bind Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Bind Plan's equitable (or other) right to obtain full restitution, reimbursement or any other available remedy.
4. Agree, to reimburse the Plan Administrator for Benefits paid by the Plan Administrator from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage or other coverage; and,
5. Provide the Plan Administrator with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court; and,
6. **Notify HMS Claims Recovery Solutions (the Plan Administrator's delegated recovery vendor) at 1 888-556-3373 or at** resources.hms.com/tpl-questionnaire.com**, or fax at 1 402-384-5190 as soon as possible, that the Plan Administrator may have a right to obtain restitution, reimbursement or any other available remedy of any and all Benefits paid by the Plan Administrator.** This also means that if you or your Eligible Dependent goes to the hospital because of an accident, Illness, Sickness or Injury that is the result of the actions of another party, you must inform the hospital staff that the Illness, Sickness or Injuries are the result of the actions of another for which that other person may be liable. Generally, the hospital staff notes this information on the report that is submitted to the Plan's Claims Administrator. You will later be contacted by the Plan Administrator or its delegated recovery vendor and you must provide the information requested. **If you retain legal counsel, your counsel must also contact the Plan Administrator or its delegated recovery vendor;** and,
7. Inform the Plan Administrator or recovery vendor in advance of any settlement proposals advanced or agreed to by another party or another insurer; and
8. Provide the Plan Administrator or recovery vendor all information requested by the recovery vendor and the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan Administrator and its recovery vendor on a timely basis; and
9. Not settle, without the prior written consent of the Plan Administrator, or its delegated recovery vendor, any claim that you or your eligible Dependents may have against another party, including an insurance carrier; and
10. Take all other action as may be necessary to protect the interests of the Bind Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Bind Plan may deny Benefits to you or your eligible Dependents or take such other action as the Plan Administrator deems appropriate.

**Note: The Bind Plan (Health, Life, Disability, BTA/ADD) is subject to ERISA. Certain plans - specifically, the Health Plan and Disability Plan - are self-funded, and for those plans you and your Eligible Dependent are also required to do the following:**

1. Ensure that any Recovery is kept separate from and not comingled with any other funds or you or your Eligible Dependent's general assets (for example, your household checking account) and agree to hold and retain that the portion of any Recovery required to fully satisfy the lien or other right of Recovery of the Bind Plan in trust for the sole benefit of the Bind Plan until such time it is conveyed to the Plan Administrator; and
2. **Direct any legal counsel retained by you or your Eligible Dependent or any other person acting on behalf of you or your Eligible Dependent to hold 100% of the Bind Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Bind Plan or its assignee and to comply with and facilitate the reimbursement to the Bind Plan of the monies owed it.**

# 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 Administrator, the Claims Administrator, or the Pharmacy Claim Administrator may need information from you. You agree to furnish the Plan Administrator, the Claims Administrator, or the Pharmacy Claim Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Bind 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 Bind Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Bind Plan, the Claims Administrator, or the Pharmacy Claim Administrator with all information or copies of records relating to the services provided to you. The Plan Administrator, the Claims Administrator, or the Pharmacy Claim 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 Participants, including Enrolled Dependents whether or not they have signed the enrollment form.

The Bind Plan agrees that such information and records will be considered confidential. The Plan Administrator, the Claims Administrator, or the Pharmacy Claim Administrator have the right to release any and all records concerning healthcare services which are necessary to implement and administer the terms of the Bind 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, the Plan Administrator, the Claims Administrator, or the Pharmacy Claim 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 Bind Plan, the Plan Administrator and our related entities may use and transfer the information gathered under the Bind Plan, including Claim information for research, database creation, and other analytic purposes.

## C. Interpretation of the Bind 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 Bind Plan
- Interpreting the other terms, conditions, limitations, and exclusions set out in the Bind Plan, including this SPD
- Determining the eligibility, rights, and status of all persons under the Bind Plan
- Making factual determinations, finding, and determining all facts related to the Bind Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Bind 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 Bind 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 Lumen 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 Bind Plan to the Lumen 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 Bind Plan in a fully accurate manner, any inadvertent error, misstatement, or omission will be disregarded, and the actual Bind Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Bind Plan, nor will it continue coverage that should have ended under the terms of the Bind 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 Bind Plan or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other *Plan Document*s.

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

For purposes of the Bind 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 the Bind 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 Bind Plan, unless and to the extent otherwise required by applicable law.

