Bind Health Plan

(Administered by Bind Benefits, Inc.)

Summary Plan Description (SPD) for Eligible Active Lumen Employees

Effective January 1, 2022

(Updated March 16, 2022)

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

You can find all the Plan SPDs on the Summary Plan Descriptions page on the Intranet

You can go online to obtain an electronic copy or call the Lumen Health and Life Service Center at Businessolver, 833-925-0487 or 317-671-8494 (International callers), to request a paper copy of a Summary Plan Description (SPD).

Note: When enrolling during 2022 Annual Enrollment, Nov. 3 – Nov. 17, 2021, use lumen.com/bschealthandlife (if actively working) or lumen.com/bschealthbenefits. During the 2022 Plan Year, use lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits.

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1. INTRODUCTION

Lumen Technologies, Inc. (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 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 Health 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 Health Plan. However,the two medical plans work together to administer these Benefits.

This SPD must be read in conjunction with the **General Information (Active) SPD** which explains many details of yourcoverage and provides a listing of the other benefit options under the Plan.

The Effective Date of this SPD is January 1, 2022. 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 (Active) 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 Health Plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Bind 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

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage”. The Bind Health Plan does provide minimum essential coverage. In addition, the Affordable CareAct 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 (Active) 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 24* ***“What Do I Do If My Medical Claim Is Denied?”*** *and in the* ***General Information (Active) SPD*** *for more information about the timing of thesedeadlines.*

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

Agent for Service of Legal Process:
Chief Privacy Officer,
931 14th Street, 9th Floor, Denver, 80202

Legal process may also be served on:
CT Corporation System
7700 East Arapahoe Road, Suite 220
Centennial, CO 80112

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 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 *PlanDocument* and the **General Information (Active) 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 (Active) 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 (Active) SPD**.

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

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

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

E. Bind 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 health care expenses and not to guide or direct the course of treatment of any Employee, retiree, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is approved or 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 health care Provider can decide what is the right health care decision for you.*** *Decisions by the Claims Administrator or the Plan Administrator are solely decisions with respect to Bind Plan coverage and do not constitute health care 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 Health Plan benefit option is just one benefit option offered under the Plan. This SPD **must** be read in conjunction with the **General Information (Active) SPD** which explains details of your coverage andprovides a listing of the other benefit options under the Plan.

*Refer to the **General Information (Active) 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 Health and Life Service Center at 833-925-0487 to request a paper copy of the **General Information (Active) 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 not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Plan provision will not interfere with the Bind Health 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 enforcethe 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 Health and Life Service Center within 45 days, regardless of if you have anobligation 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 (Active) SPD*** *as applicable.*

C. You Must Follow Bind Health 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 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.

Bind Health Plan (Medical) MemberService	**Phone:** 866-683-6440 6:00 a.m.-9:00 p.m. (Central) Monday-Friday **Website:** MyBind.com **Mobile App:** Download the MyBind mobile app from the Apple App Store or Google Play Store.
OptumRx (Pharmacy) Member Service	Refer to Section 21 "**PRESCRIPTION DRUGS**"
Bind Website and App	**Once enrolled:** You are encouraged to visit MyBind.com or download the MyBind mobile app from the Apple App Store or Google Play Store for easy access to what is covered, how much it costs and where you can get care. **When enrolling:** Lumen.com/ChooseBind **Access Code:** enroll2022
Bind (Medical Claims Administrator) Mailing Address	**For Medical Claims:** To file medical Claims, appeal requests and any written inquiries to: Attention: Claims Bind Benefits, Inc. P.O. Box 211758 Eagan, MN 55121 **For Medical Appeals/Complaints:** To file a medical appeal for Bind, mail the appeal to: Bind Benefits, Inc. Attn: Appeals P.O. Box 211758 Eagan, MN 55121 For more information on how to appeal a Claim, refer to Section 23 "**MEDICAL CLAIMS PROCEDURES**"
OptumRx (Pharmacy Claims Administrator) Mailing Address	**For Prescription Claims:** To file a Prescription Drug appeal, mail the appeal to: UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432

4. BIND HEALTH PLAN BENEFIT

A. Eligibility

Bind Health Plan

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

Electing and Activating Conditional Coverages

Once enrolled in the Bind Health Plan, any Participant is eligible to elect and activate one or more conditional coverages. To elect a conditional coverage into your Bind 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 for that specific elected and activated conditional coverage–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.*

**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.*

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 Health Plan for thetest, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period for that specific elected and activated conditional coverage, 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.

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

Bind Health Plan

*Refer to the **General Information (Active) SPD** for more information regarding eligibility under the Plan and otherimportant 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 Health Plan forthe conditional coverage test, treatment, or therapy.

If you are already enrolled in the Bind Health 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 for that specific elected and activated conditional coverage. To elect a conditional coverage into your Bind coverage you **must** takethe 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.*

**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.*

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 Health Plan for thetest, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period for that

specific elected and activated conditional coverage, 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 Health 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.

Note: 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 Health Plan. More information can be found on the MyBind mobile app or MyBind.com website or by contacting Bind Help.

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

Bind Health Plan

*Refer to the **General Information (Active) SPD** for more information regarding eligibility under the Plan and otherimportant information.*

For Conditional Coverages You Must Elect and Activate

Your conditional coverage will terminate on the earliest of the following dates:

- 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 Health Plan coverage for the subsequent Plan Year.
- If you have activated conditional coverage under the Bind Health Plan, and have a remaining balance when terminating from Lumen, and elect the Bind Health 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 Health Plan benefit option.

5. BIND HEALTH PLAN FEATURES AND HOW THE BIND HEALTH PLAN WORKS

The Bind 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 any geographic location 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 Health Plan are referred to as “Participants” in this SPD.

The Bind Health Plan has features that Participants know and understand — including, for example: no deductible; simple copayments for Covered Health Services; an annual out-of-pocket maximum; and available comprehensive coverage. The Bind Health Plan also has a feature that allows Participants with an Adverse Health Factor to elect and activate conditional coverages in advance of seeking care, if and when the Participant determines it is needed.

A. Here’s How It Works

When you enroll in the Bind Health Plan, your coverage automatically includes substantial coverage of Physician andHospital services – including for example preventive care, Emergency and Urgent Care, office visits, inpatientand 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 Health Plan, Bind coverage also includes the right to elect conditional coverages into your benefit package for 45 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 Health 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. Conditional coverage tests, treatments, and therapies must be received from Network Providers.

To elect a conditional coverage into your Bind 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:

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.*

**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.*

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 Health Plan for thetest, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period for that specific elected and activated conditional coverage, 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.

All Bind coverages are underwritten as one Plan offering. Participants and Plan Sponsors share in the costof the Bind Health Plan. Your premium contribution amount depends on the Dependents you choose to enroll.

To summarize, the Bind Health Plan gives you cost, and coverage options, and allows you to customize and personalize your coverage during the Plan Year if you experience an Adverse HealthFactor.

B. What Are My Benefits?

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

The total cost of Covered Health Services is shared between you and the Plan Sponsor. Your share (including conditional coverages) consists of premium contributions and copayments. The Bind Health Plan does not have a deductible or coinsurance. Your Bind Health Plan does have an Out-of-Pocket Maximum which is the maximum amount you will pay each Plan Year for Covered Health 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 premium contributions a special tax advantage. 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 premiums are deducted on an after-tax basis.

Bind assigns prices to Covered Health Services. These prices are referred to as Copayments. Your Copayments for Covered Health Services are listed in Section 12 "**A. Copayments**", Section 21 "**PRESCRIPTION DRUGS**", and Section 19 "**Conditional Coverage Copayments**"– and also on the MyBind mobile app and MyBind.com website.

The Bind Health Plan pays for the remainder of the amount billed by your Network Provider for Covered Health 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 be responsible for (in addition to your higher out-of-network Copayment) all amounts that exceed the Usual and Customary amount, when applicable.

Once your total Copayments (including those for conditional coverages) reach your applicable Out-of-Pocket Maximum, the Bind Health Plan provides benefits at 100% of Eligible Charges for the remainder of the Plan Year, except for amounts you pay for out-of-network Covered Health Services in excess of the Usual and Customary amount, when applicable. 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.

In-Network Benefits

As a Participant in the Bind Health Plan, you may choose any eligible Provider of health services each time you needto receive a Covered Health Service. The choices you make may affect the amount you pay, as well as the level of Benefits you receive. You will receive the highest level of Benefits from the Bind Health Plan (and in most instances, your out-of-pocket expenses will be far less) when you receive care from Network Providers.. The Bind Health Plan features a large network or Network of Providers which can be found in the MyBind mobile app or MyBind.com website, or by calling Bind Help for assistance..

These Providers will:

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

Network Providers are responsible for obtaining Prior Authorization, Pre-Admission Notification, pre-admission certification for planned inpatient admissions,and/or Emergency admission notification requirements for you. Therefore, it is important that you confirm the Provider's status before you receive services as a Provider's network status may change. For current Network Provider information, refer to Lumen.com/ChooseBind or connect with Bind via web, mobile app, or phone using theinformation found in Section 3 "CLAIMS ADMINISTRATOR AND CONTACT INFORMATION".

If you receive health care services from an out-of-network Provider and were informed incorrectly by us prior to receipt of the Covered Health Service that the Provider was an in-network Provider, either through our database, our provider directory, or in our response to your request for such information) via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (copayment) that would be no greater than if the Covered Health Service had been provided from an in-network Provider.

You must show your insurance identification "ID" card every time you request health care services from a Network Provider which can be found on the MyBind mobile app. If you do not show your member ID card, Network Providers have no way of knowing that you are enrolled under the Bind Health Plan. As a result, they may bill you for the entire cost of the services you receive.

Do not assume that an in-network Provider's agreement includes all Covered Health Services. Some in-network Providers contract with Bind to provide only certain Covered Health Services, but not all Covered Health Services. Some in-network Providers choose to be an in-network Provider for only some of our products. Refer to the MyBind mobile app or MyBind.com website or call Bind Help for assistance.

For in-network benefits for Covered Health Services provided by an in-network Provider, except for your copayment obligations, you are not responsible for any difference between the Eligible Charge and the amount the Provider bills. Eligible Charges are based on the following:

- When Covered Health Services are received from an in-network Provider, Eligible Charges are our contracted fee(s) with that Provider.
- When Covered Health Services are received from an out-of-network Provider as arranged by us, Eligible Charges are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable copayment. We will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

The Bind Health Plan generally provides Benefits for medical Claims incurred with an out-of-network Provider at a lower level. As a result, if you choose to seek Covered Health Services out-of-network, except as described below, you will be responsible for the difference between the amount billedby the out-of-network Provider or facility and the amount we determine to be the Eligible Charge for reimbursement. You are required to pay any 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 billing practices before you receive care.

- For Covered Health Services that are ***Ancillary Services received at certain in-network facilities on a non-Emergency basis from out-of-network Physicians***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your copayment which is based on the Recognized Amount as defined in Section 28 (Glossary).
- For Covered Health Services that are ***non-Ancillary Services received at certain in-network facilities on a non-Emergency basis from out-of-network Providers who have not satisfied the notice and consent criteria as described below***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your copayment which is based on the Recognized Amount as defined in Section 28 (Glossary).
- For Covered Health Services that are ***Emergency Health Services provided by an out-of-network Provider***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 28 (Glossary).
- For Covered Health Services that are ***air ambulance services provided by an out-of-network Provider***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your applicable copayment which is based on the rates that would apply if the service was provided by an in-network Provider.

Eligible Charges are determined in accordance with our reimbursement policy guidelines or as required by law.

When Covered Health Services are received from an out-of-network Provider as described below, Eligible Charges are determined, as follows:

- **For non-Emergency Covered Health Services received at certain in-network facilities from out-of-network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Ac*t with respect to a visit as defined by the Secretary, the Eligible Charge is based on either:
  - The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement.*
  - The initial payment made by us or the amount subsequently agreed to by the out-of-network Provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For Ancillary Services, and for non-Ancillary Services provided without notice and consent, you are not responsible, and an out-of-network physician may not bill you, for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 28 (Glossary).
- **For Emergency health care services provided by an out-of-network Provider**, the Eligible Charge is based on either:
  - The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement.*
  - The initial payment made by us or the amount subsequently agreed to by the out-of-network Provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 28 (Glossary).
- **For air ambulance transportation provided by an out-of-network Provider**, the Eligible Charge is based on either:
  - The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement*.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-network Provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your copayment which is based on the rates that would apply if the service was provided by an in-network Provider.

Out-of-network Benefits apply to Covered Health Services that are provided by an out-of-network Provider, or Covered Health Services that are provided at an out-of-network facility. 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 Health Plan.

