Surest Health Plan

(Administered by Surest)

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

Including:

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

Effective January 1, 2023

This SPD must be read in conjunction with the Lumen Retiree General Information 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 Lumen 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).

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1. Introduction and General Plan Information

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 SurestHealth 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 "**Surest 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 Surest Health Plan. However,the two medical plans work together to administer these Benefits.

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

The Effective Date of this SPD is January 1, 2023. 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 **Retiree General Information SPD** and materials you receive at Annual Enrollment) (hereafter "*Plan Documents*") briefly describe your Benefits as well as rights and responsibilities, under the Plan. These documents make up your official Summary Plan Description for the Surest Health Plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Surest 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.

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 Surest Health Plan does provide minimum essential coverage. In addition, the Affordable Care Act establishes a minimum value standard of Benefits to a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the Benefits it provides.

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

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information about the Plan Administrator and the Claims Administrator can be found in the ***Retiree General Information SPD****.*

Note: While the Plan has processes in place to prevent errors and mistakes if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or benefit premiums under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Service Center to correct the error or omission. *There are deadlines to file Claims and Benefit related actions; please refer to Section 8* ***"What Do I Do If My Medical Claim Is Denied?"*** *and in the* ***Retiree General Information SPD*** *for more information about the timing of thesedeadlines.*

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 Surest Health Plan benefit option without describing all the details set forth in the *Plan Document*. The SPD is not the *Plan Document*. Other important details can be found in the *Plan Document* and the **Retiree General Information SPD**. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan. If any terms of the *Plan Document* conflict with the contents of the SPD, the *Plan Document* will always govern.

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

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

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

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

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

General Plan Information

The Surest Health Plan benefit option is just one benefit option offered under the Plan. This SPD **must** be read in conjunction with the **Retiree General Information SPD** which explains details of your coverage andprovides a listing of the other benefit options under the Plan.

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

- Eligibility
- When Coverage Begins

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- 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 **Retiree General Information SPD** or you can go online at lumen.com/healthandlife to obtain an electronic copy.

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 Providersany 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 Surest 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.

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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 oryour 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 falsificationof, 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 possibleconsequences 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 forBenefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.*

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

You Must Follow Surest Health Plan Procedures

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

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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.

Surest Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Surest Plan is to provide for the payment of certain healthcare expenses and not to guide or direct the course of treatment of any Employee, retiree, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean

it is approved or payable under the Surest 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 Surest 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 Surest Plan coverage and do not constitute health care recommendations or advice.*

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.

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1.1 Quick Reference

This section is a quick reference guide. Please review this entire Summary Plan Description (SPD) for additional details about your coverage.

Website Access to what is covered, how much it costs, and where you can get care.	**Once enrolled:** Benefits.Surest.com
Mobile App Access — from your smartphone - to what is covered, how much it costs, and where you can get care.	**Once enrolled:** Surest mobile app
Phone Numbers Who to contact to help answer any questions.	**Surest Plan Questions:** **Surest Member Services Team** 1-833-576-6519 **Monday – Friday** 6:00 am to 9:00 pm Central **Prescription Drug Questions:** OptumRx (Pharmacy) Member Service Refer to Section 5.2, Prescription Drugs
Name of the Plan (referred herein as the "Surest Plan")	Lumen Technologies, Inc. Retiree and Inactive Health Plan (Surest Option)
Plan Administrator Who is ultimately responsible for administering the Surest Plan.	Lumen Technologies, Inc.
Claims Administrator Who processes Claims, administers appeals, and runs the Surest Member Services team, Surest mobile app, and Benefits.Surest.com website.	Surest
Medical Claims/Appeals Mailing Address Where to mail medical Claims, written inquiries, and medical Claims appeal requests.	Surest P.O. Box 211758 Eagan, MN 55121
Prescription Claims Mailing Address for OptumRx Where to mail prescription Claims, prescription appeal requests and any written inquires.	UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432

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2. How Does the Surest Health Plan Work?

The Surest Health Plan ("Surest Plan") design allows each Participant to make informed choices about their health care, cost, and coverage needs – in advance of receiving care. With the Surest mobile app and the Benefits.Surest.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 Surest Member Services for assistance navigating their coverage options. Eligible employees and eligible dependents who properly enrolled in the Surest Plan are referred to as "Participants" in this SPD.

The Surest Plan has features that Participants already know and understand — including, for example: no deductible; simple copayments for Covered Health Services; an annual out-of-pocket maximum; and available comprehensive coverage.

When enrolled in the Surest Plan, coverage automatically includes substantial coverage of Physician and hospital services — including, for example: preventive care, Emergency and urgent care, office visits, inpatient and outpatient hospital visits, and prescription drugs. Coverage also provides substantial coverage for common and/or Medically Necessary services and treatments such as, maternity care, cancer treatment, and physical therapy, all of which are more fully described below.

Participants and the Plan Sponsor share in the cost of the Surest Plan. Your paycheck deductions amount depends on the dependents you choose to enroll.

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3. Am I Eligible and How Do I Enroll?

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

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4. When Does My Coverage Begin and End?

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

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5. What Are My Benefits?

Claims for Benefits under the Surest 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 consists of paycheck deductions and copayments. The Surest Plan does not have a deductible or coinsurance. Your Surest Plan does have an out-of-pocket maximum which is the maximum amount of copayments you will pay each Plan Year for Covered Health Services. Your paycheck deductions do not count against the Surest Plan's out-of-pocket maximum.

Your premium contributions are 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 paycheck deductions a special tax advantage. Your paycheck deductions are subject to review, and the Plan Administrator reserves the right to change your paycheck deduction amount from time to time. You can obtain current paycheck deductions by contacting the Plan Administrator.

Surest assigns prices to Covered Health Services. These prices are referred to as copayments. Your copayments for Covered Health Services are listed in Section 5.1 (Covered Health Services), Section 13 (Attachment I – Outpatient Prescription Drugs) and on the Surest mobile app and Benefits.Surest.com website.

The Surest Plan provides Benefits for the remainder of the amount billed by your in-network Provider for Covered Health Services after any discounts are applied.

Discounts are negotiated with in-network Providers. If you use an in-network Provider, 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.

Once your total copayments reach your applicable out-of-pocket maximum, the Surest 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. These amounts are NOT counted towards your out-of-pocket maximums.

Benefits and Providers (for those residing in a Network area)

In-Network Benefits

As a Participant in the Surest Plan, you may choose any eligible Provider of health services each time you need to 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 Surest Plan (and in most instances, your out-of-pocket expenses will be far less) when you receive care from in-network Providers. The Surest Plan features a large network of in-network Providers which can be found in the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance.

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These in-network Providers will:

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

In-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 in-network Provider information, refer to the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance..

You must show your member identification "ID" card every time you request health care services from an in-network Provider. Your member ID card can be found on the Surest mobile app; you will also receive an actual member ID card in the mail prior to the Effective Date. If you do not show your member ID card, in-network Providers have no way of knowing that you are enrolled under the Surest 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 Surest 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 Covered Health Services. Refer to the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance.

Out-of-Network Benefits

The Surest 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, you will be responsible for the difference between the amount billed by the out-of-network Provider or facility and the amount Surest determines to be the Eligible Charge for reimbursement (plus any applicable copayments). 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.

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 Surest 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 Surest Member Services at the number on your member ID card **before** you obtain such services.

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

Benefits and Providers for Out-of-Area Members

If you live outside of the Surest Health Plan area ("out of area"), the Surest 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 Surest 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 youneed to receive Covered Health Services.