## 27. CLAIM FOR PAYROLL ADJUSTMENT AND THE DEADLINES

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

### A. Reminder to Review Your Paycheck Deductions

Review your paycheck along with the Lumen Benefits and Payroll schedule (available online) to confirm your benefit premium deductions for Health & Welfare including Savings and Spending Accounts. Any questions

related to benefit premiums should be directed to the Lumen Service Center at 866-935-5011 or 800-729-7526, option 1, option 1 and then option 1 again. Do not contact the Lumen Payroll Department as the Payroll staff will be unable to assist you.

If your benefit premium deductions are not correct or not what you expect you must make a claim to the Plan Administrator in accordance with the claim's procedures as soon as possible after the year's Payroll Deductions begin.

**If your claim is denied, be advised that there is a deadline to file an appeal and if you miss the deadline, your deductions remain in place for the benefit Plan Year. The time period to make an appeal is the *earlier of*:**

1. within 180 days of an adverse 1st level 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 appeal is not filed by this deadline it shall be deemed untimely and denied on that basis.**

## B. 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 Retiree wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

## C. Administrative Services

The Plan Administrator may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Bind 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.

## D. Examination of Participants

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

## E. Workers' Compensation Not Affected

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

## F. Conformity with Statutes

Any provision of the Bind 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 Bind Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Bind Plan generally is not subject to state laws and regulations including, but not limited to, state law Benefit mandates.

## G. 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 Lumen 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**".

## H. Incentives to Providers

The Bind Plan and the Claims Administrator do not provide healthcare services or supplies, nor does Lumen 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 Lumen 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 Bind Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Bind Plan or the Claims Administrator to promote the delivery of healthcare in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to healthcare. Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, Participant satisfaction, and/or cost effectiveness
- Capitation is when a group of Network Providers receives a monthly payment for each Participant 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 healthcare 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 Participant, or an amount per service with targeted outcome. If the amount paid is more than the cost of providing or arranging a Participant'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 Participant'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

## I. Refund of Benefit Overpayments

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

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

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

If the Participant, 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 Bind Plan. The reductions will equal the amount of the required refund. The Bind 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 Participant was determined not to be eligible for the Benefits under the Bind Plan, that individual must refund the amount of the excess Benefit payment and the Bind Plan may undertake collection actions, subject to the requirements of applicable law.

## J. Your Relationship with the Claims Administrator and the Bind Plan

In order to make choices about your healthcare coverage and treatment, the Bind 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 Bind 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 Bind Plan will cover or pay for the healthcare that you may receive (the Bind Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Bind Plan may not pay for all treatments you or your Physician may believe are necessary. If the Bind Plan does not pay, you will be responsible for the cost.

The Bind 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 Bind 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 Bind Plan and the Claims Administrator will use de-identified data for commercial purposes including research.

## K. Relationship with Providers

The relationships between the Bind Plan, the Claims Administrator and Network Providers are solely contractual relationships between independent contractors. Network Providers are not Lumen agents or Employees, nor are they agents or Employees of the Claims Administrator. Lumen 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 Bind Plan and the Claims Administrator do not provide healthcare services or supplies, nor do they practice medicine. Instead, the Bind Plan and the Claims Administrator arrange for healthcare 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 Lumen's Employees nor are they Employees of the Claims Administrator. The Bind Plan and the Claims Administrator do not have any other relationship with Network Providers such as principal-agent or joint venture. The Bind 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 the Bind 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 Bind Plan.

## L. 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 Participant responsibility, including Copayments 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 In-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.

## M. Payment of Benefits

When you assign your Benefits under the Bind 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 Bind Plan, the assignment must reflect the Participant's agreement that the non-network Provider will be entitled to all the Participant's rights under the Bind Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Participant's Benefits, and that the Participant 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, the Bind Plan 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, Lumen reserves the right to offset Benefits to be paid to the Provider by any amounts that the Provider owes Lumen (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Bind Plan) pursuant to *Refund of Overpayments* in Section 24 "**COORDINATION OF BENEFITS (COB)**".

The Bind Plan will pay Benefits to you unless:

- The Provider submits a Claim form to the Bind Plan 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.

- The Bind Plan 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.

## N. Rebates and Other Payments

The Bind 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 Bind 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 Copayments.

## O. Review and Determine Benefits in Accordance with the Bind Plan 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 the Bind Plan 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 its 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 Bind 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 Bind 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 Bind Plan. ***In addition to this Medical Glossary, and throughout this document, there are also terms defined in the General Information SPD.***

**Adverse Health Factor:** A new or deteriorating health or medical condition that coincides with the treatment(s) described in a specific conditional coverages (see Section 18 "**CONDITIONAL COVERAGES**"), and to which you must self-attest that you have as part of the election and activation process to activate conditional coverage Benefits.