If the Claims Administrator confirms that care is not available from an in-network Provider, the Claims Administrator will work with you to coordinate care through an out-of-network Provider as outlined in the written policy established by the Claims Administrator. Covered Health Services rendered by an out-of-network Provider will be processed at the in-network Benefit level when there are no available in-network Providers. Requests for this Benefit should be made by calling Bind Help at the number on your member ID card **before** you obtain such services.

Out-of-network Providers are not required to file Claims with Bind. If you receive Covered Health Services outside of the Bind network and the Provider and/or facility requires that you remit the full amount, contact

Bind Help for a Claim form to file a Claim for reimbursement. This may require an itemized bill from the Provider.

Depending on the service you receive and the Provider you receive it from, you may have access to a discount through the Network partner's Shared Savings Program for out-of-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 out-of-network Copayment will remain the same as if receiving Covered Health Services from out-of-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 out-of-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. Out-of-Area Members

If you live outside of the Bind Health Plan area ("out of area"), the Bind Health Plan will still pay Benefits for you and your covered Dependents at In-Network levels. This out-of-area coverage is designed to help Employees who live in rural areas with no access to Network Providers. You may be asked to pay the Provider at the time of service and then submit a Claim to the Bind Health Plan for reimbursement.

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

Network and Out-of-Network Providers/Facilities (for Out-of-Area Members)

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

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

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

6. HEALTH REIMBURSEMENT ACCOUNT (HRA) AND BIND

If you elect the Bind Health Plan and have a prior CDHP Health Reimbursement Account (HRA) balance these dollars will follow you. Your prior account HRA dollars will not be available until after the run-out period (for Claims from your prior coverage to clear under the CDHP Plan benefit option HRA). This typically takes 90 days. Under the Bind 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 Health Plan, you will have access to your HRA accountbalance. You can then use the money to pay yourself back for eligible Bind health care expenses.

To be reimbursed from your available HRA funds simply submit a reimbursement form, called a *Request for Withdrawal Form*, for the HRA Eligible Expenses that have been incurred. A *Request for Withdrawal Form* is available on the Internet at 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. *(See the FSA SPD for this information as it relates to the FSA)*

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

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

See the Health Reimbursement Account SPD for more information.

If you are enrolled in the Bind 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. FLEXIBLE SPENDING ACCOUNTS AND ROLLOVER HRA

A. Which Account Will Pay First

For eligible medical and Prescription Drug expenses, the HRA balance should always be accessed **first** until it is depleted before FSA funds can be used. Because of this, you must use your FSA funds in the current year **or risk losing** them during the January through March FSA extended period of the following year.

Important! If you want expenses paid out of the prior year's (grace period) FSA funds, Claims will need to be submitted manually by filling out a manual Claim form found on UHCs website at myuhc.com. The prioryear FSA funds can be used for dental and vision or non-Plan covered eligible medical expenses. *See the Flexible Spending Account SPD for more information*.

If you have allocated your prior year (grace period) FSA funds for specific dental or vision expenses, you can

turn off Auto Reimbursement (Auto Rollover) by going to the myuhc.com website under Accounts and Balances.

See the Flexible Spending Account SPD for more information.

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

8. PRIOR AUTHORIZATION AND PRE-ADMISSION NOTIFICATION

Select services require Prior Authorization or notification. Prior Authorization is required by service type, regardless of whether the services are rendered by both Network and out-of-network Providers.

Network Providers are responsible for obtaining Prior Authorization for select Covered Health 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 (SNF) 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 Health Plan. Contact Bind Help prior to obtaining services to determine whether Prior Authorization is required orask your Provider to contact the pre-certification number on your ID card.

If your Prior Authorization or Pre-Admission Notification is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). This information can also be found in Section 24 “**WHAT DO I DO IF MYMEDICAL CLAIM IS DENIED?**”.

The Prior Authorization list is subject to change without notice. The most current information can be obtained by having your Provider contact the pre-certification number onyour 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
- Advance behavioral analysis
- Bone growth stimulators
- BRCA testing
- Clinical Trials
- Cochlear implant surgery
- Coverage with Evidence Development
- Gender reassignment surgery
- Intensity-modulated radiation therapy
- Long-term acute care
- MR-guided focused ultrasound
- Non-Emergency air transportation
- Organ transplants
- Orthognathic surgery
- Partial hospitalization
- Potentially Cosmetic and Reconstructive surgery
- Proton beam therapy
- Residential treatment facilities
- Select cardiovascular procedures
- Select chemotherapy
- Select Durable Medical Equipment, orthotics, and prosthetics
- Select genetic and molecular tests
- Select injectable medications
- Select spinal surgeries
- Skilled Nursing Facilities
- Sleep apnea procedures
- Sleep studies
- Vein procedures
- Ventricular assist devices

9. BIND CLINICAL PROGRAMS

A. Bind Care Management

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

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

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

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 at the number on the back of your member ID card 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 member ID card for more information onTransplant Resources Services and access to the Transplant Center of Excellence Providers.

Once you are enrolled in Transplant Resource Services, a dedicated nurse case manager who specializes in transplant cases will provide assistance in:

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

Organs that are included in the program are heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and bone marrow (blood forming stem cell transplants). While corneal transplantis 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 program.

Diabetes Care Management – Virta

Bind offers a personalized virtual diabetes control program focused on reversing type 2 diabetes. Eligible Bind members can enroll in Virta at no additional charge and no out-of-pocket costs. When you enroll, Virta will support you with nutritional and medication changes as well as provide biomarker feedback. To find out additional information, visit the MyBind mobile app or MyBind.com website, or call using the information found in Section 3"**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

Chronic Condition Self-Management – Canary

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, visit the MyBind mobile app or MyBind.com website, or call using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

Maternity Support Program – Pacify

Bind offers a maternity support program with round-the-clock access to maternity nurses, lactation consultants, and early childhood experts. To find out additional information, the MyBind mobile app or MyBind.com website, or call using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACTINFORMATION**".

Bind may offer additional or varying Care Model Innovations throughout the year. To find out additional information, visit the MyBind mobile app or MyBind.com website, or call using the information found in Section 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**".

D. Other Condition-Focused Programs Made Available by Lumen

Hinge Health

Hinge Health Virtual Physical Therapy program can help you conquer back and joint pain. Best of all, Hinge Health's programs are provided at no cost to you and your eligible dependents enrolled in a Lumen medical plan. Hinge Health provides all the tools you need to get moving again from the comfort of your home. Here are some ways your treatment plan could be tailored to you:

- Get a personal care team, including a physical therapist and health coach.
- Get a second opinion on your recommended surgery and treatment plan.
- Receive wearable sensors that give live feedback on your form in their app.
- Schedule as many personal physical therapy sessions as needed.

If you don't have pain and are just looking to stay healthy, you can sign up for their free app. Recommended exercises will be tailored to you based on your job and lifestyle.

For questions you can call Hinge Health at 855-902-2777 or send an email to hello@hingehealth.com.

PotentiaMetrics

MyCancerJourney by PotentiaMetrics is a decision support tool that helps people and their families understand survival statistics and the likely outcomes of different treatment options for a cancer diagnosis. MyCancerJourney's big data platform leverages the largest cancer outcomes dataset of its kind to help cancer patients find answers to questions about cancer that can affect their quality of life. In addition, Cancer Patient Navigators are trained to identify and help resolve common frustrations and can help guide members throughout their cancer experience. For additional information, visit the MyBind mobile app or MyBind.com website or call Bind Help.

Progyny Fertility Solutions Program

The Progyny benefit includes comprehensive treatment coverage leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists, and personalized emotional support and guidance from dedicated Patient Care Advocates (PCAs). This Benefit is limited to two (2) Smart Cycle per lifetime.

Covered Participants must contact Progyny Fertility Solutions at 833-281-0080 to enroll and activate this Benefit. Progyny will provide you with the *Understanding Your Progyny Benefit Member Guide,* which provides specifics regarding the Progyny Fertility Benefits and eligibility.

10. TRANSITION OF CARE AND CONTINUITY OF CARE

If you are new to the Bind Health Plan 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. Transition of Care Benefits are managed on a case-by-case basis.

If you are currently covered by the Bind Health Plan and your health care Provider leaves the Network, you have the opportunity to apply for Continuity of Care. Continuity of Care Benefits, if approved, allow you 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. Continuity of Care Benefits are managed on a case-by-case basis.

If you are currently receiving treatment for Covered Health Services from a Provider whose network status changes from in-network to out-of-network during such treatment due to termination (non-renewal or expiration) of the Provider's contract, you may be eligible to request continued care from your current Provider under the same terms and conditions that would have applied prior to termination of the Provider's contract for specified conditions and timeframes. This provision does not apply to Provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, call Bind Help for assistance.

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

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

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 the Bind Health Plan.
- **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 number on your Bind member 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.

11. CLINICAL TRIALS

Clinical Trials are research studies designed to find ways to improve health care or to improve prevention, diagnosis, or treatment of health problems. The purpose of many Clinical Trials is to find out whether a medicine or treatment is safe and effective for treating a certain condition or disease. Clinical Trials compare the effectiveness of 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 health care costs for qualifying individuals participating in approved Clinical Trial. For more information call Bind Help at the number on your member ID card.

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 health care services that generate better clinical outcomes at lower cost. CED medical policies provide coverage for promising new technologies that have not yet been established as effective according to generally accepted professional medical standards, but:

1. Are not eligible to be covered under the Clinical Trials policy;
2. Would otherwise be considered Medically Necessary;
3. Are safe;
4. Show substantial potential to improve health outcomes and reduce waste and inefficiency in the health care system;
5. Are being evaluated in a high-quality research or clinical study;
6. Can be operationally administered by Bind;
7. Do not substantially increase health care costs;
8. 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 Health Plan benefit design. This will require Prior Authorization and Medical Necessity review.

12. COVERED BIND HEALTH PLAN BENEFITS

A. Copayments

A copayment is the amount you pay each time you receive certain Covered Health Services. The table below describes how your coverage works and includes Copayments and any premium contributions applicable to the Covered Health Services you choose. Some Copayments are listed as a range. Bind assigns Provider Copayments within ranges based on Bind's analysis of treatment outcomes and cost information that identifies Physicians, 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 for a specific provider or location may be updated from time to time, but never higher than the maximum Copayment.**

For current Provider-specific copayment information, Participants should check the MyBind mobile app or MyBind.com website or call Bind Help prior to utilizing any services covered under the Bind Health Plan. The MyBind mobile app and the MyBind.com website will display at least 60 days in advance when a cost for a specific Provider will be moving up or down and the date when the change will occur.

The full range of Copayments displayed may not be available in all geographical 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 for the Bind Health Plan.

B. Benefit Features

The Bind Health Plan	In-Network	Out-of-Network
Deductible	$0	$0
Out-of-Pocket Maximum per Plan Year		
Individual	$3,600	$7,200
Employee (EE) + Spouse/Employee (EE) + Child	$5,400	$10,800
Family	$6,850	$14,400

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- If you enroll in individual coverage, once you meet the individual Out-of-Pocket Maximum, Benefits are payable at 100% of the Eligible Charge during the rest ofthat Plan Year.
- If you have other family members enrolled (Family coverage) in the Bind Health 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.
- In-Network benefits apply if you are a member located out-of-area.

C. Covered Health Services

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

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Out-of-network Ambulance Services copayment applies to the in-network out-of-pocket maximum.
- Ground or air ambulance, as the Claims Administrator determines appropriate. Air ambulance is medical transport by helicopter or airplane.
- Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) 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 approve 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 Health 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 the closest Network Hospital or facility that provides Covered Health Services that were not available at the original Hospital or facility.
  - To a more Cost-Effective acute care facility.
  - From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.
  - From facility to home when member is in end-of-life care.
- Non-Emergency ground and air ambulance services may require Prior Authorization and Medical Necessity review.

Behavioral Health: Mental Health and Substance Use Disorder Services	In-Network	Out-of-Network
Mental Health Office Visit	$20 Copayment / visit	$130 Copayment / visit
Mental Health Telehealth Visit	$20 Copayment / visit	$130 Copayment / visit
Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder Visit	$20 Copayment / visit	$130 Copayment / visit
Mental Health Habilitative, 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
Outpatient Mental Health	$100 Copayment / visit	$300 Copayment / visit
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
- It is important to note that returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Inpatient residential and partial hospitalization services may require Prior Authorization and Medical Necessity review

The Bind Health Plan provides Benefits for 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.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, or impairment in daily functioning.
- Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.

- 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 Health Service for which Benefits are available under the applicable medical Covered Health 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 may require Prior Authorization and Medical Necessity review..