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

Generally, when you receive Covered Health Services from a Network Provider (including facilities), you payless 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-pocketexpenses 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 aNetwork Provider if you wish.

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Out-of-Network Provider

These Providers are not listed by Surest on Benefits.Surest.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 tochange.

Note: Network Providers are independent practitioners and are not Employees of Lumen or the Claims Administrator.

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 applicable to the Covered Health Services you choose. Some copayments are listed as a range. Surest assigns Provider copayments within the ranges based on the Surest analysis of treatment outcomes and cost information that identifies Physicians, clinics, and hospitals that provide cost-efficient care.

For current Provider-specific copayment information, Participants should check the Surest mobile app or Benefits.Surest.com website or call Surest Member Services prior to utilizing any services covered under the Surest Plan.

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 Surest mobile app or Benefits.Surest.com website or call Surest Member Services.

You may also be eligible for reduced copayments for certain Benefits and for specific focused programs if you use in-network Providers that Surest has designated as preferred, high-value Providers.

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The following chart shows the deductibles and out-of-pocket maximums for the Surest Plan.

Benefit Features

The Surest Plan	In-Network	Out-of-Network
Deductible	$0	$0
Out-of-Pocket Maximum per Plan Year		
Employee Only	$3,600	$7,200
Employee + Spouse; Employee + Child	$5,400	$10,800
Family	$6,850	$14,400

Notes:

- Refer to the Surest mobile app for additional coverage information.
- If you enroll in individual coverage, once you reach the out-of-pocket maximum for the Employee Only coverage for a Plan Year, Benefits are payable at 100% of the Eligible Charge during the remainder of the Plan Year.
- If you have a Spouse or Child enrolled in the Surest Plan, the overall out-of-pocket maximum for the Employee + Spouse / Employee + Child coverage must be met before the Surest Plan will pay 100% of Eligible Expenses for Covered Health Services for the remainder of the Plan Year.
- If you have more than one family member enrolled in the Surest Plan, the overall out-of-pocket maximum for the Family coverage must be met before the Surest Plan will pay 100% of Eligible Expenses for Covered Health Services for the remainder of the Plan Year.
- You must pay any amounts greater than the out-of-pocket maximum if any Benefit, day, or visit maximums are exceeded, and for health care services that are not Covered Health Services. 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.
- Your paycheck deductions for coverage will not apply towards satisfaction of the out-of-pocket maximum.
- Except as specifically noted in the schedule of benefits in Section 5.1 below, the amount applied to your in-network out-of-pocket maximum also applies to your out-of-network out-of-pocket maximum. The amount applied to your out-of-network out-of-pocket maximum does not apply to your in-network out-of-pocket maximum.

5.1 Covered Health Services

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

Notes:

- Refer to the Surest mobile app for additional coverage information.
- 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 Surest Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as Surest determines appropriate) between facilities when the transport is:
  - From an out-of-network hospital to an in-network hospital.
  - To a hospital that provides the required care that was not available at the original hospital.
  - To a more cost-effective acute care facility.
  - From an acute care facility to a sub-acute care setting.

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- 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 (including Telehealth)	$20 copayment / visit	$130 copayment / visit
Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder Visit	$20 copayment / visit	$130 copayment / visit
Mental Health Biofeedback	$20 copayment / visit	$130 copayment / visit
Mental Health Habilitative, Cognitive, Occupational Therapy	$10 copayment / visit	$40 copayment / visit
Mental Health Physical Therapy	$10 copayment / visit	$40 copayment / visit
Mental Health 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 / day	$350 copayment / day
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)	$150 to $650copayment / 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 Surest mobile app for additional coverage information.
- Benefits include:
  - Diagnostic evaluations, 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.
- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.
- 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 Surest 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.

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  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, 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 Surest 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 Surest Plan provides 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 health care 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 Surest mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- Coverage is available for a non-screening colonoscopy received on an outpatient basis at a hospital, alternate facility, or in a Physician’s office.
- When this procedure is performed to diagnose disease symptoms, a copayment applies.
- Services for preventive screenings are provided under the Preventive Care Services section.

Complex Imaging	In-Network	Out-of-Network
MRI (Magnetic Resonance Imaging)	$250 to $775 copayment / visit	$1,550 copayment / visit
CT (Computed Tomography)	$250 to $775 copayment / visit	$1,550 copayment / visit
PET (Position 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 Surest mobile app for additional coverage information.
- 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, in this section, for coverage notes.

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Dental Services: Accidental Dental	In-Network	Out-of-Network
Office Visit	$20 to $90 Copayment / visit	$180 Copayment / visit
All Other Services		
• **Outpatient Hospital Visit**	$150 to $650 Copayment / visit	$1,500 Copayment / visit
• **Inpatient Hospital**	$1,400 Copayment / stay	$2,800 Copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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 Surest 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 dental treatment. Coverage is limited to facility and anesthesia charges.
- Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
- Medical 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**	$150 to $650 Copayment / visit	$1,500 Copayment / visit
• **Inpatient Hospital**	$1,400 Copayment / stay	$2,800 Copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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 Surest 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 dental treatment. Coverage is limited to facility and anesthesia charges.
- Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization

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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 Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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, androot 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
Dialysis	$100 to $400 copayment / visit	$1,200 copayment / visit
Home Dialysis	$70 copayment / visit	$210 copayment / visit

Notes:
- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- The Surest Plan provides Benefits for therapeutic treatments received in an office, home, outpatient hospital, or alternate facility.
- Benefit includes services and supplies for renal dialysis, including both hemodialysis and peritoneal dialysis.
- Benefit also includes training of the patient.

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Durable Medical Equipment (DME) and Supplies	In-Network	Out-of-Network
Purchase:		
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
Rental:		
Tier 1	$0 copayment / month	$2 copayment / month
Tier 2	$2 copayment / month	$4 copayment / month
Tier 3	$4 copayment / month	$8 copayment / month
Tier 4	$6 copayment / month	$12 copayment / month
Tier 5	$8 copayment / month	$16 copayment / month
Tier 6	$10 copayment / month	$20 copayment / month
Tier 7	$15 copayment / month	$30 copayment / month
Tier 8	$20 copayment / month	$40 copayment / month
Tier 9	$25 copayment / month	$50 copayment / month
Tier 10	$35 copayment / month	$70 copayment / month
Tier 11	$50 copayment / month	$100 copayment / month
Tier 12	$100 copayment / month	$200 copayment / month

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 Surest mobile app or Benefits.Surest.com website.
- 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, multiple copayments will apply (such as for formula, nursing visit and administration).

The Surest Plan provides Benefits for durable medical equipment, prosthetics, orthotics, and supplies subject to the limitations listed below:

- Refer to the Surest mobile app for additional coverage and copayment information.
- This durable medical equipment and supplies list is subject to periodic review and modification (generally quarterly, but no more than six times per Plan Year).
- You may also view which tier a particular DME item has been assigned to by using the Surest mobile app or Benefits.Surest.com website or call Surest Member Services 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,

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and is 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. Length of rental may vary by DME item. The purchase copayment based on tier may be split over a period of time, 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. Refer to Surest mobile app or Benefits.Surest.com website for additional information.

- 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. 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 a maximum Benefit of $350 per Plan Year for in-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 a one-year supply of disposable contact lenses.
- Hearing aids are limited to one hearing aid per ear every 36 months for in-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.
- 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 Surest mobile app for additional coverage information.
- Copayment applies to Emergency room facility, professional expenses, and includes related expenses.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Emergency Room visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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 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.