**Addendum:** Any attached written description of additional or revised provisions to the Bind 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 healthcare 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/Bind Plan. Amendments are subject to all conditions, limitations, and exclusions of the Plan/Bind Plan, except for those that the Amendment is specifically changing.

**Annual Enrollment:** The period of time, determined by Lumen, during which eligible Retirees may enroll themselves and their eligible Dependents under the Bind Plan. Lumen 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 by the American Psychiatric Association.*

**Benefits:** The healthcare services covered under the Bind Plan approved by the Plan Administrator as Covered Services and as applicable, conditional coverage elected and activated by a Participant, as explained in this SPD and any Amendments.

**Bind Plan:** Refers to the Bind personalized health plan as used in this SPD.

**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 Participant 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 Bind 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).

**Copayment(s):** The percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 5 "**BIND PERSONALIZED HEALTH PLAN: BIND PLAN FEATURES AND HOW THE BIND PLAN WORKS**".

**Company:** Lumen Technologies, 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 General Information SPD for more information.***

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

**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 Medically Necessary, provided by your Provider or clinic, and are covered by the Bind Plan, and as applicable, conditional coverages that have been elected and activated by a Participant, subject to all of the terms, conditions, limitations, and exclusions.

**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 Bind Plan, as described in the **General Information SPD**. A Dependent does not include anyone who is also enrolled as an Employee/Retiree. No one can be a Dependent of more than one Employee/Retiree.

**Designated Facility:** A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Bind 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 **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 Consult with your Physician after an Emergency Room Visit:** Care provided by designated participating Providers performed without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone.

**Effective Date:** The first day of the Plan Year if you have timely completed all applicable enrollment requirements – and for conditional coverages, three business days after properly electing and activating the conditional coverage.

**Eligible Charge:** A charge for healthcare services, subject to all of the terms, conditions, limitations, and exclusions for which the Bind Plan or Participant will pay.

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

Eligible Expenses are determined solely in accordance with the Claims Administrators reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrators 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.

Network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage 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.

**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 Copayments.

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines.

**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 Participant'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/Retiree:** Meets the eligibility requirements specified in the **Retiree General Information SPD**, as described in the Eligibility section. An Employee/Retiree must live and/or work in the United States. The determination of whether an individual who performs services for the Company is an Employee/Retiree of the Company or an independent contractor and the determination of whether an Employee/Retiree of the Company was classified as a member of any classification of Employees/Retirees 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:** Lumen Technologies, 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 Participant's responsibility. The EOB is not a bill, it is a statement provided by the Claims Administrator to you, your Physician, or another healthcare professional that explains:

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

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

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender at birth, 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 at birth).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender at birth).
    - 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 at birth).

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 at birth, 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 at birth).
  - In boys (assigned gender at birth), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender at birth), 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 at birth), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender at birth), 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.

**Home Health Agency:** A program or organization authorized by law to provide healthcare 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, equipment, or supply will be considered Experimental and/or investigational if it is not covered under 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 approved 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 healthcare. The federal and state governments share the program's costs.

**Medically Necessary/Medical Necessity:** A healthcare service is deemed Medically Necessary when it is delivered or supervised by a licensed healthcare Provider acting within the scope of the Provider's license 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 Physician and Health Care Provider Specialty Society recommendations and the view of Physicians and healthcare Providers practicing in relevant clinical areas.
- Consistent with clinical guidelines generally accepted in practice.
- Clinically appropriate – type, frequency, site, 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.
- Not primarily for the convenience of the patient, healthcare Provider or other Physicians.
- Or covered under a Bind Coverage with Evidence Development policy.

Bind ensures Medical Necessity through Utilization Management processes.

**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 Mental Disorders by 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 Mental Disorders by 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 Lumen who provides or arranges Mental Health and Substance Use Disorder Services under the Bind 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 Mental Disorders by 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 Mental Disorders by the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service

**Network/In-Network:** When used to describe a Provider of healthcare 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 an out-of-network Provider for other Covered Health Services and products. The participation status of Providers will change from time to time.

**Network/In-Network (Benefits):** Description of how Benefits are paid for Covered Health Services provided by Network Providers. Refer to Section 5 "**E. Network and Out-of-Network Providers/Facilities (for Virtual Network)**" (for those residing in a Network area) and Section 19 "**M. Providers**" 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

**Observation Stay:** Observation care consists of evaluation, treatment and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital.