Cancer Chemotherapy	In-Network	Out-of-Network
Cancer Chemotherapy	$525 to $1,100 Copayment / visit	$2,200 Copayment / visit
Central Venous Catheterization	$525 to $1,100 Copayment / visit	$2,200 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Benefits include Physician services and facility charges.
- Copayments for Cancer Chemotherapy and Central Venous Catheterization may vary based on Provider and location.
- The Bind Health Plan pays Benefits for therapeutic treatments received in an office, outpatient Hospital or Alternate Facility, including central venous catheterization, intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.
- Covered Health Services include medical education services that are provided in an office, outpatient Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals.
- Select Cancer Chemotherapy services may require Prior Authorization and Medical Necessity review.

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

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- The Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- 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.
- When this procedure is performed to diagnose disease symptoms, a Copayment applies.
- Services for preventive screenings are provided under the Preventive Care Services for coverage notes.

Complex Imaging	In-Network	Out-of-Network
MRI (Magnetic Resonance Imaging)	$250 to $775 Copayment / visit	$1,550 Copayment / visit
MRA (Magnetic Resonance Angiography)	$250 to $775 Copayment / visit	$1,550 Copayment / visit
CT (Computed Tomography)	$250 to $775 Copayment / visit	$1,550 Copayment / visit
PET (Positron Emission Tomography)	$250 to $775 Copayment / visit	$1,550 Copayment / visit
Nuclear Medicine	$250 to $775 Copayment / visit	$1,550 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- The Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- If imaging occurs on multiple areas of the body, such as the lumbar spine and the cervical spine on the same date of service, more than one Copayment may apply.
- If your Physician suggests a low-dose CT Scan (LDCT) for lung cancer screening, refer to “Preventive Care Services” section for coverage notes.

Dental Services: Accidental Dental	In-Network	Out-of-Network
Office Visit	$20 to $90 Copayment / visit	$90 Copayment / visit
All Other Services		
• **Outpatient Hospital Visit**	$750 Copayment / visit	$750 Copayment / visit
• **Inpatient Hospital**	$1,400 Copayment / stay	$1,400 Copayment / stay

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- It is important to note that returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- The Bind Health 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 startedwithin six months and completed within twelve months of the date of the Injury.
- Accidental Dental Services may require Prior Authorization and Medical Necessity review.

Dental Services: Medical Dental	In-Network	Out-of-Network
Office Visit	$20 to $90 Copayment / visit	$180 Copayment / visit
All Other Services		
• **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.
- Copayments for office visits may vary based on Provider and location.
- It is important to note that returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.
- The Bind Health 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 dentaltreatment. 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.
- Medical Dental Services may require Prior Authorization and Medical Necessity review.

Dental Services: Oral Surgery	In-Network	Out-of-Network
• **Oral Surgery (removal of impacted teeth)**	$140 Copayment / visit	$280 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- It is important to note that returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- 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.
  - The correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Oral Surgery may require Prior Authorization and Medical Necessity review.

Dialysis Services	In-Network	Out-of-Network
Home Dialysis	$70 Copayment / visit	$210 Copayment / visit
Dialysis	$100 to $475 Copayment / visit	$1,425 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for Dialysis may vary based on Provider and location.
- The Bind Health Plan pays 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.

Durable Medical Equipment (DME)	In-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:

- Durable Medical Equipment (DME) and supplies are tiered based on average cost and allowed amount. Supplies such as tubing, syringes, and catheters are assigned to a lower tier and will result in a lower copayment. Equipment such as glucose monitors, pumps, and wheelchairs are assigned to a higher tier and will result in a higher copayment.
- Each piece of durable medical equipment and supplies are assigned to a tier, which corresponds to a copayment. A breakdown of the tiers and corresponding copayments can be found on MyBind mobile app or MyBind.com website.
- Note that returning home from an appointment with a health care Provider or from the hospital with durable medical equipment, such as crutches, may result in an additional copayment. Copayments will be dependent on the tier the item falls into.
- For Enteral Nutrition administered at home, two copayments will apply: the copayment stated for the DME tube (Tier 7) and the copayment stated under Home Health Care.

The Bind Health 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.
- This DME and supplies list is subject to periodic review and modification (generally quarterly, but no more than six times a year).
- To view which tier a particular DME item has been assigned to, visit Lumen.com/ChooseBind, MyBind.com website, the MyBind mobile app or call Bind Help for assistance.
- 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. If you need certain durable medical equipment for an extended period of time, there may be an option to rent. The copayment you see based on tier may be split over a 10-month period, at which point the DME may be considered “purchased” or coverage may end. Note that some equipment such as oxygen equipment, will be set to rental for the duration of time the equipment is needed, which may extend well beyond 10 months.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Cranial orthoses such as head shaping helmets and head reconstruction are a set of orthotic devices and services to reshape the head are covered when it is needed to prevent surgery when the condition will not self-correct but worsen over time. They may be medically indicated for plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- Scalp/cranial hair prostheses (wigs) are a Covered Health Service for scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy, and are limited to one wig per Participant per Calendar Year up to a maximum of $350 for Network and out-of-network Providers combined.
- Cataract surgery or aphakia is limited to one frame and one pair of lenses, or one pair of contact lenses or one-year supply of disposable contact lenses.
- Hearing aids are limited to one hearing aid per ear every 36 months for Network and out-of-network Providers combined.
- Communication aids or devices; equipment to create, replace, or augment communication abilities, including but not limited to communication board or computer or electronic-assisted communication, speech processors, and receivers.
- Purchase of one standard breast pump, either manual or electric, per pregnancy or postpartum Participants per pregnancy. Participant may have to pay a surcharge to the Provider if they purchase enhanced models.
- 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 are 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)
- Shoes as prescribed by a Provider for a Participant. Limited to one pair per Plan Year.
- Orthotics are limited to up to $350 per Participant per Calendar Year for foot orthotics for Network and out-of-network Providers combined.
- Compression stockings are a covered benefit when they are used in combination with a UHC approved pneumatic compression device in the treatment of Lymphedema.
- 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	Out-of-Network
Emergency Room Visit	$500 Copayment / visit	$500 Copayment / visit
Observation Stay	$750 Copayment / stay	$1,500 Copayment / stay

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Out-of-network Emergency Room Visit copayment applies to the in-network out-of-pocket maximum.
- Out-of-network Observation Stay copayment applies to the in-network out-of-pocket maximum.
- Copayment applies to Emergency Room facility and professional expenses and includes related expenses.
- It is important to note that returning home from an Emergency Room visit or hospital with durable medical equipment, such as crutches, may result in an additional Copayment.
- 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 Observation Stay Copayment.
- Refer to Hospital Services section for additional coverage notes.

Gender Dysphoria Services	In-Network	Out-of-Network
Mental Health Office Visit	$20 Copayment / visit	$130 Copayment / visit
Outpatient Hospital Visit	$100 Copayment / visit	$100 Copayment / visit
Inpatient Hospital	$1,400 Copayment / stay	$1,400 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 including gender reassignment surgery including genital reconstruction (clitoriplasty, vaginoplasty, scrotoplasty), mastectomy, and breast augmentation.
- Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.

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.

Genetic Testing	In-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	Out-of-Network
Home Health Care Visit	$25 Copayment / visit	$170 Copayment / visit
Home Enteral Feeding	$15 Copayment / visit	$45 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Home Health Care Visits are 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 health care 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.
- For Enteral Nutrition administered at home, two copayments will apply: the copayment stated for the DME tube (DME-Tier 7) and the copayment stated under Home Health Care.
- 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 administered by a Home Health Agencywill apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.

Hospice Care	In-Network	Out-of-Network
Home Hospice Visit	$25 Copayment / visit	$170 Copayment / visit
Inpatient Hospice Care	$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 in the home or an inpatient setting 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	Out-of-Network
Outpatient Hospital Visit	$750 Copayment / visit	$1,500 Copayment / visit
Inpatient Hospital	$1,400 Copayment / stay	$2,800 Copayment / stay

Notes:

- Hospital Services: The Copayments above apply for Covered Health Services not specifically listed in this SPD, MyBind mobile app or MyBind.com website.
- Refer to the MyBind mobile app for additional coverage information.
- Multiple Copayments may apply if more than one treatment or procedure is performed during a visit/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 Health 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 Stay Copayment will be waived, and you will be responsible for the Inpatient Hospital Services Copayment.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

Fertility Treatments – Designated Provider: Progyny	In-Network	Out-of-Network
Two (2) Smart Cycles per family (employee and spouse)	Up to $2,000 copayment per Smart Cycle limited to 2 Smart Cycles per lifetime	Not Covered
Two (2) Initial Consultations		Not Covered
Progyny Rx – fertility medications		Not Covered
Fertility preservation – Egg and sperm freezing coverage		Not Covered
Tissue storage (specific treatment)		

Notes:

- **Covered Participants must contact Progyny at 833-281-0080 to enroll and activate this Benefit. Progyny will provide you with the *Understanding Your Progyny Benefit Member Guide.*** This guide provides specifics regarding the Progyny Fertility Benefits and eligibility.
- You may also contact Bind Help for additional coverage information regarding what specific services are covered and what copayment applies to a procedure/service or refer to the MyBind mobile app for additional coverage information.
- The Progyny benefit includes comprehensive treatment coverage leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists, and personalized emotional support and guidance from dedicated Patient Care Advocates (PCAs) limited to two Smart Cycle per lifetime. Your coverage includes:
  - Two Smart Cycles per family (employee and spouse) limited to two Smart Cycles per lifetime while on the Bind Health Plan.
  - Two Initial consultations (per calendar year until lifetime maximum of two Smart Cycles are exhausted).
  - Progyny Rx – fertility medication coverage.
  - Fertility preservation – Egg and sperm freezing coverage.
  - Tissue storage – Tissue storage is included in applicable treatment cycles for the first year.
- The Progyny Benefits are organized and administered in Smart Cycle components and limited to two Smart Cycles per lifetime while on the Bind Health Plan.
- Each Smart Cycle is a bundle of all standards of care services (such as in-cycle monitoring, anesthesia, assisted hatching, genetic testing, ICSI, and first year of storage) needed for the most prevalent fertility treatments, including:
  - Comprehensive Consultations.
  - IUI (Intrauterine Insemination).
  - IVF (In Vitro Fertilization).
  - Preimplantation Genetic Testing.
  - Medications for fertility treatments through Progyny Rx.
- There are some services that are not covered by Progyny; however, they may be covered under the Bind medical plan (e.g., corrective surgeries like hysteroscopies, laparoscopies, myomectomies, and testicular sperm extractions).
- The health Plan and Progyny will not cover treatments considered Experimental by the American Society of Reproductive Medicine (ASRM) or not reflected in the Progyny Member Guide.
- Benefits for certain pharmaceutical products, including specialty pharmaceutical products, for your fertility treatments are covered under the Progyny Rx Benefit.
- Cryopreservation and storage (up to 12 months) for a covered Participant who will undergo cancer treatment that is expected to render them infertile. You may contact Bind Help for additional information if you are not enrolled with Progyny.
- Treatment for the diagnosis and treatment of the underlying cause of infertility is covered under the Bind medical Plan as described in this SPD.
- Eligibility for the Progyny Fertility Benefit will be outlined by PCA and include but are not limited to:
  - The lifetime Smart Cycle benefit is per family (employee and covered spouse), not per member.
  - You must be covered under the Bind Health Plan.
  - If you have a spouse, your spouse must be claimed as dependent and covered on your Bind primary medical Plan, Progyny Benefits are not available to spouses who are not covered under the Bind Health Plan or not claimed as a dependent.
  - You and your spouse must enroll in the Progyny Fertility Benefit program in order to activate these Benefits. If you do not enroll you will not have coverage for fertility treatment under this plan.
- See the ***Understanding Your Progyny Benefit Member Guide*** for additional information.
- **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 requirementsor the Health Resources and Services Administration (HRSA) requirement or care to save the life of the mother. If you residein the State of Massachusetts, the benefit coverage for a Dependent Child's Pregnancy is different, and the Bind Health Plan coversadditional 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	Out-of-Network
Non-Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds	$35 to $700 Copayment / visit	$130 to $2,100 Copayment / visit
Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds	$0 Copayment / visit	$0 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information and the Copayment that has been assigned to your procedure/service.
- Copayments for Non-Routine Diagnostic Laboratory Services/X-ray/Ultrasounds may vary based on Provider, location, and procedure.
- Non-Routine diagnostic tests or scopes such as Upper GI Endoscopy require a Participant to elect and activate coverage prior to receiving service. Please see Section 19 “Conditional Coverages” and Section 5 “Bind Health Plan Features and How the Bind Health Plan Works” for additional information and the full list of coverages that require you to elect and activate coverage. 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:
    - Cardiac Event Monitoring.
    - Cystometrogram (CMG).
    - Echocardiogram Exercise Stress Test.
    - EKG Exercise Stress Test.
    - Electroencephalogram (EEG).
    - Electromyography (EMG) and Nerve Conduction Studies (NCS).
    - Gastrointestinal Motility Testing.
    - Sleep Study.
    - Tilt Table Testing.
    - Transthoracic Echocardiogram (TTE).
  - Routine diagnostic testing such as:
    - Diagnostic labs, pathology tests, and interpretation charges, such as blood tests, analysis of tissues, liquids from the body.
    - Diagnostic ultrasounds and X-rays, such as fluoroscopic tests and interpretation.
- If more than one type of imaging occurs, such as an x-ray and ultrasound, on the same date of service, more than one Copayment may apply.
- If more than one type of diagnostic testing occurs, such as an EKG exercise stress test and an electroencephalogram (EEG), on the same date of service, more than one Copayment may apply.
- Select Laboratory services and Diagnostic Testing may require Prior Authorization and Medical Necessity review.