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

Notes:

- Refer to the MyBind mobile app for additional coverage information.
- To be eligible for Benefits, the Participant:
  - Must be under age 44, if female and using own eggs/oocytes; or
  - Must be under age 55, if female using donor eggs/oocytes.
  - For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.
- Participant must meet the one of the following clinical criteria to be eligible for specific infertility services:
  - Failure to achieve or maintain a pregnancy due to impotence/sexual dysfunction;
  - Infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization;
  - Diagnosis of a males factor causing infertility (e.g., with anatomical variants such as aspermia or varicocele resulting in an inability to reproduce, or treatment of sperm abnormalities, including the surgical recovery of sperm);
  - Women with documented FSH levels less than or equal to 19 mIU/ml on day 3 of the menstrual cycle; or
  - Women who have not met time criteria for failure to conceive, but who have a documented anatomic variant resulting in the inability to achieve Pregnancy (e.g., severe pelvic inflammatory disease, endometriosis, or ectopic Pregnancy requiring surgical removal of both fallopian tubes).
- The Bind Plan coverage pays Benefits for infertility services and associated expenses including:
  - Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician;
  - Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Pronuclear stage tubal transfer (PROST), and zygote intrafallopian transfer (ZIFT);
  - Ovulation induction and controlled ovarian stimulation;
  - Cryopreservation, also known as embryo freezing, and storage (up to 24 months) for embryos produced from one (1) cycle for a Participant who will undergo cancer treatment that is expected to render them infertile; and
  - Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
  - Preimplantation Genetic Testing (PGT) is a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. (e.g., PGT-M for monogenic disorder (formerly Chromosomal PGD) and PGT-MR for structural rearrangements (formerly chromosomal PDG)).
  - Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm;
  - There is a lifetime maximum of $10,000 per Participant for covered infertility treatments and prescription medications. This lifetime maximum is combined across all health Plans sponsored by the Plan Administrator.
- If a Participant is bypassing reversal of sterilization and requesting the direct infertility treatment (IVF), the IVF would be covered. Benefits include implanting only one embryo per cycle. A cycle is defined as one partial or complete fertilization attempt extending through the implantation phase only.
- Multiple Copayments may apply if more than one service is performed during a visit.
- **Dependent Child’s Pregnancy:** Direct or indirect expenses incurred for a Dependent Child’s Pregnancy are not covered. **Please Note:** This exclusion does not apply to prenatal services for which Benefits are provided under the Preventive Care Services Benefit, including certain items and services under the United States Preventive Services Task Force requirements or the Health Resources and Services Administration (HRSA) requirement or care to save the life of the mother. If you reside in the State of Massachusetts, the benefit coverage for a Dependent Child’s Pregnancy is different, and the Bind Plan covers additional Benefits. If you have questions on which prenatal services for a Dependent Child’s Pregnancy are covered, please contact Surest Member Services.

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Gender Dysphoria Services	In-Network	Out-of-Network
Mental Health Office Visit	$20 copayment / visit	$130 copayment / visit
Voice Therapy for Gender Dysphoria	$10 copayment / visit	$40 copayment / visit
Gender Dysphoria Surgery - Inpatient Hospital	$1,400 copayment / stay	$2,800 copayment / stay
Gender Dysphoria Surgery - Outpatient Hospital	$100 copayment / visit	$300 copayment / visit
Gender Dysphoria Reconstructive Services - Inpatient Hospital	$1,400 copayment / stay	$2,800 copayment / stay
Gender Dysphoria Reconstructive Services - Outpatient Hospital	$100 copayment / visit	$300 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- The following services are covered for Gender Dysphoria Services:
  - Psychotherapy for Gender Dysphoria Services and associated co-morbid psychiatric diagnoses.
  - Hormone therapy as appropriate to the patient's gender goals: Hormone therapy administered by a medical Provider (for example during an office visit). Hormone therapy dispensed from a pharmacy is provided as described under Section 13 (Attachment I - Outpatient Prescription Drugs).
  - Laboratory testing to monitor the safety of continuous hormone therapy as appropriate to the patient's gender goals.
  - Permanent hair removal for purposes of genital reconstruction.
  - Permanent face and neck hair removal or reduction, including electrolysis and laser treatment.
  - Voice lessons and voice therapy.
- Surgery for the treatment for Gender Dysphoria Services, including the surgeries listed below:
  - Liposuction.
  - Genital surgeries:
    - Clitoroplasty (creation of clitoris).
    - Hysterectomy (removal of uterus).
    - Labiaplasty (creation of labia).
    - Metoidioplasty (creation of penis, using clitoris).
    - Orchiectomy (removal of testicles).
    - Penectomy (removal of penis).
    - Penile prosthesis.
    - Phalloplasty (creation of penis).
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).
    - Scrotoplasty (creation of scrotum).
    - Testicular prosthesis.
    - Urethroplasty (reconstruction of female urethra).
    - Urethroplasty (reconstruction of male urethra).
    - Vaginectomy (removal of vagina).
    - Vaginoplasty (creation of vagina).
    - Vulvectomy (removal of vulva).
  - Chest surgeries:
    - Bilateral mastectomy or breast reduction.
    - Breast enlargement, including augmentation mammoplasty and breast implants.
    - Pectoral implants.
  - Face and neck surgeries ($50,000 lifetime maximum for facial feminization/masculinization):
    - Blepharoplasty (eyelid lift).
    - Brow lift.
    - Forehead lift.
    - Facial bone remodeling.
    - Lip reshaping.
    - Rhinoplasty (nose reshaping).
    - Thyroid cartilage remodeling (remodeling of the Adam's apple).
    - Face lift.
    - Neck tightening.

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   - Voice modification surgery.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Gender Dysphoria Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.

Genetic Testing	In-Network	Out-of-Network
	$170 copayment / visit	$510 copayment / visit

Notes:
- Refer to the Surest 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 Surest mobile app for additional coverage information.
- Home Health Care Visits are limited to 120 visits per Participant per Plan Year for in-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.
  - Provided when skilled care is required.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula, nursing visit and administration).
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Health Agency, will apply to 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 Agency will apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.

Hospice Care	In-Network	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 Surest 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 (terminally ill person) 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.

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Hospital Services - Other	In-Network	Out-of-Network
Outpatient Hospital Visit	$150 to $650 copayment / visit	$1,500 copayment / visit
Inpatient Hospital	$1,400 copayment / stay	$2,800 copayment / stay

Notes:

- Other Hospital Services: The above copayments apply for Covered Health Services not specifically listed in this SPD, Surest mobile app or Benefits.Surest.com website. Copayments may vary based in Provider and location.
- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Hospital Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest 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 Services copayment.
- Outpatient hospital care includes Radiation Device Placement, Abdominal paracentesis, Peritoneal dialysis procedure, Thoracentesis, Angiography, Percutaneous drain and stent placement, Surgical Biopsy of the Breast and Inferior Vena Cava Filter Placement (IVC).
- 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.

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	$330 to $2,100 copayment / visit
Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds	$0 copayment / visit	$0 copayment / visit

Notes:

- Refer to the Surest 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.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the facility service or surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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.

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    - Facility-based Sleep Study.
    - Home-based 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, or 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.
- Effective February 4, 2020, through the end of the *Public Health Emergency* period, as declared by the Secretary of the *Department of Health and Human Services* (*HHS*), the Participant will have a $0 copayment for the following services: approved and authorized COVID-19 diagnostic testing and evaluation, and testing-related visits at a virtual visit & telehealth, physician's office, urgent care center, or emergency department of a hospital or alternate facility. Testing must be provided at approved locations in accordance with *U.S. Centers for Disease Control and Prevention (CDC)* guidelines. This cost share waiver applies to services received from both in-network and out-of-network providers.
- Select Laboratory services and Diagnostic Testing may require Prior Authorization and Medical Necessity review.