**Out-of-Network (Benefits):** Description of how Benefits are paid for Covered Health Services provided by Network Providers. Refer to Section 5 "**E. Network and Out-of-Network Providers/Facilities (for Virtual Network)**" (for those residing in a Out-of-Network area) and Section 19 "**M. Providers**" for details about how Network Benefits apply.

**Out-of-Pocket Maximum:** The maximum amount you pay every Calendar Year. Refer to Section 11 "**Copayments**" for the Out-of-Pocket Maximum amount. See Section 5 "**B. What Are My Benefits?**" 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.

**Participant:** The person who is properly enrolled in the Bind Plan, and eligible for conditional coverages, under the eligibility rules. This could include either the eligible Employee/Retiree or an enrolled eligible Dependent as defined by the Bind Plan and only while such person(s) is enrolled and eligible for Benefits under the Bind Plan. References to "you" and "your" throughout this SPD are references to a Participant. ***See the General Information SPD for more details.***

**Payroll Deductions:** Premium contributions are paid by reducing the Participant'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. OptumRx is the PBM for Lumen.

**Pharmacy Claims Administrator:** Also known as Pharmacy Benefit Manager, or PBM, provides administrative services to the Plan Administrator in connection with the operation of the Pharmacy Plan, including processing of Claims, as may be delegated to it.

**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 Bind Plan.

**Plan:** Lumen Technologies, Inc. Health and Welfare Plan. Bind personalized health plan is a medical plan offered as a part of the 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 Bind Plan, to make factual determinations, to construe and interpret the terms of the SPD, the Bind 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 Bind Plan-connected administrative services, Lumen Employee Benefits Committee, and its designees.

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

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

**Pre-Admission Notification:** Process whereby the Provider or you inform the Bind Plan that you will be admitted to an 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 Pre-Admission Notification to you.

**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 healthcare services deemed Medically Necessary by the Claims 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 the Claims Administrator or its designee, within the Bind Plan'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 healthcare 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 Bind 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 Bind 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. Bind reserves the right to consult expert opinion in determining whether healthcare 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 the Claims Administrator or its designees' sole discretion.

Bind 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 Bind and revised from time to time), are available to Participants calling the phone number on the back of your ID card, and to Physicians and other healthcare professionals.

**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 Participant by an independent nurse who is hired directly by the Participant or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

**Provider:** A healthcare professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide healthcare services to you. The term "Provider" refers to an In-Network Provider unless other specified.

**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, licensed, 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. Bind Plan Copayments would still apply to the reduced charge. Sometimes the Bind Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the Network partner, such as a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the Provider. 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:** Infusions, Injectables, and non-injectable Prescription Drugs, as determined by the Pharmacy Claims 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 **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 Mental Disorders by 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 Mental Disorders by 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 personalized health plan and your rights and obligations under such benefit option as required by ERISA.

**Telehealth:** A visit with a Provider who uses a secure audio-video or audio-only telecommunications system allowing evaluation, assessment, and management of healthcare services.

**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 does not offer the intensity and structure needed to assist the Participant with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide Participants 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 does not offer the intensity and structure needed to assist the Participant with recovery.

**Transition of Care:** The option for a new Participant to request coverage from your current, out-of-network healthcare professional at in-network rates for a limited time due to a specific medical condition, until the safe transfer to an in-network healthcare professional can be arranged.

**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 healthcare services. These medical and drug policies are subject to change without prior notice.

**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 Participant 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 Participant 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 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 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 Claims Administrator (UHC).

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

- entered into an agreement with the Claims Administrator (UHC) to dispense Prescription Drugs to Participants;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the 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 Claims Administrator (UHC).

**Pharmacy Benefit Manager:** A Third-Party Administrator of Prescription Drug programs for commercial health plans and self-insured employer plans. OptumRx is the PBM for Lumen.

**Pharmacy Claims Administrator:** Also known as Pharmacy Benefit Manager, or PBM, provides administrative services to the Plan Administrator in connection with the operation of the Pharmacy Plan, including processing of Claims, as may be delegated to it.

**Predominant Reimbursement Rate:** The amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at an Out-of-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at an Out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax. The 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 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 at the phone number on the back of your ID card or by logging onto www.optumrx.com.

**Prescription Drug List (PDL) Management Committee:** The committee that the 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 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 www.optumrx.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 healthcare 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 healthcare 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.