Maternity Care and Delivery	In-Network	Out-of-Network
Routine Pre-natal and Post-Natal Office Visits, Including Labs and Tests	$0 Copayment / visit	$130 Copayment / visit
Amniocentesis	$325 Copayment / test	$975 Copayment / test
Chorionic Villus Sampling (CVS)	$425 Copayment / test	$1,275 Copayment / test
Inpatient Delivery	$500 to $2,000 Copayment / stay	$4,000 Copayment / stay
All Other Outpatient Services	$750 Copayment / visit	$1,500 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- The Copayments for inpatient delivery may vary based on Provider and location, this includes a birthing center.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as a fetal monitor, may result in an additional copayment.
- 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.
- There will be one Copayment for all Covered Health 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 following 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 Health 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	Out-of-Network
Medical Drug Category 1	$0 Copayment / visit	$1,110 Copayment / visit
Medical Drug Category 2	$300 to $370 Copayment / visit	$1,110 Copayment / visit
Medical Drug Category 3	$300 to $540 Copayment / visit	$1,620 Copayment / visit
Medical Drug Category 4	$300 to $540 Copayment / visit	$1,620 Copayment / visit
Medical Drug Category 5	$300 to $650 Copayment / visit	$1,950 Copayment / visit
Medical Drug Category 6	$300 to $925 Copayment / visit	$2,700 Copayment / visit
Medical Drug Category 7	$300 to $950 Copayment / visit	$2,700 Copayment / visit
Medical Drug Category 8	$300 to $1,100 Copayment / visit	$2,700 Copayment / visit
Medical Drug Category 9	$300 to $1,350 Copayment / visit	$2,700 Copayment / visit
Medical Drug Category 10	$300 to $1,350 Copayment / visit	$2,700 Copayment / visit
Medical Drug Category 11	$450 to $1,350 Copayment / visit	$2,700 Copayment / visit
Medical Drug Category 12	$500 to $1,350 Copayment / visit	$2,700 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- Benefits are available for certain medical infusions and injectables administered on an outpatient basis in a hospital facility, alternate facility, in a Physician's office, or in the home.
- The Medical Infusions and injectables require supervision and follow up with a medical professional. The Medical Drug Category 1 through Category 12 drugs will be dispensed and administered by a medical professional. Certain drugs are dispensed by a medical professional and may require special handling and storage. Certain drugs may require special handling and storage and are generally considered Specialty Drugs administered by a medical professional.
- Medical Drug Category 1 has a $0 copayment for supportive services that are often unplanned for your diagnosis and treatment, such as IV fluids or antibiotic injections.
- Medical Drug Category 2 through 12 are typically for planned administration and have their own copayments when given in a non-emergent outpatient setting.
- The Copayments apply to specific drugs that must be administered in a medical setting or under medical supervision. Call Bind Help to learn which medical drug (e.g., 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 21 "Prescription Drugs").
- Select Medical Infusions and Injectables may require Prior Authorization and Medical Necessity review.

Office Visit and Diagnostic Visit	In-Network	Out-of-Network
Office Visit - Primary Care / Specialist Visit	$20 to $90 Copayment / visit	$180 Copayment / visit
Office Visit - Telehealth	$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 - Telehealth	$20 Copayment / visit	$130 Copayment / visit
Cor Medical Onsite Clinic: Office Visit and Mental HealthOffice Visit	$0 Copayment / visit	Not Applicable
Cor Medical Onsite Clinic Preventive (Wellness)	$0 Copayment / visit	Not Applicable
Cor Medical Onsite Clinic Physical Therapy Visit	$0 Copayment / visit	Not Applicable
E-Visit and Telephone Consult with Your Physician after anEmergency Room Visit	$35 Copayment / visit	Not Covered
Outpatient Anticoagulant Management	$10 Copayment / visit	Not Covered
Virtual Visit – other than Designated Provider (see "VirtualVisits"*)	Not Covered	Not Covered
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 Health Plan provides Benefits for services provided in an office for the diagnosis and treatment of an Illness or Injury.

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Office Visit refers to face-to-face visit or Telehealth visit with your Provider.
- Multiple copayments may apply if a treatment or procedure is also performed during a visit.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Coverage is available for both face-to-face and Telehealth services.
- Vision therapy is covered as an office visit.
- * Virtual Visit refers to a visit with a Designated Virtual Provider such as Doctor on Demand. 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 illnesses and Injuries, and provide 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.
- It is important to note that returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Orthognathic Surgery and Temporomandibular(TMU) Joint Disorder	In-Network	Out-of-Network
Office Visit	$20 to $90 Copayment / visit	$180 Copayment / visit
Orthognathic (Jaw) Surgery	$1,750 Copayment / visit	$1,750 Copayment / visit
Temporomandibular Joint Dysfunction (TMJ) Surgery	$900 Copayment / visit	$900 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 Health Plan provides Benefits for services for the evaluation and treatment of TMJ and associated muscles.

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for the office visit may vary based on Provider and location.
- 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 treatments have failed.
- It is important to note that returning home from a visit with durable medical equipment, such an oral appliance, may result in an additional copayment.
- Orthognathic surgery and select services for TMJ Disorder may require Prior Authorization and Medical Necessity review.

Palliative Care	In-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.
- Copayments for the office visit may vary based on Provider and location.
- The Bind Health Plan provides Benefits for palliative care for Participants with a new or established diagnosis of progressive debilitating illness.
- Includes services for pain management received as part of a palliative care treatment plan.
- The services must be within the scope of the Provider's license to be covered.
- Select services performed in the office and outpatient hospital setting may require Prior Authorization and Medical Necessity Review.
- It is important to note that returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- See "Home Health Services" notes for services related to Home Health Care.
- See "Hospice Care" notes for services related to Hospice.

Prescription Drugs	In-Network	Out-of-Network
	See Section 21 "PRESCRIPTIONDRUGS" for details	Not Covered

Preventive Care Services	In-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 six.
  - 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 post-natal care services.
  - One routine post-natal 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 "Prescription Drugs" section 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	Out-of-Network
	$250 to $725 Copayment / visit	$500 to $1,450 Copayment /visit

Notes:

- The Bind Health Plan provides Benefits for services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.
- Refer to the MyBind mobile app for additional coverage information.
- Copayments for Radiation Therapy and Other High Intensity Therapy may vary based on Provider and location.
- Benefits include Physician services and facility charges, and services such as, but not limited to:
  - Apheresis.
  - Brachytherapy
  - Conventional External Beam Radiation Therapy (EBRT)
  - Hyperbaric Oxygen Therapy (HBOT).
  - Proton Therapy
  - Radiation Device Placement.
  - Radiation Therapy Simulation and Planning
  - Radiopharmaceutical Therapy.
  - Stereotactic Radiation Therapy
- Select Radiation Therapy may require Prior Authorization and Medical Necessity Review.

Reconstructive Surgery	In-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.
- Copayments for office visits may vary based on Provider and location
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- 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, Illness 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 Health 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 Health Services. You can contact Bind Help at the number on your member 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. 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, if improvement in appearance is the primary intended purpose, this would be considered a Cosmetic procedure. The Bind Health 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.
- Reconstructive surgery may require Prior Authorization and Medical Necessity review.

Rehabilitative/Habilitative Services and Other Low Intensity Therapy	In-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 Therapy	$10 to $30 Copayment / visit	$75 Copayment / visit
Occupational Therapy	$10 to $30 Copayment / visit	$75 Copayment / visit
Physical Therapy	$10 to $30 Copayment / visit	$75 Copayment / visit
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 certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupational, physical, and speech therapy).
- It is important to note that returning home from a visit with durable medical equipment, such as a walker, may result in an additional Copayment.
- 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 Rehabilitation does not have 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 Rehabilitation does not have 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 be assigned the home health care 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.

Skilled Nursing Facility Services	In-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 Health Plan provides Benefits for 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.
- An 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.
  - 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 an Illness 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 Health Plan does not provide Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 28 “A. Medical Glossary”.
- It is important to note that returning home from a Skilled Nursing Facility or Inpatient Rehabilitation Facility stay with durable medical equipment, such as a walker, may result in an additional copayment.
- 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	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, pancreas, liver, liver/intestine, 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.
- Bind has identified quality Providers for transplant services, except for corneal transplant, referred to as the Transplant Center of Excellence (See Section 9 “BIND CLINICAL PROGRAMS” for additional information). Transplant services, except for corneal transplant, must be received at a location specified as a Center of Excellence.
- 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.
- Benefits are available to the donor and the recipient when the recipient is covered under the Bind Health 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 coverage.
- Bind has specific guidelines regarding Benefits for transplant services. Contact Bind Help at the number on your member ID card forinformation about these guidelines.
- The Bind Health Plan provides Benefits expenses for travel and lodging for the patient, and a companion up to a maximum of $10,000 per transplant procedure (for example, the limit would apply in the event of a heart and lung transplant performed during the same procedure), 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.
  - Eligible Expenses include 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 / Tests / Therapies – Go to MyBind mobile app or MyBind.com website for additional information	**In-Network**	**Out-of-Network**
• **Level 1:** Generally, minor procedures or treatments that are typically performed in an outpatient office setting (e.g., needle biopsy and aspiration, pain management procedures, etc.)	$85 to $1,250 Copayment / visit	$110 to $3,750 Copayment / visit
• **Level 2:** Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, glaucoma surgery, etc.)	$50 to $2,400 Copayment / visit	$270 to $7,200 Copayment / visit
• **Level 3:** Generally, major procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting but may be performed in an inpatient hospital setting (e.g., thyroid surgery, prostate surgery, etc.)	$750 to $2,400 Copayment / visit/stay	$2,600 to $7,200 copayment / visit/stay
• **Level 4:** Generally, major procedures, surgeries, or treatments that are typically performed in an inpatient hospital but may be performed in an outpatient hospital setting (e.g., colon surgery, small bowel surgery, etc.)	$800 to $2,050 Copayment / visit/stay	$4,500 to $6,150 copayment / visit/stay
• **Level 5:** Generally, major procedures, surgeries, or treatments that require intensive monitoring and are performed in an inpatient hospital setting (e.g., bone marrow and solid organ transplant, brain cancer surgery (Craniotomy), coronary artery bypass graft surgery, etc.)	$1,200 to $2,450 Copayment / visit/stay	$6,150 Copayment / visit/stay
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, MyBind mobile app or MyBind.com website.
- Treatment, tests, and therapies have been tiered based on type and level (minor vs. major) of care. Some minor treatments or procedures are either included in the office visit copayment or may have a specific copayment based on the Provider and location selected. Some surgical procedures also have specific copayments based on the Provider or location selected.
- Multiple Copayments may apply if more than one planned procedure is performed during a visit/stay.
- Copayments for Procedures in Level 1 - Level 5 may vary based on Provider and location. Refer to the MyBind app, or call Bind Help, to determine what Copayment has been assigned to your procedure/service.
  - Level 1 is a category of minor procedures typically performed in an outpatient office setting.
  - Level 2 is a category of minor surgeries, procedures, or treatments typically performed in an outpatient Hospital setting.
  - Level 3 is a category of major surgeries, procedures, or treatments typically performed in an outpatient Hospital setting.
  - Level 4 is a category of major surgeries, procedures, or treatments typically performed in an inpatient Hospital setting.
  - Level 5 is a category of major surgeries and procedures that require intensive monitoring and typically performed in an inpatient Hospital setting. Transplant services must be rendered at a location specified as a Center of Excellence.
- 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 Health Plan will allow 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 Stay Copayment will be waived, and you will be responsible for the Inpatient Hospital Copayment.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- 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	Out-of-Network
Urgent Care Visit	$65 Copayment / visit	$130 Copayment / visit

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Benefits include visits at a walk-in Urgent Care center that treats Illnesses or Injuries requiring immediate care, but not serious enough to require an Emergency department visit.
- If the Urgent Care facility is unable to treat you, you may be referred to the Emergency Room or other Provider, you will be responsible for both the Urgent Care and Emergency Room Copayments.
- It is important to note that returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Virtual Visits	In-Network	Out-of-Network
Virtual Visit with a Designated Virtual Provider	$0 to $10 Copayment / visit	Not Covered
Virtual Visit – Doctor on Demand*	$10 Copayment / visit	Not Applicable
Virtual Visit with a non-Designated Virtual Provider	$20 to $90 Copayment / visit	$130 Copayment / visit (Mental Health telehealth); $180 Copayment / visit (Office Visit)

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- Please see the Behavioral Health and Office Visit sections for additional information on Telehealth Visits with your Provider (non-designated).
- Virtual visits for Covered Health Services that include the diagnosis and treatment of medical and behavioral/mental health conditions for Participants that can be appropriately managed virtually within the scope of practice of the virtual providers, through the use of interactive audio and video telecommunication and transmissions, and audio- visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care Specialist, or through or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).
- Copayments for virtual visits will vary based on Provider. If you choose a Provider that is not a member of the Designated Virtual Provider Network, the Virtual Visit other than with a Designated Virtual Provider copayment will apply.
- Please visit Lumen.com/ChooseBind, MyBind.com, the MyBind mobile app, or call Bind Help to locate a Designated Virtual Provider.
- Benefits are available only when services are delivered through a Designated Virtual Provider.
- Please note that not all medical conditions can be treated through virtual visits. The Designated Virtual Provider will identify any condition for which in-person Physician contact is needed.
- No virtual visit coverage for out-of-network Providers.
- Services for email, standard telephone calls or Telehealth visits with non-Designated Virtual Providers or that occur within medical facilities (CMS defined originating facilities) are provided under the Office Visit and Diagnostic Visit Benefits section.