Maternity Care and Delivery	In-Network	Out-of-Network
Routine Prenatal and Postnatal 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
Home Birth/Delivery	$775 copayment / visit	$2,325 copayment / visit
Newborn Nursery Care	$0 copayment / test	$0 copayment / test
Elective Abortion – Non-Surgical	$130 copayment / visit	$390 copayment / visit
Elective Abortion - Surgical	$225 copayment / visit	$675 copayment / visit
All Other Outpatient Services	Based on place of services	Based on place of services

Notes:

- Refer to the Surest mobile app for additional coverage information.
- The copayments for inpatient delivery may vary based on Provider and location; this includes a birthing center.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Maternity Care and Delivery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a fetal monitor, may result in an additional copayment.
- Routine prenatal and postnatal 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 one visit immediately following discharge of mother and newborn.
- Hospital visits or admissions 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.
- Home Birth/Delivery copayment includes medical supplies used for a home delivery of an infant. Birthing tubs are not covered.

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- 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.

Medical Infusions and Injectables	In-Network	Out-of-Network
Provider Administered Drugs	$30 to $1,350 copayment / visit	$660 to $2,700 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- Copayments may vary based on Provider and location.
- 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 Provider Administered 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 drugs for supportive services that are often unplanned for your diagnosis and treatment, such as IV fluids or antibiotic injections, have a $0 copayment.
- Provider Administered Drugs 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 Surest Member Services to learn which medical drug (e.g., infusions and injections) are subject to these copayments.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Medical Drug copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- See the Cancer Chemotherapy section for coverage notes related to Cancer 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 13 [Attachment I - Outpatient 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 (including Telehealth Visit)	$20 to $90 copayment / visit	$180 copayment / visit
Mental Health Office Visit (including Telehealth Visit)	$20 copayment / visit	$130 copayment / visit
Allergy Injection Visit	$0 copayment / visit	$130 copayment / visit
Allergy Testing and Treatment	$85 copayment / visit	$170 copayment / visit
Convenience Care / Retail Visit	$20 copayment / visit	Not Covered
E-Visit and Telephone Consult with Your Physician	$35 copayment / visit	$180 copayment / visit
Outpatient Anticoagulant Management	$10 copayment / visit	$30 copayment / visit
Provider House Call (Home Visit)	$55 copayment / visit	Not Covered
Virtual Visit – other than Designated Provider (see Virtual Visit*)	See Virtual Visit section for details	Not Applicable

Notes:

The Surest Plan provides Benefits for services provided in an office for the diagnosis and treatment of an illness or injury.

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Office Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Office Visit refers to face-to-face visit or Telehealth visit with your Provider.

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- 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.
- Virtual Visit refers to a visit with a Designated Virtual Provider such as Doctor on Demand or K Health, or with a Non-Designated Virtual Provider. See Virtual Visit Section for 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.
- *See Virtual Visit section for virtual visit details.
- If your Provider refers you for a test or service within a hospital or other facility, the Outpatient Hospital copayment may apply.
- Returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Orthognathic Surgery and Temporomandibular Joint (TMJ) Disorder	**In-Network**	**Out-of-Network**
Orthognathic (Jaw) Surgery	$1,750 copayment / visit	$3,500 copayment / visit
Temporomandibular Joint (TMJ) Dysfunction Surgery	$900 copayment / visit	$1,800 copayment / visit
All other services:		
• **Office Visit**	$20 to $90 copayment / visit	$180 copayment / visit
• **Outpatient Hospital Visit**	$150 to $650 to copayment / visit	$1,500 to copayment / visit
• **Inpatient Hospital**	$1,400 copayment / stay	$2,800 copayment / stay

Notes:

The Surest Plan provides Benefits for services for orthognathic surgery and the evaluation and treatment of TMJ and associated muscles.

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Orthognathic and TMJ copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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.
- 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 Health Care Visit	$25 copayment / visit	$170 copayment / visit
Outpatient Hospital Visit	$150 to $650 to copayment / visit	$1,500 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- The Surest 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.
- 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.

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- See Hospice Care notes for services related to Hospice.

Prescription Drugs	In-Network	Out-of-Network
	See 13 (Attachment I – Outpatient Prescription Drugs) for details	Not Covered

Preventive Care Services	In-Network	Out-of-Network
Preventive Care Services	$0 copayment / visit	$130 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Preventive Care Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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.
- Effective February 4, 2020, through the end of the *Public Health Emergency* period, as declared by the Secretary of the *Department of Health and Human Services* (*HHS*), qualifying coronavirus preventive services, including vaccines. Vaccines are covered at a $0 copayment in and out-of-network.
- 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 visits 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 a diagnosis of family history.
  - Routine immunizations. Age limits may apply.
  - Routine lab tests, pathology, and radiology.
  - Hearing and vision screening limited to one exam per Plan Year for children up to age of 21.
  - Routine pre-natal and post-natal services.
  - One routine postnatal care exam provided during the period immediately after childbirth that includes a health exam, assessment, education, and counseling.
  - Preventive contraceptive methods and counseling for women.
    - Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.
- For Prescription Drug Coverage see Section 13 (Attachment I - Outpatient Prescription Drugs).
- 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
	$50 to $925 copayment / visit	$525 to $2,775 copayment / visit

Notes:

- The Surest Plan provides Benefits for services received on an outpatient basis at a hospital, alternate facility, or in a Physician’s office.
- Refer to the Surest mobile app for additional coverage information and the copayment assigned to your procedure/service.
- Copayments may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Radiation Therapy copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Benefits include Physician services and facility charges, and services such as, but not limited to:
  - Apheresis.
  - Brachytherapy.
  - Conventional External Beam Radiation Therapy (EBRT).

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- Hyperbaric Oxygen Therapy (HBOT).
- Proton Therapy.
- Radiation Therapy Simulation and Planning.
- Radiopharmaceutical Therapy.
- Stereotactic Radiation Therapy.

- Select Radiation Therapies may require Prior Authorization and Medical Necessity Review.
- See notes under Hospital Services – Other for services related to Radiation Device Placement.

Reconstructive Surgery	In-Network	Out-of-Network
Office Visit	$20 to $90 copayment / visit	$180 copayment / visit
Outpatient Hospital	$150 to $650 to copayment / visit	$1,500 to copayment / visit
Inpatient Hospital	$1,400 copayment / stay	$2,800 copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital 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.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Reconstructive Surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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 illness, injury, 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 Surest 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 Surest Member Services 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 Surest 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 illness, injury, 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.

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Rehabilitative/Habilitative Services and Other Low Intensity Therapy	In-Network	Out-of-Network
Acupuncture Visit	$20 copayment / visit	$40 copayment / visit
Biofeedback	$60 copayment / visit	$180 copayment / visit
Aural Therapy – Post Cochlear Implant	$20 to $90 copayment / visit	$180 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
Vision Therapy	$20 copayment / visit	$90 copayment / visit

Notes:
Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Benefits include 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 section.