13. 2ND.MD

*See the **General Information (Active) SPD** for more Information.*

Note: Lumen requires that you consult with 2nd.MD prior to a hip, knee, shoulder or spine surgery (on a non-emergency basis). If you don't seek a second opinion for these surgeries, you will be responsible for an additional $500 of out-of-pocket cost, whether or not you've met your annual out-of-pocket maximum.

14. NURSELINE℠

NurseLine℠

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

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that 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.
- Healthy living habits.
- How to take Prescription Drug products safely.
- Men's, women's, and children's wellness.
- Self-care tips and treatment options.
- Any other health related topic.

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

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

With NurseLine℠, you also have access to nurses online. To use this service, log onto optum.com whereyou 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 ofthe conversation to use as a reference.

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

15. COR MEDICAL

*See the **General Information (Active) SPD** for more Information*.

16. CANCER RESOURCE SERVICES

The Bind Health Plan pays Benefits for oncology services provided by Designated Facilities participating in the CancerResource 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 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 Health Plan pays Benefits as described under Section 12 "**COVERED BIND PLAN BENEFITS**":

Cancer Clinical Trials (see Section 11 "**CLINICAL TRIALS**") and related treatment and services are covered by the Bind Health 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 timethe 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.***

17. 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.

18. WELL CONNECTED INCENTIVE PROGRAM AND RESOURCES TO STAY HEALTHY

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

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

The Incentive. Employees and their eligible Spouses/Domestic Partners can participate in a variety of Well Connected wellness activities and earn up to a maximum of $600 each for the Calendar Year. Activities completed by December 31, 2022, are eligible for reward in 2022. Although you are not required to completethe health survey or participate in the biometric screening; the health survey and the biometric screening are the gatekeeper to unlock your wellness rewards. Only Employees and their eligible Spouses/Domestic
Partners who do so will be eligible to receive rewards for other wellness activities and receive up to a maximum of $600.

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, who 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 health care consumer. To that end, it has made available several convenient educational and support services, accessible by phone and the internet, which can help you to:

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

B. Well Connected Rewards Programs

The Plan Administrator offers a health incentive and consumer engagement program that seeks to increase consumer awareness. Rewards are provided when Employees and eligible Spouses/Domestic Partners complete the activities shown in the table:

Participation is completely voluntary and without extra charge. For details on how the incentive program works, visit lumen.com/wellconnected.

Participants electing the Bind Health Plan as their medical Plan option have the option to receive earned wellnessrewards as a gift card. The IRS considers Wellness Rewards taxable.

Reward dollars are taxable and will appear on your paycheck and W-2 statement. You are responsible for any tax consequences or liabilities incurred in connection with any incentive rewards received from your Employer.

C. Earn Up to $600 in Rewards

You and your eligible Spouse/Domestic Partner can participate in the wellness activities outlined below and earn a maximum of $600 each for the Calendar Year. Activities completed by December 31, 2022, are eligible for reward in 2022.

The health survey and the biometric screening are the gatekeeper to unlock your wellness rewards. Once you complete both wellness activities, you are eligible for a $150 reward as well as any other rewards for activities you have completed. Employees have the option to receive earned rewards as a gift card. *See "Additional Incentive Program Details" section D*.

The Well Connected Rewards program will no longer require you to select a rewards option during Annual Enrollment. Effective January 1, 2022, members will be able to select where to apply reward dollars after completing a wellness activity, upon redemption. The same two requirements apply to earn rewards: Complete the Rally Health Survey and complete a Biometrics Screening in order to unlock additional rewards.

You will see your reward options outlined in Rally in 2022, along with how to redeem rewards.

In addition to the rewards, you can earn *Rally coins* for specific wellness activities as indicated. Rally coins are accumulated and can be used to enter sweepstakes for prizes. You can donate coins earned to charities listed on Rally or exchange your Rally coins for a gift card during select times of the month. ***(Note:** Sweepstakes winners will be taxed (and receive a 1099) only if the prize value exceeds $599.)*

Incentive	Wellness Activity	What You Can Expect
$150 (Complete Both: Rally Health Survey and Biometric Screening)	Take your health survey and get a biometric screening. **Biometric screenings** can be completed in several ways: • Onsite local screening (if offered at your location) • Home kit • Your Provider MD Form • Quest Labs (at select locations) Cor Medical Clinics (Monroe, LA, Littleton, CO & Broomfield, CO)	Confidential health survey provides suggested areas and resources for improving your health. Biometric screening includes blood pressure measurements, BMI (Body Mass Index), fasting blood sugar and LDL cholesterol, which can help you assess your risk for certain health problems. More information is available on the Rally site: lumen.com/wellconnected
$200 for each exam and screening (if applicable)	**Get your Annual Checkup / Annual Preventive Exam Services** Incentive includes: • Annual exam; • Cervical screening; • Colorectal screening • Mammogram	Annual checkups/annual preventive exam services help you maintain your health and identify potential health concerns before they become a major issue. All Employees are eligible for an annual exam and depending on age and gender, may receive one or more of the screenings identified. More information is available on the Rally site: lumen.com/wellconnected
Earn $200 for receiving COVID-19 vaccine or booster in 2022	**COVID-19 Vaccine Attestation**	Earn $200 for receiving a COVID-19 Vaccine or booster in 2022.
$250 You must complete your personalization session and nine (9) Real Appeal program sessions to receive the $250 reward	**Weight Management Program** Enroll in Real Appeal	The Real Appeal program represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. You must have a BMI of 23 or higher in order to be eligible for Real Appeal. More information is available on the Rally site: lumen.com/wellconnected
Earn $250 for completing the Quit for Life Program	**Quit or Life**	In the Quit for Life® Program, you'll work with a personal coach who will help you create a customized plan to quit tobacco. Must complete the 5 required sessions (phone, group, chat, SMS) to earn a reward. More information is available on the Rally site: lumen.com/wellconnected
Earn $250 for completing the Virta Diabetes Reversal Program	**Complete the Virta Diabetes Reversal Program**	Virta can help you with your type 2 Diabetes by lowering your blood sugar A1c and losing weight; which can reduce the need for diabetes medications. Eligible Bind members can enroll in Virta at no additional charge or out-of-pocket costs. Complete your first 12 weeks then you'll earn $250 (once you've completed your Health Survey and Biometrics)!

Incentive	Wellness Activity	What You Can Expect
Earn $50 for completing 12 weeks of Weight Watchers	**Complete 12 weeks of online or in person Weight Watchers coaching** or if you're a lifetime member complete 3 monthly weigh-ins.	Weight Watchers is an engaging digital experience a face-to-face group workshops, members follow a livable and sustainable program that encompasses healthy eating, physical activity, and a helpful mindset. Once completed, confirm you've done so in Rally to earn $50.
$100 for enrollment **$250** for program completion	**Develop a plan for Condition Management Program** Includes: • Asthma • Chronic Obstructive Pulmonary Disease (COPD) • Coronary Artery Disease (CAD) • Diabetes • Heart failure	Work with a Bind coach to develop a health action plan/ program tailored to your specific condition. https://eligibility-bindhealth.selfmanage.org/
$250 (Per completion of three interactions with a coach or completion of digital coaching) ($500 max)	**Personal Coaching** Telephonic coaching topics: • Diabetes Lifestyle • Eat Smart • Family Wellness • Fit for Life • General Wellness • Healthy Heart • Sleep Well • Stress Less • Weight Wellness Digital coaching topics: • Eat Smart • Fit for Life • Happiness • Sleep Well • Weight Wellness Coaching • Stress Less • Financial Wellbeing • Meditation	Online and over-the-phone coaching options, access to new online courses 24/7 and a personalized action plan to help you meet your goals. Call 800-478-1057 to enroll.
$250	**Healthy Pregnancy Program through the Bind Maternity Support Program** Enroll and complete to earn the reward.	A personalized maternity program that provides Participants with additional support and education throughout their Pregnancy. https://pacify.com/bind
You can earn a $50 reward after your second A1C test in the same plan year.		Manage your diabetes by completing two A1C tests each year.
$25	Challenges – Complete a Rally Public City Walk, Lumen Team Battle Challenge or a Non-Step Challenge	Rally offers public walking challenges on an ongoing basis. In addition, Lumen may sponsor a companywide private Team Battle/Challenge. You can also complete a Non Step Challenge. Complete one of the following Team Battle, Public or Private City walk to earn $25. More information on the Rally site: lumen.com/wellconnected
Register on 2nd.MD to earn $25		Consult with a medical expert for a FREE virtual face-to-face expert medical consultation from the comfort of your home.

Incentive	Wellness Activity	What You Can Expect
Complete 3 Missions in first 6 months to earn $25; Complete 3 Missions in second 6 months to earn an additional $25	**Rally Missions** Recommendations will be made just for you under four categories: Move, Eat, Feel and Care.	A "mission" is a customized digital action plan designed to help you improve your life.
Earn $25 by creating an account through Principal Financial	(Employees only) Complete one to earn $25: • -Update and Review beneficiary information • -Use retirement calculator	Improve your financial wellness using Principal Financial's Milestone tools
$25	Watch a Mindfulness Video	Video available through the Rally site. More information on the Rally site: lumen.com/wellconnected
$25	Watch a Behavioral Health Anxiety Video	Video available through the Rally site. More information on the Rally site: lumen.com/wellconnected
Earn $25 for completing a Quiz Bundle	Mini Quiz bundle	Earn $25 in first half of the year by completing a Tech Neck Quiz, Mediterranean Diet Quiz and Back Pain Quiz; Earn $25 in the second half of the year by completing a Healthy Pantry Quiz, Mental Health Quiz and Sleep Quiz.
$25	SmartPath	Complete the financial assessment to learn more about your financial wellness and earn a reward. Go to Lumen.com/smartpath
$25 **For registering or completing Doctor On Demand**	Doctor on Demand 24/7/365 access to board-certified doctors and dermatologists.	Doctor on Demand provides anytime, anywhere access to quality healthcare from local Physicians who can diagnose, treat, and write prescriptions for routine medical conditions. And registration is free. https://patient.doctorondemand.com/
$20/month ($240 Max.)	Rally Stride	Walk or run to meet your daily steps goals to expand your opportunity to earn rewards. More information on the Rally site: lumen.com/wellconnected
Earn $25	Link a device on Rally	After connecting your device to Rally and agreeing to share activity data you can earn reward.

D. Additional Incentive Program Details

Health Survey

You and your eligible Spouse/Domestic partner must be enrolled in a Lumen Medical Plan and are invited to learn more about your health and wellness at lumen.com/wellconnected and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your health habits as well as potential health risks.

To find the health survey log onto lumen.com/wellconnected. 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. Lumen does not receive the results or data from your survey.

Real Appeal Program

UnitedHealthcare provides the Real Appeal program which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support employees over the age of 18.

This intensive, extremely interactive weekly online group coaching sessions that combines video with live coaching to drive small behavior changes week-by-week for 26 weeks and then monthly for the remaining 26 weeks and (52-week virtual approach). The experience will be personalized for each employee though an introductory call and may include, but not limited to, the following:

- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss;
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes;
- Online support and self-help tools: Personal 1:1 coaching, group support sessions, including integrated telephonic support, and mobile applications.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 844-344-REAL (7325) Or visit lumen.com/realappeal.

All benefit eligible employees with a **BMI of 23** or greater are eligible to participate in Real Appeal, including those who have waived Lumen medical coverage. (This program replaces the previous Diabetes Prevention Program.)

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.

There 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, and supportive network of members, and more. If you would like to additional information regarding the Weight Watchers Program visit weightwatchers.com/us/.

Employees 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 Watcher 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 Intranet.

Additionally, you can earn the $50 Well Connected reward if you complete 12 weeks of online or in person Weight Watchers coaching, or lifetime members can receive the $50 reward after they complete 3 monthly weigh ins. Once completed, confirm you've done so in Rally to receive your $50 reward.

Condition Management program

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

These programs offer:

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

Examples of support topics include:

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

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

Personal/Telephonic Coaching

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

- Access to online courses, 24/7, guided discussion, live chat or secure message with a Wellness Coach
- Online and telephonic coaching options
- Personalized action plan

Choose the goals you want to focus on:

- Eating better
- Reducing Stress
- And more

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

*You may be eligible for a discount to your medical benefit premiums based on how you answer the enrollment question on tobacco products usage. If you and your eligible Dependents are enrolled in a Lumen medical Plan option and are non-tobacco users or are enrolled in a company recognized tobacco cessation program, you will receive a discount to the cost of your medical plan premium. Please contact the Service Center at 833-925-0487 for further assistance prior to completing your enrollment to learn about alternatives to obtain the discount or review the General Information (Active) SPD. The Plan will accommodate the recommendations of an individual’s personal doctor, if needed.

E. Gift Cards

Rewards are earned and redeemed for a variety of gift cards that are displayed online. You can either request an eGift Card or a plastic Visa gift card. You are taxed on the value of the card at the time the card is **redeemed not at the time you actually use it as a transaction. Note:** There will be a fee of $3.95 for cards that are inactive for 13 months. Also, the minimum and maximum amount for the plastic Visa gift card is $20 and $500.

You have up to 120 days after the end of the Plan Year to request your gift cards as they will be considered as forfeited at that time. Once you have selected your gift card, the value and expiration of the gift card is based on the terms and conditions of that retailer's rules.

F. Redeem Wellness Rewards

Once you are no longer an active Employee or eligible for the Bind Health Plan for any reason (i.e., termination, retiree, LTD, COBRA, leave the US, etc.) or your eligible Spouse/Domestic Partner are no longer covered by the Bind Health Plan, your wellness rewards cannot be redeemed after the last day of the month in which you or yourSpouse/Domestic Partner's coverage or employment with Lumen ends.

19. CONDITIONAL COVERAGES

Once enrolled in the Bind Health 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.

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 Health Plan, without requiring you to elect and activatea conditional coverage, if you or your Dependent meet certain age requirements. Please call Bind Help for additional information.

To elect a conditional coverage as your Bind Health Plan 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 for that specific elected and activated conditional coverage – in order tohave 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.*

**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.*

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 Health Plan for thetest, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period for that specific elected and activated conditional coverage, 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 properlyactivated and effective, it cannot be cancelled for the duration of the coverage period.

Note: 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 Health Plan.

A. Conditional Coverage Copayments

Conditional Coverages	In-Network Copayment Maximum	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

Conditional Coverages	In-Network Copayment Maximum	Out-of-Network Copayment	Coverage Period
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 Health 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 health care services:

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

B. Exclusions to Activated Conditional Coverages

- For activated conditional coverage procedures performed in a clinic or outpatient facility: health care 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 Health Plan coverage may already be available for such services under the Bind Health Plan.
- For activated conditional coverage performed in an inpatient facility: health care 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 Health Plan coverage may already be available for such services under the Bind Health Plan.
- Health care services that are not Medically Necessary.
- Items listed in the Exclusions: Bind Health Plan Benefits Not Covered.

20. EXCLUSIONS: NOT COVERED UNDER BIND HEALTH PLAN

The Bind Health 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 unlessspecifically described or listed in Section12 "**COVERED BIND HEALTH PLAN BENEFITS**".

A. Alternative Treatments

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

B. Behavioral Health: Mental Health/Substance Use Disorder

10. Educational/behavioral services that are focused primarily on building skills and capabilities in communication, social interaction, and learning.
11. Inpatient or intermediate or outpatient care services that were not pre-authorized.
12. Investigational therapies for treatment of autism.
13. 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 withdrawal, using peer and social support rather than medical and nursing care.
14. 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.
15. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, kleptomania, gambling disorder, paraphilic disorder, and pyromania.
16. 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.
17. 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.
18. Transitional living services.
19. 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.
20. Unproven intensive behavioral therapy treatment programs for the treatment of Autism Spectrum Disorders, including Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas.
21. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.
22. Wilderness therapy, nature camps, and similar arrangements.

C. Conditional Coverage

23. Health care services listed as a conditional coverage in Section 19 “CONDITIONAL COVERAGES”, are not covered by the Bind Health Plan unless you elect and activate the coverage, except for Emergency, trauma, or cancer- related services (i.e., post-diagnosis).

D. Dental

24. Dental braces (orthodontics).
25. 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.
26. 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.
27. Dental implants, bone grafts, and other implant-related procedures.
28. Endodontics, periodontal surgery, and restorative treatment are excluded.
29. Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums.
30. Treatment of congenitally missing, malposition or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

E. Devices, Appliances, Supplies and Prosthetics

31. Cranial banding, except when Medically Necessary for the treatment of plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape). This exclusion does not apply to cranial helmet when it is needed to prevent surgery when the condition will not self-correct but worsen over time.
32. Devices and computers to assist in communication and speech.
33. Devices used specifically as safety items or to affect performance in sports-related activities.
34. Disposable supplies for home use such as, but not limited to, Ace- type bandages, antiseptics, bandages, diapers, dressings, incontinence supplies, gauze, and tape.
35. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits.
36. Household equipment, household fixtures, and modifications to the structure of the home, escalators or elevators, hot tubs and saunas, ramps, swimming pools, whirlpools, wiring, plumbing, or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, , hypo-allergenic pillows, mattresses, water purifiers, or waterbeds.
37. Oral appliances for snoring.
38. 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.
39. 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.
40. Repairs to prosthetic devices due to misuse, malicious damage, or gross neglect.
41. Replacement of prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.
42. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.
43. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.
44. Supplies, equipment, and similar incidentals for personal comfort. Examples include air conditioners, air purifiers, exercise equipment, humidifiers, Jacuzzis, recliners, , saunas and vehicle modifications such as van lifts.
45. Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts, and car carrier.

F. Drugs

46. See Section 22 “EXCLUSIONS: PRESCRIPTION DRUGS NOT COVERED”.

G. Experimental or Investigational or Unproven Services

47. Biofeedback that is Experimental or Investigational or Unproven.
48. Intracellular micronutrient testing.
49. 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.

H. Foot Care

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

I. Gender Dysphoria

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

J. Nutrition

53. 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).
54. 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).

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. Hair removal or replacement by any means.
    b. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    c. Pharmacological regimens, nutritional procedures, or treatments.
    d. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skinabrasion procedures).
    e. Skin abrasion procedures performed as a treatment for acne.
    f. Treatments for hair loss.
    g. Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
    h. Treatment for spider veins of the lower extremities when it is considered Cosmetic.
    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. Physical conditioning programs such as athletic training, body-building, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
59. 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.
60. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic procedure.
61. Medical and surgical treatment of excessive sweating (hyperhidrosis).
62. Treatment of benign gynecomastia (abnormal breast enlargement in males).
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. Chelation therapy, except to treat heavy metal toxicity and overload conditions.
66. Elective abortion, except in situations where the life of the covered Participant (mother) would be endangered if the fetus is carried tofull term.
67. Helicobacter pylori (H. pylori) serologic testing.
68. Home Births.
69. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
70. Outpatient cognitive rehabilitation except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
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. Rehabilitation services and manipulative treatment to improve general physical condition and not therapeutic in nature that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term, or maintenance/preventive treatment.
73. Rehabilitation services for speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, or congenital anomaly.

74. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care Providers specializing in smoking cessation and may include a psychologist, social worker, or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

M. Providers

75. Services ordered or delivered by a Christian Science practitioner.
76. Services performed by a Provider who is a family member by birth or marriage, including your Spouse, Domestic Partner, brother, sister, parent, or Child. This includes any service the Provider may perform on himself or herself.
77. Services performed by a Provider with your same legal residence.
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. All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to, fees for laboratory tests.
    b. All costs associated with surrogate parenting including, but not limited to, donor oocytes (eggs), donor sperm and host uterus.
    c. Artificial reproductive treatments done for genetic or eugenic (selective breeding).
    d. Cloning.
    e. 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.
    f. Donor ovum or oocytes (eggs), embryos and semen and related costs, including collection, preparation, and storage of.
    g. Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees).
    h. Fertility Services following a voluntary sterilization procedure.
    i. Home ovulation prediction kits.
    j. Multi-embryo implantation.
    k. Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
    l. Non-genetic disorder reproductive treatments done for purposes of gender selection purposes.
    m. Non-medical costs associated with a 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).
    n. Reversal of voluntary sterilization.
    o. Services for partners, spouses, and the maternity expenses of gestational carriers not covered by the Bind Health Plan.
    p. Services and supplies furnished by an out-of-network Provider or not listed as covered in the Progyny Member Guide.
    q. Treatments considered Experimental by the American Society of Reproductive Medicine.

O. Services Provided Under Another Plan

80. Services for which coverage is available:
    a. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.
    b. 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.
    c. Under another medical plan, except for Eligible Expenses, or Recognized Amount when applicable, payable as described in this SPD.

d. Under Workers' Compensation, or similar legislation if you could elect it, or could have it elected for you.

e. While on active military duty.

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 required as Emergency Health Care Services.

84. Travel or transportation expenses, even if ordered by a Physician, except as identified under Ambulance and Transplant in Section 12 "**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 12 "**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. Eye exercise.

94. Implantable lenses used only to correct a refractive error such as radial keratotomy or related procedure, and artificial retinal devices or retinal implants.

95. Refractive surgery (e.g., Lasik) for ophthalmic conditions that are correctable by contacts or glasses.

96. Routine eye exams (including refraction), eyeglasses, contact lenses and any fittings associated with them, except as identified in Section 12 "**B. Benefit Features**".

97. Surgery and other related treatment that is intended to correct farsightedness, nearsightedness, presbyopia, and astigmatism, including but not limited to, procedures such as laser and other refractive eye surgery, and radial keratotomy.

98. 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.

99. The Bind Health 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 Health 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.

100. Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or anyother language assistive devices.

T.All Other Exclusions

101. Autopsies and other coroner services and transportation services for a corpse.

102. Charges for:

a. Completion of Claim forms.

b. Missed appointments.

c. Record processing.

d. Room or facility reservations.

103. Charges prohibited by federal anti-kickback or self-referral statutes.

104. Direct to consumer retail genetic tests.

105. Expenses for health services and supplies.

a. For which the Participant has no legal responsibility to pay, or for which a charge would not ordinarily be madein the absence of coverage under the Bind Health Plan.

b. For Illness or Injury occurring during illegal acts.

c. That are received after the date the Participant's coverage ends, including health services for medical conditions which began before the date the Participants coverage ends.

d. 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 orotherwise affected by war, any act of war or terrorism in a non-war zone.

e. That exceed Eligible Expenses, or the Recognized Amount when applicable, or any specified limitation in this SPD.

106. Foreign language and sign language services.

107. Health care services that Bind determines are not Medically Necessary.

108. Long-term (more than 30 days) storage of blood, umbilical cord, or material (e.g., cryopreservation of tissue, blood, and blood products.

109. 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.

110. Physical, psychiatric, or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:

a. Conducted for purposes of medical research.

b. Related to judicial or administrative proceedings or orders unless determined to be Medically Necessary.

c. Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage,adoption, or as a result of incarceration.

d. Required to obtain or maintain a license of any type.

111. 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 health care service, no Benefits are provided for the health care service.

112. Health care services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services that would otherwise be determined to be a Covered Health Service if the service treats complications that arise from the non-Covered Health Service. For the purpose of this exclusion a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.

21. 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 optumrx.com or phone using the information found in Section 25 "**COORDINATION OF BENEFITS (COB)**".