- Refer to the Surest mobile app for additional coverage and copayment information.
- The copayments for certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupational, physical, and speech therapy).
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Rehabilitative/Habilitative Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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 in-network and out-of-network Providers combined.
- Aural Therapy does not have visit limits.
- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.
- Cardiac Rehabilitation does not have visit limits.
- Chiropractic Visits are limited to 60 visits or services, per Participant per Plan Year for in-network and out-of-network Providers combined.
  - Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.
- Occupational and Cognitive therapy visits are limited to 60 visits per Participant per Plan Year for in-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 in-network and out-of-network Providers combined.
- Pulmonary Rehabilitation does not have limits.
- Speech therapy is limited to 60 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Vision therapy does not have visit limits.
- Therapies provided in the home will be assigned the home health care visit copayment. See Home Health Services 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.

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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 Surest Plan provides Benefits for services provided during an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.

- Refer to the Surest mobile app for additional coverage information.
- Skilled Nursing Facility stays are limited to 120 days per Participant per Plan Year for in-network and out-of-network Providers combined.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Skilled Nursing Facility Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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 anesthesiologists, pathologists, and radiologists.
  - 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:
  - Services 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.
  - Services are ordered by a Physician.
  - Services 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.
  - Services require 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 Surest Plan does not provide Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12 (Glossary).
- 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 Prior Authorization and Medical Necessity review.
- See Hospital Services 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**	$2,450 copayment / visit	Not Covered
• **Inpatient Hospital**	$2,450 copayment / stay	Not Covered

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for outpatient hospital visits may vary based on Provider and location.

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- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Transplant Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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.
- Surest has identified quality designated providers for transplant services (except for corneal transplant) that are accessible through Transplant Resource Services. See Section 5.4 (Clinical Programs) for additional information. Transplant services (except for corneal transplant) must be rendered at a designated provider.
- 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 Surest 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.
- Surest has specific guidelines regarding Benefits for transplant services. Contact Surest Member Services at the number on your member ID card for information about these guidelines.
- The Surest Plan provides Benefits for 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 an in-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 in-network Provider.
  - Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the 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 in-network Provider.
  - Taxi fares (not including limos or car services).
  - Economy or coach airfare.
  - Parking.
  - Trains.
  - Boat.
  - Bus.
  - Tolls.
- **Examples of items that are not covered:**
  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.

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- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Treatment / Tests / Therapies – Go to Surest mobile app or Benefits.Surest.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, pain management procedures, etc.)	$60 to $1,250 copayment / visit	$150 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 $2,900 copayment / visit	$300 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.)	$200 to $3,000 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.)	$250 to $3,000 copayment / visit / stay	$2,800 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 tumor surgery, coronary artery bypass graft surgery, etc.)	$1,200 to $3,000 copayment / visit / stay	$4,500 to $6,150 copayment / visit / stay
Other Treatments/Tests/Therapies: Refer to the Surest mobile app or Benefits.Surest.com website for coverage and copayment information or call Surest Member Services. Copayments may vary based on Provider, location and treatment, test, or therapy.		
• **Office Visits**	$20 to $90 copayment / visit	$180 copayment / visit
• **Outpatient Hospital Visit**	$150 to $650 to copayment / visit	$1,500 copayment / visit
• **Inpatient Hospital**	$1,400 copayment / stay	$2,800 copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- The copayments above apply unless a Benefit is specified in another section of this SPD, Surest mobile app or Benefits.Surest.com website.
- Copayments for outpatient hospital visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Treatment / Tests / Therapies copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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 treatment or 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 Surest mobile app, or call Surest Member Services to determine the copayment 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 and procedures or services typically performed in an outpatient hospital setting.
  - Level 3 is a category of major surgeries and procedures typically performed in an outpatient hospital setting.
  - Level 4 is a category of major surgeries and procedures typically performed in an inpatient hospital setting.

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  - 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.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location. Refer to the Surest mobile app, or call Surest Member Services to determine the copayment assigned to your procedure/service.
- 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, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest 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 Services copayment.
- 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 Surest mobile app for additional coverage information.
- Benefits include visits at a walk-in Urgent Care center that treats illnesses and injuries requiring immediate care, but not serious enough to require an Emergency department visit.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Urgent Care Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- 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.
- 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 copayment / visit	Not Covered

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Please see the Behavioral Health and Office Visit sections for additional information on Telehealth Visits with your Provider.
- 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 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 between the patient and a Provider, 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).
- Copayments will vary based on Provider. If you choose a Provider that is not a member of the Designated Virtual Provider Network (Other Virtual Provider), see Office Visit section for additional Virtual/Telehealth Visit copayment information. Benefits are available only when services are delivered through a Designated Virtual Provider that are specified by your Surest Plan.
- Please visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services to locate a Designated Virtual Provider.

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- No virtual visit coverage for out-of-network Providers.
- 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.
- Effective February 4, 2020, through the end of the *Public Health Emergency* period, as declared by the Secretary of the *Department of Health and Human Services* (*HHS*), the Participant will have a $0 copayment for the following services: approved and authorized COVID-19 diagnostic testing and evaluation, and testing-related visits at a virtual visit & telehealth, physician's office, urgent care center, or emergency department of a hospital or alternate facility. Testing must be provided at approved locations in accordance with *U.S. Centers for Disease Control and Prevention (CDC)* guidelines. This cost share waiver applies to services received from both in-network and out-of-network providers.

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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 an approved clinical trial. For more information call Surest Member Services at the number on your member ID card.

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

Coverage with Evidence Development

Surest 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 Surest.
7. Do not substantially increase health care costs.
8. Meet all of the requirements defined by the Surest clinical rationale policy and procedures.

Services covered by a CED policy are covered according to the Surest Plan benefit design. This will require Prior Authorization and Medical Necessity review.

5.2 Prescription Drugs

See Section 13 (Attachment I – Outpatient Prescription Drugs).

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5.3 Prior Authorization and Pre-Admission Notification

Select services require Prior Authorization or Pre-Admission Notification. Prior Authorization is required by service type, regardless of whether the service is rendered by in-network or out-of-network Providers.

In-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 at least 24 hours of admission of Emergency inpatient admissions. 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 Surest Member Services.

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 Surest Plan. Only certain out-of-network Covered health Services are available for Benefits (e.g., ambulance, Emergency room, Observation Stay). Contact Surest Member Services prior to obtaining services to determine whether Prior Authorization is required or ask your Provider to contact the pre-certification number on your member 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 8 (What Do I Do If My 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 on your member ID card or call Surest Member Services.

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

- Acute care hospitalizations (planned)
- Acute inpatient rehabilitation
- Applied behavioral analysis
- Non-Emergency air transportation
- Bariatric surgery
- Bone growth stimulators
- BRCA testing
- Select cardiovascular procedures
- Select chemotherapy
- Clinical trials
- Cochlear implant surgery
- Coverage with Evidence Development

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- Potentially Cosmetic and Reconstructive surgery
- Select durable medical equipment, orthotics, and prosthetics
- Gender affirming surgery
- Select genetic and molecular tests
- Select injectable medications
- Intensity-modulated radiation therapy
- Long-term acute care
- MR-guided focused ultrasound
- Organ transplants
- Orthognathic surgery
- Partial hospitalization
- Proton beam therapy
- Residential treatment facilities
- Skilled Nursing Facilities
- Sleep apnea procedures
- Sleep studies
- Select spinal surgeries
- Vein procedures
- Ventricular assist devices

5.4 Clinical Programs

Surest Care Management

Surest Care Management offers support to help you use your Benefits, improve your health, and achieve an optimal quality of life.

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

- Assisting you in making important health care decisions.
- Coordinating your care with your health care Providers.
- Helping you develop self-management skills.
- Identifying available treatment options.
- Offering personalized coaching to help you live better with an illness or recover from an acute condition.
- Researching resources, such as Digital Health Solutions (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

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using the resources available in your community, this program can help you through a difficult time.