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

	30-Day Supply		90-Day Supply	
	In-Network Pharmacies	**Out of Network Pharmacies**	**In-Network Pharmacies and Mail Order Pharmacy**	**Out of Network Pharmacies**
Preventive	$0 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 3 "**CLAIMS ADMINISTRATOR AND CONTACT INFORMATION**" 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 an out-of-network Pharmacy is a percentage of the PredominantReimbursement 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 product; or
- the Prescription Drug Charge for that Prescription Drug product;

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 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 21 "**J. Prior Authorization/Medical Necessity Requirements**". The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment that applies will reflect the number of days dispensed; or days the drug will be delivered;
- 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 lifetime Prescription Benefit maximum of $15,000.

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:

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

In addition, some drugs require prior approval before the prescription can be obtained, as described later in Section 21 "**J. 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 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

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 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 definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the tables at the beginning of Section 21 “**A. Specialty Drug Tiers**” 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 in 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 Prior Authorization

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

L. Out-of-Network Pharmacy Prior Authorization

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

If prior authorization is not obtained from the Pharmacy Claims Administrator 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 prior authorization is not obtained from the Pharmacy Claims Administrator before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug. See Section 21 “**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 optumrx.com or call the toll-freenumber 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 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. See Section 18 **"WELL CONNECTED INCENTIVE PROGRAM AND RESOURCES TO HELP YOU STAY HEALTHY"** for more information.

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 or Mail Order medication, 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.

22. EXCLUSIONS: PRESCRIPTION DRUGS NOT COVERED

The exclusions listed below apply to Section 21 "**PRESCRIPTION DRUGS**". In addition, exclusions from coverage listed in Section 20 "F**. 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. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition;
8. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
9. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
10. certain Prescription Drugs that have not been prescribed by a Specialist Physician;
11. certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee
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 OptumRx 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. A Pharmaceutical Product for which Benefits are provided in the medical (not in the Outpatient Prescription Drugs) portion of the Plan.
18. certain unit dose packaging or repackagers of Prescription Drug Products;
19. 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;

20. in a particular Therapeutic Class;
21. unit dose packaging of Prescription Drugs;
22. 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 "**B. Prescription Drug Glossary**";
23. 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.*
24. used for Cosmetic purposes; and
25. vitamins, except for the following which require a prescription: prenatal vitamins; vitamins with fluoride; and single entity vitamins.

23. MEDICAL CLAIMS PROCEDURES

(For outpatient prescription drug 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 medical Claim to the Bind Health 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 Health Plan to be reviewed for Benefits. Whether you pay out-of-pocket or your Provider bills the Bind Health 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 Health 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 Health Plan. This section summarizes the procedures you must follow to submit a Claim for payment, and theprocedures the Bind Health Plan will use to determine whether and how much to pay for that Claim.

If you would like more details about medical Claims procedures and your rights and responsibilities, contact Bind Help at the number on the back of your medical ID card.

A. Regular Post-Service Medical Claims

Post-service medical Claims are non-urgent medical Claims after you have received treatment. Pre-service and Urgent Care Request for Benefit are described under Section 24 **"WHAT DO I DO IF MY MEDICAL CLAIM IS DENIED**" (Urgent Care and concurrent care Claims have different timelines and requirements, see below.) Generally, you do not need to file a medical 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 medical Claims or if you receive Emergency care outside the United States and are seeking reimbursement from the Bind Health Plan, you can submit a medical Claim using this procedure.

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

- The name and birthdate of the Participant who received the care
- The Participant ID listed on the Bind member 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 medical 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 health care 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 health care service for Claims purposes.

You will receive a decision within 30 days of submitting your Claim. If we need more information on a Claim, we will reach out to you to request that additional information, but we will still make a decision on your Claim within 30 days. If you 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 a Claim for a welfare benefit is denied or ignored, in whole or in part, a Participant has a right to know why this was done, to obtain copies of documents (without charge) relating to the decision, and to appeal any denial, all within certain time schedules.

C. Notice of Adverse Claim Determination

If your medical Claim is denied in whole or in part, you will receive a written notice of denial. The notice will be written in an understandable and, where required by law, in a culturally and linguistically appropriate manner and will include all of the following:

- Information sufficient to identify the medical Claim involved (including the date of service, the health care Provider, and the medical Claim amount [if applicable]); you can also request from the Claims Administrator the diagnosis and treatment codes, and their explanation.
- The specific reason or reasons for the denial, the denial code and its meaning and a description of the Plan standard, if any, that was used in denying the Claim and a discussion of the decision.
- The specific reference to the relevant Plan provision on which the decision is based.
- A description of additional information needed to support your medical Claim and an explanation of why it is needed.
- Information about how to appeal your Claim and any time limits, should you want to pursue it further and your right to bring a civil action under ERISA if your appeal is denied.
- A statement about available external review processes, including information on how to initiate the review.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either a copy of the document or a statement that such a document was relied on and that a copy will be provided (free of charge) upon request.
- Either an explanation of the scientific or clinical judgment for the decision (applying the Plan terms to your medical circumstances) or a statement that such an explanation was relied on and that a copy will be provided (free of charge) upon request, if the decision was based on a limit (for example, a decision that the proposed service is not Medically Necessary).
- A description of the expedited review process in the case of a denial concerning a Claim involving urgent care. If we tell you about our decision orally within the timeframes required, we will follow up within three business days with a written or electronic notice.
- A statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A description of any voluntary processes the Plan offers.

24. 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 are encouraged to call Bind Help before requesting a formal appeal. If Bind Help cannot resolve the issue to your satisfaction over the phone, you have the right to file aformal appeal as described below.

To submit an appeal:

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

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

B. Review of an Appeal

Bind will conduct a full and fair review of your medical appeal. You can send us written comments, documents, records, and any other information you think will help us decide the appeal.

You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Participant's claim for Benefits. "Relates to" means at least one of the following:

- That we used the information to make the Benefit determination.
- The information was submitted, used, or created while making the Benefit determination.
- The information shows that we made the Benefit determination based on your Plan documents and made the same decision for other Plan Participants in the same situation.
- The information is one of our policies or guidance.

When we review your appeal, we will take into account all comments, documents, records, and other information you give us, even if we did not have that information when we denied the Claim.

Bind adheres to the following review practices:

- The appeal will be reviewed by an appropriate individual(s) who did not make the initial Benefit determination and who does not report to the person who did make the initial Benefit determination.
- If your Claim involves medical judgment or whether the Claims is about investigational or Experimental services, the appeal will be reviewed by a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.
- Bind will review all medical Claims in accordance with the rules established by the U.S. Department of Labor and applicable state law.
- Our reviewers avoid conflicts of interest and act independently and impartially. We do not hire, pay, terminate, promote, make decisions, or incentivize Claims reviewers to make denials.

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

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

C. Access to New or Additional Information

If you ask us, we will give you the identification of any medical expert who gave us an opinion – whether or not we used that opinion to decide your Claim. 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 Health Plan in connection with the Claim; and, (ii) a reasonable opportunity for any Participant to respond to such new evidence or rationale.

D. Pre-Service and Urgent Care Request for Benefits

A pre-service request for Benefits is a type of Benefit request that requires Prior Authorization but is not urgent. An urgent care request for Benefits 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. An urgent care request for Benefits will be decided as soon as possible, taking into account the medical exigencies, but no more than 72 hours after we receive your request. Urgent care requests for Benefits filed improperly or missing information may be denied.

If your pre-service or urgent care request for Benefits is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request an expedited review).

E. Timing of Appeals Determinations

Separate schedules apply to the timing of Benefit requests and Claims appeals, depending on the type of request. There are four types of requests:

- **Urgent Care Request for Benefits:** A request for Benefits provided in connection with Urgent Care services.
- **Concurrent Care Requests:** A request to extend an already approved ongoing course of treatment that was approved for a specific period of time or a specific number of treatments. If the request is urgent, we will follow the urgent care request for Benefits and appeals process. If it is not urgent, it will be treated like a new request for services and will follow the Pre-Service Request for Benefits and Appeal process.
- **Pre-Service Request for Benefits:** A request for Benefits which the Bind Health Plan must approve or for 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 Health Plan for theproposed 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 a decision letter to you from Bind.

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

F. Urgent Care Request for Benefits and Appeal*

Request for Urgent Care or Concurrent Care Benefits	Claims Timing
If your request for Benefits is incomplete, Bind must notify you within:	**24 hours** and advise you what information is needed
You must then provide a completed request for Benefits to Bind within:	**48 hours** after receiving notice of additional informationrequired
Bind must notify you of the Benefit determination within:	**48 hours** of receiving the needed information
If your request for Benefits is complete when it is filed, Bind must notify you within:	**72 hours**
If Bind denies your request for Benefits, you must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination
Bind must notify you of the appeal decision within:	**72 hours** after receiving the appeal – if the appeal is still urgent. If services have already been provided, we follow the Post-service appeals process.

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

G. Pre-Service Request for Benefits and Appeal*

Request for Pre-Service Benefits	Claims 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***
* Bind may require a one-time extension for the request for Pre-Service Benefits, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Bind Health Plan. We will notify you if we determine that the additional time is needed before the 15 days expires.	
You must appeal an adverse Benefit determination no later than:	**180 days** after receiving the Adverse Benefit Determination
Appeals (Pre-Service)	**Appeals Timing**
Bind must notify you of the first-level appeal decision within:	**15 days** after receiving a complete first-level appeal
You must appeal the first-level appeal (file a second-level appeal) within:	**60 days** after receiving the first-level appeal decision
Bind must notify you of the second-level appeal decision within:	**15 days** after receiving a complete second-level appeal

H. Post-Service Claim Request for Benefits and Appeal*

Post-Service Claim	Claims 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**
* Bind may require a one-time extension for the initial Post-Service Claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Bind Health Plan. We will notify you if we determine that the additional time is needed before the 30 days expires.	
You must appeal an adverse Benefit determination no later than:	**180 days** after receiving the adverse Benefit determination
Appeals (Post-Service)	**Appeals Timing**
Bind must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Bind must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

I. 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 may 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 ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Bind will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If we inform you about our decision orally, we will follow up within three business days with a written or electronic notice.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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

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). You may have the right to an 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 decision letter to you from Bind.

J. Notice of Claim Denial on Appeal

If your Claim is denied on review, the reviewer will provide you with a notice of the Adverse Benefit Determination that will:

- Be written in a manner designed to be understood by an average individual and, where required by law, in a culturally and linguistically appropriate manner.
- Include information sufficient to identify the Claim involved (including the date of service, the health care Provider, and the Claim amount [if applicable]); you can also request from the reviewer the diagnosis and treatment codes and their explanation.
- Include the specific reasons for the Adverse Benefit Determination (including the denial code and its meaning and a description of the Plan's standard, if any, that was used in denying the Claim and a discussion of the decision).
- Refer to the specific Plan provisions on which the determination was based.
- Inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to the Claim for Benefits.
- Notify you of your right to bring legal action under ERISA.
- Include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such material is available (free of charge) upon request.
- Either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge, if the determination was based on Medical Necessity or similar exclusion or limit.
- Contain a statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A statement about any voluntary appeal procedures your Plan may offer.
- Notify you that you can contact the Department of Labor or State Insurance Regulatory Agency to learn about other voluntary alternative dispute resolution options.

The reviewer’s decision on appeal is the final internal Adverse Benefit Determination.

K. Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Bind, you may be entitledto request an external review. The process is available at no charge to you.

You can also start the external review process without exhausting the internal appeals if Bind fails to follow the internal appeals process described above (unless it is a minor failure).

If one of the above conditions is met, you may request an external review of Adverse Benefit Determinations based upon any of the following:

- Medical judgement and/or Clinical reasons— for example Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered Benefit..
- for a determination that a treatment, service, drug, or device is an Experimental or Investigational Service(s) or Unproven Service(s).
- Whether a Participant is entitled to a reasonable alternative standard for a reward under a wellness program.
- A determination as to whether a Plan is complying with non-quantitative mental health parity requirements.
- 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 120 days after the date you received the final internal Adverse Benefit Determination 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 member 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, and both are free to you.

L. Standard External Review

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

- A preliminary review by Bind of the request completed within five business days following Bind's receipt 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 criteria:

- Is or was covered under the Bind Health Plan at the time the health care service or procedure that is at issue in the requestwas provided.
- The denial does not relate to your eligibility to participate in the Plan.
- Has exhausted the applicable internal appeals process or is deemed to have exhausted the 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 within one business day. 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.

If the request is complete but not eligible for external review, Bind will provide notification that includes the reasons for ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete; you will have at least 48 hours (or, if longer, until the end of the four-month filing period) to complete the request.