It is your choice to participate in Surest 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 Surest Member Services if you think you can use this support.

Transplant Resource Services

For a solid organ and blood/marrow transplant to be a Covered Health Service, you must be enrolled in Transplant Resource Services and use a designated provider. Most transplants are expensive and complicated. At Surest, we ensure you are going to a reputable facility that has expertise in the specific type of transplant you need. Contact Surest Member Services at the number on your member ID card for more information on Transplant Resource Services and access to designated providers.

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

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

Organs 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 transplant is a solid tissue transplant, it is not considered part of the Transplant Resource Services program.

Surest Digital Health Solutions (formerly Bind Care Model Innovations)

Surest Digital Health Solutions are Providers contracted with Surest to provide health-related services that prevent, treat, or reverse one or more chronic diseases or conditions. 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 may be excluded Benefits, if provided outside of Surest Digital Health Solutions.

Surest may offer additional or varying Digital Health Solutions throughout the year. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services.

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.

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To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services, or go to eligibility-surest.selfmanage.org/.

Diabetes Care Management - Virta

Surest offers a personalized virtual diabetes control program focused on nutritional changes, medication changes, and biomarker feedback with the goal of helping implement lifestyle changes to reverse diabetes. The program is for Type-2 diabetics who meet certain criteria. Eligible Surest members can enroll in Virta at no additional charge and no out-of-pocket costs. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services, or go to www.virtahealth.com/join/surest.

Kaia Health (new in 2023)

Kaia is a digital therapy app for various fitness levels and lifestyles. Kaia offers a personalized therapy program that addresses both the causes and symptoms pain. Surest has partnered with Kaia to offer you and your dependents access to Kaia at no additional cost. When you sign up with Kaia, you'll immediately gain access to their clinically validated therapy, including:

- Personalized exercises.
- One-on-one coaching.
- Whole-person mind-body training.
- Wellness education.
- Advanced motion analysis technology.

Learn more about Kaia and sign up at startkaia.com/surest

Maternity Support Program - Pacify

Surest offers a maternity support program with round-the-clock access to maternity nurses, lactation consultants, and early childhood experts. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services, or go to http://www.pacify.com/surest.

MyCancerJourney

MyCancerJourney, powered by PotentiaMetrics, is a decision support service 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 Surest mobile app or website or call Surest Member Services, or go to www.mycancerjourney.com/join-surest.

Other Condition-Focused Programs Made Available by Lumen Technologies, Inc.

Well Connected Incentive Program and Resources to Stay Healthy

See Attachment II.

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2nd.MD

See the ***Retiree General Information 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.

Cor Medical

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

Cancer Resource Services

The Surest 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 treata 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 Surest 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 youreceive oncology services from a facility that is not a Designated Facility, the Surest Health Plan pays Benefits as described under Section 5.1 (Covered Health Services):

Cancer Clinical Trials (see Section 5.1 for Clinical Trials) and related treatment and services are covered bythe Surest 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 withcancer-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 Surest 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.***

Congenital Heart Disease Resource Services

Because Congenital Heart Disease (CHD) care is complex, covered Surest Participants with CHD have access to a CHD Resources Service that can help you locate CHD Centers of Excellence Providers and best practice CDH programs throughout the U.S. A nurse can work with you to help you:

- Identify the CHD hospital options for you, including Centers of Excellence.
- Evaluate your needs for information and support before and after a CHD treatment.

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- Understand your benefits and provide resources to help you navigate the health system to make sure you and your Participants get the care you need.

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.

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.

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.

MDLIVE – Virtual Visits

MDLIVE is a leading telehealth provider, offering solutions designed to increase access to high-quality care, improve health outcomes, and reduce the total cost of care for patients. Your benefit includes MDLIVE best-in-class core virtual care solutions including urgent care, primary care, behavioral health, and dermatology.

Urgent Care: 24/7/365 access to on-demand and scheduled urgent care visits via phone, video or mobile app. Virtual urgent care is a convenient, low-cost alternative to visiting an urgent care clinic or emergency department. MDLIVE's national network of board-certified doctors allows you to seek care even while traveling.

Primary Care: High-quality, patient-centric preventative wellness screening and routine care, including non-urgent medical conditions and ongoing care for chronic conditions including

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diabetes, asthma, and heart disease. Available through scheduled appointments, via phone and video.

Behavioral Health: Talk therapy and medication management for a wide range of mental health needs including anxiety, depression, addiction, relationships, grief and loss. Offering phone or video visits, by appointment, from the convenience and privacy of your own home.

Dermatology: Asynchronous consultations for more than 3,000 skin, hair and nail conditions. Offering access to board-certified dermatologists from the convenience of your home with average turnaround around time of 15 hours from request to diagnosis.

You and your covered dependents (if applicable) are eligible for this benefit if:

1. you are enrolled in a Lumen medical plan option (CDHP, Doctors Plan, HDHP or Surest) under the Lumen Health Care Plan and
2. you are:
   - an Active Employee;
   - an Employee on long-term disability, or
   - a COBRA participant If you or your eligible covered dependent(s) meet these criteria, you may access the MDLIVE benefit.

Services are provided either through phone, video or mobile app. You can register by calling MDLIVE toll free at **888-632-2738**, going to lumen.com/mdlive or through the MDLIVE Mobile App. If you are a CDHP Member, you are not required to pay a co-payment for your visit. If you are an HDHP member, the co-pay is $40 for medical services and $59 for dermatology services.

You can use MDLIVE Urgent Care when:

- You're considering the ER or urgent care center for non-emergency medical use. Remember in an emergency or life-threatening situation, call 911 or go directly to the emergency room.
- Your primary care Physician is not available.
- You are traveling and in need of medical care.
- You need an appointment during or after normal business hours, nights, weekends and holidays.
- You need to request prescriptions or get refills. MDLIVE doctors provide prescriptions only if they deem it is necessary and MDLIVE does not prescribe DEA medications.

NurseLine℠

Benefits for NurseLine℠ services described below (including any references to the program elsewhere in this document) are administered by NurseLine℠, independent of the Surest 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 Participants have access to 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:

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- A recent diagnosis.
- A minor illness or injury.
- Men's, women's, and children's wellness.
- How to take prescription drug products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

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

NurseLine℠ is available to you at no additional cost. To use this service, call 1-800-705-0821.

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

With NurseLine℠ you also have access to nurses online. To use this service, log onto www.myuhc.com where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

5.5 Transition of Care and Continuity of Care

If you are new to the Surest 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 in-network copayments for a limited time due to a qualifying medical condition until the safe transfer to an in-network Provider can be arranged. Transition of Care Benefits are managed on a case-by-case basis.

If you are currently covered by the Surest Plan and your health care Provider leaves the network, you can apply for Continuity of Care. If you have medical reasons preventing immediate transfer to a network provider, Continuity of Care Benefits will allow you the option to request extended care from your out-of-network Provider while paying in-network copayments until a safe transition can be made to an in-network Provider. Continuity of Care Benefits are managed on a case-by-case basis.

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

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

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

- **Inpatient and Residential Care:** If you are actively receiving inpatient or residential care at a Provider that 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.
- **Recent Major Surgery:** If you have had a recent surgery or procedure with an in-network provider who becomes out-of- network, are in the acute phase and follow-up period (generally six to eight weeks after surgery) you may qualify for Transition of Care or Continuity of Care.
- **Scheduled Surgery/Procedure:** If you are scheduled to undergo a nonelective surgery or procedure with an in-network Provider who becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits. Surest
- **Pregnancy:** If you are pregnant and receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care and Continuity of Care Benefits.
- **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 qualify for Transition of Care and Continuity of Care Benefits.
- **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 qualify for Transition of Care and Continuity of Care Benefits.
- **Transplant:** If you are a transplant candidate or 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 qualify for Transition of Care and Continuity of Care Benefits.

To request an application for Transition of Care (new Participants) or Continuity of Care (existing Participants), call Surest Member Services at the number on your Surest member ID card. Applications are also available on Benefits.Surest.com. 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, Surest 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.

- If your request is approved for the medical condition(s) listed on your application(s), you will receive the network level coverage for treatment of the specific condition(s) by the Provider for:
  - Up to 30 days from the effective date of coverage for new members,
  - Up to 90 days from when your provider leaves your health plan network, or
  - Through completion of the current active course of treatment period, whichever comes first.

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6. What Is Not Covered

The Surest Plan does not provide Benefits for the following services, treatments, or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition, unless specifically described or listed in Section 5.1 (Covered Health Services).

Alternative Treatments

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

Behavioral Health: Mental Health/Substance Use Disorder

12. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
13. Inpatient or intermediate or outpatient care services that were not pre-authorized.
14. Investigational therapies for treatment of autism.
15. 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.
16. 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*.
17. 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.
18. 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*

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Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

19. School-based Intensive Behavioral Therapies (IBT) service or services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA).
20. 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*.
21. Transitional living services.
22. 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.
23. Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas. This exclusion does not apply when required for the treatment of Autism Spectrum Disorders.
24. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.
25. Wilderness, adventure, camping, outdoor, or other similar programs.

Dental

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

Devices, Appliances, Supplies and Prosthetics

33. Birthing tub.
34. Cranial banding except when Medically Necessary for the treatment of plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
35. Devices and computers to assist in communication and speech except as described in Section 5.1, Durable Medical Equipment (DME) and Supplies.
36. Devices used specifically as safety items or to affect performance in sports-related activities.

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37. Disposable supplies for home use such as, but not limited to Ace-type bandages, antiseptics, bandages, diapers, dressings, incontinence supplies, gauze, and tape.
38. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits.
39. 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.
40. Oral appliances for snoring.
41. 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, and arch supports, and include orthotic braces available over-the-counter.
42. 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.
43. Repairs to prosthetic devices due to misuse, malicious damage, or gross neglect.
44. Replacement of prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.
45. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.
46. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.
47. 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.
48. Vehicle/car or van modifications including, but not limited to, car carriers, handbrakes, and hydraulic lifts.

Drugs

49. Charges for giving injections that can be self-administered.
50. Drugs dispensed by a Physician or Physician’s office for outpatient use.
51. Investigational or non-FDA-approved drugs.
52. Non-prescription supplies.
53. Over-the-counter drugs, except as specified in Section 5.2 (Prescription Drugs).
54. Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
55. Vitamin or dietary supplements, except as specified in Section 5.2 (Prescription Drugs).

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Experimental or Investigational or Unproven Services

56. Intracellular micronutrient testing.
57. Services that are considered Experimental or Investigational as determined by Surest 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 Surest Member Services.

Foot Care

58. Hygienic and preventive maintenance foot care.
59. Routine foot care (except for standard diabetic foot care). Examples include the cutting or removal of corns and calluses.

Gender Dysphoria

60. Cosmetic procedures related to a diagnosis of Gender Dysphoria including:
    a) Buttock lift.
    b) Calf implants.
    c) Chemical peels.
    d) Dermabrasion.
    e) Ear reduction (Otoplasty).
    f) Fertility preservation services.
    g) Laser or electrolysis hair removal *not* related to genital reconstruction.
    h) Neurotoxins .
    i) Piercing.
    j) Scalp tissue transfer (scalp advancement).
    k) Treatment for hair growth.
    l) Treatment received outside the United States.
    m) Wrinkle removal.

Nutrition

61. 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).
62. 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).

Physical Appearance

63. 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.

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64. Cosmetic Procedures such as:
    a) Hair removal or replacement by any means, except as part of a genital reconstruction procedure by a physician for the treatment of gender dysphoria.
    b) Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.This exclusion does not apply to liposuction for which Benefits are provided as described under Reconstructive Procedures in Section 5.1, Covered Health Services.
    c) Pharmacological regimens, nutritional procedures, or treatments.
    d) Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion 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.
65. Excision or removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
66. Physical conditioning programs such as athletic training, bodybuilding, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
67. 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.
68. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic procedure.
69. Medical and surgical treatment of excessive sweating (hyperhidrosis).
70. Treatment of benign gynecomastia (abnormal breast enlargement in males).
71. Weight loss programs, whether or not they are under medical supervision or for medical reasons, even if for morbid obesity, except as described in Section 5.4 Clinical Programs.
72. Wigs (scalp/cranial hair prostheses) except for Participants with scalp/head wound, burns, injuries, alopecia areata, and cancer who are undergoing chemotherapy or radiation therapy.

Procedures and Treatments

73. Chelation therapy, except to treat heavy metal toxicity and overload conditions.
74. Helicobacter pylori (H. pylori) serologic testing.

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75. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
76. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
77. 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.
78. 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.
79. 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.
80. 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 behavior modification techniques, intensive psychological support, and medications to control cravings.

Providers

81. Services ordered or delivered by a Christian Science practitioner.
82. 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.
83. Services performed by a Provider with your same legal residence.
84. Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.

Reproduction

85. The following fertility 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) purposes.
    d) Cloning.
    e) Cryopreservation and storage, unless it is embryo freezing and storage (up to 12 months) for embryos produced from one cycle for a Participant who will undergo cancer treatment that is expected to render them infertile.

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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) Embryo or oocyte accumulation, defined as a fresh oocyte (egg) retrieval prior to the depletion of previously banked frozen embryos or oocytes (eggs).
i) Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
j) Multi-embryo implantation.
k) Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
l) Ovulation predictor kits.
m) Reversal of voluntary sterilization.
n) Services for partners, spouses, and the maternity expenses of gestational carriers not covered by the Bind Plan.
o) Treatments considered Experimental by the American Society of Reproductive Medicine.

Services Provided Under Another Plan

86. 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, 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.

Transplants

87. Health services for transplants involving permanent mechanical or animal organs.
88. 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.)

Travel

89. Health services provided in a foreign country, unless an Emergency
90. Travel or transportation expenses, even if ordered by a Physician, except as identified under ambulance and transplant in Section 5.1 (Covered Health Services).

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Types of Care

91. Custodial Care.
92. Domiciliary Care.
93. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
94. Private Duty Nursing.
95. Respite care, except as defined under Hospice Care in Section 5.1 (Covered Health Services).
96. Rest cures.
97. Services of personal care attendants.
98. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision, Hearing and Voice

99. Implantable lenses used only to correct a refractive error such as radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
100. Refractive surgery (e.g., Lasik) for ophthalmic conditions that are correctable by contact lenses or glasses.
101. Routine eye exams (including refractions), eyeglasses, contact lenses and any fittings associated with them, except as identified in Section 5.1 (Covered Health Services).
102. 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.
103. Over-the-counter hearing aids.
104. 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.
105. The Surest 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 Surest 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.
106. Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or any other language assistive devices.