The IRO will timely notify you in writing of the request's eligibility and acceptance for external review. Within 10 business days following the date of receipt of the notice, you may submitin in writing to the IRO additional information for the IRO to consider in conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

Bind will provide to the assigned IRO the documents and information considered in making the determination, including:

- 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 Health Plan will immediately provide coverage or payment for the Benefit Claim at issue in accordance with the terms and conditions of the Bind Health 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 Health Plan will not be obligated to provide Benefits forthe health care service or procedure.

M. Expedited External Review

An expedited external review is similar to a standard external review. The time for completing the review process is much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

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

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

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

- Is or was covered under the Bind Health Plan at the time the health care service or procedure that is at issue in the requestwas 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.

N. 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.

25. COORDINATION OF BENEFITS (COB)

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

26. RIGHT OF FULL RESTITUTION (SUBROGATION) AND REIMBURSEMENT

The Bind Health 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 notlimited 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 Health 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 Health Plan, the Bind Health Plan may conditionally advance the payment of the Benefits. **If the Bind Health Plan advances payment of Benefits, the terms of this entire subrogation and reimbursement provision shallapply, and the Bind Health 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 Health Plan advanced. The Bind Health Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or allegedcomparative 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 Health 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 Health Plan ID card. His claims are paid by his Claims Administrator under the Bind Health Plan. Once these claims are paid by the Bind Health Plan, they areelectronically 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 Health Plan. The recovery services administrator obtains all the informationregarding the accident (auto carrier/attorney/ etc.) and contacts the involved parties putting them on noticeof the Bind Health Plan's interest. The recovery services administrator follows the case until a settlement is madebetween Mr. Jones and the at fault auto carrier and/or any uninsured/underinsured auto insurance. The Bind Health 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 Health Plan.

Benefits Conditional Upon Cooperation

By participating in the Bind Health Plan, you and your eligible Dependents acknowledge and agree to the terms of the Bind Health 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 legalaction 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 submittingor 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 Health Plan the right to subrogate and recover Benefits directly from any third party or otherinsurer. A Bind Health Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Bind Health 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 Cotiviti at 888-556-3373 or fax at 402-384-5190 as soon as possible, that the Plan may have a right to obtain restitution, reimbursement or any other available remedy of any and all Benefits paid by the Plan.** 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 actionsof 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 orits 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 Health Plan.

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

Note: The Bind Health Plan is subject to ERISA. –The Bind Health Plan is self-funded, and 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 Health Plan in trust for the sole benefit of the Bind Health 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 Health 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 Health Plan or its assignee and to comply with and facilitate the reimbursement to the Bind Health Plan of the monies owed it.**

27. 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 Health 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 Health Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Bind Health 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 ClaimsAdministrator, or the Pharmacy Claim Administrator has the right to request this information at any reasonabletime 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 Health 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 health care services which are necessary to implement and administer the terms of the Bind Health 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 Health Plan, the Plan Administrator and our related entities may use and transferthe information gathered under the Bind Health Plan, including Claim information for research, database creation, andother analytic purposes.

C. Interpretation of the Bind Health 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 Health Plan
- Interpreting the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Determining the eligibility, rights, and status of all persons under the Bind Health Plan
- Making factual determinations, finding, and determining all facts related to the Bind Health Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Bind Health 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 including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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 Health Plan to theLumen 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 Health Plan in a fully accurate manner, any inadvertent error, misstatement, or omission will be disregarded, and the actual Bind Health Plan provisions will be controlling. A clerical error will not void coverage to which a Participant isentitled under the terms of the Bind Health Plan, nor will it continue coverage that should have ended under the terms of the Bind Health 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 Health 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 Health Plan

For purposes of the Bind Health 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 Health Plan, including but not limited to any outstanding Benefit payments or reimbursements that revert to the Company after remaining uncashed or unclaimed for a periodof 12 months, shall be the sole property of the Company, and no portion of these amounts shall constitute "assets" of the Bind Health Plan, unless and to the extent otherwise required by applicable law

G. CLAIM FOR PAYROLL ADJUSTMENT AND THE DEADLINES

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

Reminder to Review Your Paycheck Deductions

Review your paycheck along with the Benefit Premiums documents on the intranet or your confirmation statement, and:

- Confirm your medical bi-weekly premium deductions based on your medical plan election and how you answered the enrollment questions for the tobacco-free discount and the working spouse/domestic partner surcharge.
- If you are enrolled in the Savings HDHP and contributing to a Health Savings Account, you will want to also confirm your HSA bi-weekly premium deductions. Any questions relatedto benefit premiums should be directed to the Lumen Health and Life Service Center at 833-925-0487. 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.

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

H. 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 Health 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 performanceof their responsibilities.

I. Examination of Participants

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

J. 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.

K. Conformity with Statutes

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

L. 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 an out-of-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 9 "**BIND CLINICAL PROGRAMS**".

M. Incentives to Providers

The Bind Health Plan and the Claims Administrator do not provide health care 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 Health Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Bind Health Plan or the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended toimpact your access to health care. 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 health care is less than or more than the payment
- Risk-sharing payments. The Network Provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per 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

N. Refund of Benefit Overpayments

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

- The Bind Health 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 Health Plan.
- All or some of the payment was made in error.

The refund equals the amount the Bind Health Plan paid in excess of the amount the Bind Health Plan should have paid under the Bind Health Plan. If the refund is due from another person or organization, the Participant agrees to help the Bind Health 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 Health Plan. The reductions will equal the amount of the required refund. The Bind Health Plan may have other rights in addition to the right to reducefuture 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 Health Plan, that individual must refund the amount of the excess Benefit payment and the Bind Health Plan may undertake collectionactions, subject to the requirements of applicable law.

O. Your Relationship with the Claims Administrator and the Bind Health Plan

In order to make choices about your health care coverage and treatment, the Bind Health 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 Health Plan and the Claims Administrator do not decide what care you need or will receive. You and your Physicianmake those decisions;
- the Claims Administrator communicates to you decisions about whether the Bind Health Plan will cover or pay for the healthcare that you may receive (the Bind Health Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Bind Health Plan may not pay for all treatments you or your Physician may believe are necessary. If the Bind Health Plan does not pay, you will be responsible for the cost.

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

P. Relationship with Providers

The relationships between the Bind Health 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 Health Plan and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, the Bind Health Plan and the Claims Administrator arrange for health care Providers to participate in a Network and pay Benefits. Network Providers are independent practitioners who

run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. They are not Lumen's Employees nor are they Employees of the Claims Administrator. The Bind Health Plan and the Claims Administrator do not have any other relationship with Network Providers such as principal-agent or joint venture. The Bind Health 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 Health 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 Health Plan.

Q. 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.

R. Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a Provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a Provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Participant or beneficiary, or derivatively, as an assignee of a Participant or beneficiary.

References herein to "third parties" include references to Providers as well as any collection agencies or third parties that have purchased accounts receivable from Providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Participant, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a Provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a Provider as a convenience to you, the Claims Administrator will treat you, rather than the Provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a Provider by any amounts that the Provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments.

S. Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which the Claims Administrator makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

T. Rebates and Other Payments

The Bind Health Plan and the Claims Administrator may receive rebates for certain drugs that are administered to youin a Physician's office, or at a Hospital or Alternate Facility. The Bind Health Plan and the Claims Administrator do notpass these rebates on to you, nor are they applied to your Out-of-Pocket Maximum or taken into account in determining your Copayments.

U. Review and Determine Benefits in Accordance with the Bind Health 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 Health 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, out-of-network Providers are not subject to this prohibition, and may bill you for any amounts the Bind Health 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 foryourself or to share with your out-of-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 Health 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 Health Plan. ***In addition tothis Medical Glossary, and throughout this document, there are also terms defined in the General Information (Active) SPD.***

Adverse Health Factor: A medical condition that coincides with the services described under Conditional Coverages (see Section 19 "**CONDITIONAL COVERAGES**"), and to which you must self-attest that you have as part of the election and activation process for conditional coverage Benefits.

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

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

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

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

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

Ancillary Services: Items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Enrollment: The period of time, determined by Lumen, during which eligible Employees may enroll themselves and their eligible Dependents under the Bind Health Plan. Lumen determines the period of time that is theAnnual 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.

Assisted Reproductive Technology (ART) – The term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).

- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

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 health care services covered under the Bind Health Plan approved by the Plan Administrator as Covered Health Services and as applicable, conditional coverage elected and activated by a Participant, as explainedin this SPD and any Amendments.

Bind Health Plan: Refers to the Bind 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 Health Plan, including processing of Claims, asmay 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 HEALTH PLAN FEATURES AND HOW THE BIND HEALTH 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 (Active) SPD for more information.***

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

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: those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD.
- Provided to a Participant who meets the Plan's eligibility requirements.

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

Designated Facility: A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Bind Health 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.

Designated Virtual Provider: Designated Virtual Providers are contracted with Bind to provide diagnosis and treatment of covered medical conditions virtually through the use of synchronous or asynchronous, interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. These Providers services are provided exclusively or primarily though virtual communication methods.

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 (Active) 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 health care services, subject to all of the terms, conditions, limitations, and exclusions for which the Bind Health Plan or Participant will pay.

Eligible Expenses: Charges for Covered Health Services that are provided while the Bind Health Plan is in effect anddetermined 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 Care Services: With respect to an Emergency:

- A medical screening exam (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section

1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided).

- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation or an inpatient stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a) The Provider or facility, as described above, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation.

  b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

  c) The patient is in such a condition to receive information as stated in b above and to provide informed consent in accordance with applicable law.

  d) Any other conditions as specified by the Secretary.

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

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

Employer: 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 health care professional that explains:

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

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

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

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

Independent Freestanding Emergency Department: A health care facility that:

- Is geographically separate and distinct and licensed separately from a hospital under applicable state law; and
- Provides Emergency Health Care services

Infertility: A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

Injury: Damage to the body, including all related conditions and 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 health care. The federal and state governments share the program's costs.

Medically Necessary/Medical Necessity: A health care service is deemed Medically Necessary when it is delivered or supervised by a licensed healthcare Provider 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 health care 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, health care 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: 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 Health 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 health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those Providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only some products. In this case, the Provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and 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 **"C. Network and Out-of-Network Benefits and Providers** (for those residing in a Network area) and Section 20 "**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 out-

of-network Providers. Refer to Section 5 “D**. Out-of-Area Members**” (for those residing in an Out-of-Network area) and Section 20 “**M. Providers**” for details about how Network Benefits apply.

Out-of-Pocket Maximum: The maximum amount you pay every Calendar Year. Refer to Section 12 “**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 Health Plan, and eligible for conditional coverages, under the eligibility rules. This could include either the eligible Employee or an enrolled eligible Dependent as defined by the Bind Health Plan and only while such person(s) is enrolled and eligible for Benefits under the Bind Health Plan. References to “you” and “your” throughout this SPD are references to a Participant. ***See the General Information (Active) 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 Health Plan.

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

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

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

Pre-Admission Notification: Process whereby the Provider or you inform the Bind Health 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 inadvance 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 health care 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 Health 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 health care Provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease, or symptoms;

If you and/or a covered Dependent have had services including medical devices approved in the past by 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 Health 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 health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within 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 health care 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:

- services exceed the scope of Intermittent Care in the home;
- 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 health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term “Provider” refers to an In-Network Provider unless other specified.

Recognized Amount: The amount which the copayment is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following:

1. Applicable state law,
2. An All Payer Model Agreement if adopted, or
3. The qualifying payment amount as determined under applicable law.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

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 an out-of-network Provider’s billed charges. This discount is usually based on a schedule previously agreed to by the out-of-network Provider. When this happens, you may experience lower out-of-pocket amounts. Bind Health Plan Copayments would still apply to the reduced charge. Sometimes the Bind Health Plan

provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the Network partner, such as apercentage 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 bya third party vendor or a negotiated rate with the Provider. In this case the out-of-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 (Active) 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: Services for the diagnosis and treatment of alcoholism and substance-related and addictive disordersthat 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 Health Plan and your rights and obligations under such benefit option as required by ERISA.

Surrogate: A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child.

Transitional Living: Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision including those defined in the American Society of Addiction Medicine (ASAM) Criteria, 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 health care professional at in-network rates for a limited time due to a specific medical condition, until the safe transfer to an in-network health care 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 health care 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).

Virtual Visit (Telehealth): Virtual visits are Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).

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 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 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.

Prescription Drug Product: A medication, or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters including continuous glucose monitors
  - Certain vaccines/immunizations administered in a Network Pharmacy.

Preventive Care Medications (PPACA Zero Cost Share)- the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- 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*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives through the internet at myuhc.com or by calling UnitedHealthcare at the number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

Preventive Medications - a list that identifies certain Prescription Drug Products, on the Prescription Drug List (PDL) that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at myuhc.com or by calling the number on your ID card.

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