All Other Exclusions

107. Autopsies and other coroner services and transportation services for a corpse.
108. Charges for:

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a) Completion of Claim forms.
b) Missed appointments.
c) Record processing.
d) Room or facility reservations.

109. Charges prohibited by federal anti-kickback or self-referral statutes.
110. Direct-to-consumer retail genetic tests.
111. 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 made in the absence of coverage under the Surest Plan.
    b) That are received after the date the Participants coverage ends, including health services for medical conditions which began before the date the Participants coverage ends.
    c) That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war, or terrorism in a non-war zone.
    d) That exceed Eligible Expenses, or any specified limitation in this SPD.
112. Foreign language and sign language services.
113. Health care services that Surest determines are not Medically Necessary.
114. Long-term (more than 30 days) storage of blood, umbilical cord, or other material (e.g., cryopreservation of tissue, blood, and blood products).
115. 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.
116. Physical, psychiatric, or psychological exams, testing, and 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 adoption, career or employment, education, insurance, marriage, sports or camp, travel, or as a result of incarceration.
    d) Required to obtain or maintain a license of any type.
117. 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.

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7. Claims Procedures

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 Surest 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 medical Claim to the Surest Plan to be reviewed for Benefits. Whether you pay out-of-pocket, or your Provider bills the Surest 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 Surest Plan's portion of the costs, or you pay for your medical care out-of-pocket and need to be reimbursed, you must submit a medical Claim to the Surest Plan. This section summarizes the procedures you must follow to submit a medical Claim for payment, and the procedures the Surest Plan will use to determine whether and how much to pay for that medical Claim.

If you would like more details about medical Claims procedures and your rights and responsibilities, contact Surest Member Services.

Regular Post-Service Medical Claims

Post-service medical Claims are non-urgent medical Claims processed after you have received treatment. Pre-Service and Urgent Care Request for Benefits are described in Section 8 (What Do I Do If My Claim Is Denied). Generally, you do not need to file a medical Claim for services from in-network Providers; the Provider will handle the filing of the medical 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 Surest 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 Surest to be able to process your medical Claim and determine the appropriate Surest Plan Benefits:

- The name and birthdate of the Participant who received the care.
- The Participant ID listed on the Surest 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 Surest.

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Regular Post-Service Pharmacy Claims

See Section 13, Attachment I – Outpatient Prescription Drugs

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 Surest. 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.

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.

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- 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.

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8. What Do I Do If My Claim Is Denied?

If your Pharmacy Claim is Denied

See Section 13, Attachment I – Outpatient Prescription Drugs.

If Your Medical Claim is Denied

If a medical Claim for Benefits is denied in part or in whole, you are encouraged to call Surest Member Services before requesting a formal appeal. If Surest Member Services cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

To submit a medical Claim appeal:

1. Contact Surest Member Services to request a medical Appeal Filing Form or refer to the medical Appeal Filing Form included with your Explanation of Benefits.
2. Complete the medical Appeal Filing Form.
3. Submit the completed medical Appeal Filing Form along with your denial notice and any supporting documentation to:
   Surest
   Appeals Department
   PO Box 211758
   Eagan, MN 55121

Review of a Medical Appeal

Surest will conduct a full and fair review of your medical Claim appeal.

You can send us written comments, documents, records, and any other information you think will help us decide the medical Claim 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 medical 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 medical Claim 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 medical Claim.

Surest 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.

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- If your medical Claim involves medical judgment or whether the medical Claim 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.
- Surest 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 medical Claims reviewers to make denials.

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

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

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 medical 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 Surest Plan in connection with the medical Claim; and (ii) a reasonable opportunity for any Participant to respond to such new evidence or rationale.

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).

Timing of Medical Claim Appeals Determinations

Separate schedules apply to the timing of Benefit requests and medical Claim 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.

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- **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 Surest Plan must approve or for which you must notify Surest before non-urgent care is provided.
- **Post-Service Medical Claim Request for Benefits:** A medical 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 Surest Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon 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 Surest.

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

Urgent Care Request for Medical Benefits and Appeal*

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

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

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Pre-Service Request for Medical Benefits and Appeal*

Request for Pre-Service Benefits	Claims Timing
If your request for medical Benefits is filed improperly, Surest must notify you within:	**5 days**
If your request for medical Benefits is incomplete, Surest must notify you within:	**15 days**
You must then provide a completed request for medical Benefits information to Surest within:	**45 days**
Surest must notify you of the medical Benefit determination:	
• If the initial request for medical Benefits is complete, within:	**15 days**
• After receiving the completed request for medical Benefits (if the initial request for medical Benefits is incomplete), within:	**15 days***
*Surest 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 Surest 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**
Surest must notify you of the first-level medical Claim appeal decision within:	**15 days** after receiving a complete first-level medical Claim appeal
You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within:	**60 days** after receiving the first-level medical Claim appeal decision
Surest must notify you of the second-level medical Claim appeal decision within:	**15 days** after receiving a complete second-level medical Claim appeal

Post-Service Medical Claim Request for Benefits and Appeal*

Post-Service Claim	Claims Timing
If your medical Claim is incomplete, Surest must notify you within:	**30 days**
You must then provide completed medical Claim information to Surest within:	**45 days**
Surest must notify you of the Benefit determination:	
• If the initial medical Claim is complete, within:	**30 days**
• After receiving the completed medical Claim (if the initial medical Claim is incomplete), within:	**30 days**
*Surest 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 Surest 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

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Appeals (Post-Service)	Appeals Timing
Surest must notify you of the first-level medical Claim appeal decision within:	**30 days** after receiving the first-level medical Claim appeal
You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within:	**60 days** after receiving the first-level medical Claim appeal decision
The Plan Administrator must notify you of the second-level medical Claim appeal decision within:	**30 days** after receiving the second-level medical Claim appeal

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. Surest 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 Surest 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 Surest.

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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.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Surest, you may be entitled to 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 Surest fails to follow the internal appeals process described above (unless it is a minor failure).

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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.
- 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, call Surest Member Services 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 Surest.

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). Surest 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.

Standard External Review

A standard external review comprises of all of the following:

- A preliminary review by Surest of the request completed within five business days following Surest's receipt of the request.
- A referral of the request by Surest to the IRO.
- A decision by the IRO.

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Within the applicable timeframe after receipt of the request, Surest 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 Surest Plan at the time the health care service or procedure that is at issue in the request was 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 for Surest to process the request.

After completing the preliminary review, Surest will issue a notification in writing to you within one business day. If the request is eligible for external review, Surest will assign an IRO to conduct such review. Surest 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, Surest 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 whether the request is eligible for external review. Within 10-business days following the date of receipt of the notice, you may submit 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.

Surest 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 Surest.
- 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 Surest 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 Surest. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after receiving 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 Surest, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the determination made by Surest, the Surest Plan will immediately provide coverage or payment for the Benefit Claim at issue in

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accordance with the terms and conditions of the Surest Plan, and any applicable law regarding Plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Surest Plan will not be obligated to provide Benefits for the health care service or procedure.

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, Surest will determine whether the individual meets both of the following criteria:

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

After completing the review, Surest will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Surest will assign an IRO in the same manner Surest utilizes to assign standard external reviews to IROs. Surest will provide all necessary documents and information considered in making the Adverse Benefit Determination or final Adverse Benefit Determination to the assigned IRO electronically, by telephone, 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 Surest. 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

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initial notice the assigned IRO will provide written confirmation of the decision to you and to Surest.

You may contact Surest Member Services for more information regarding external review rights, or if you are making a verbal request for an expedited external review.

Limitation of Action

See the Retiree General Information Summary Plan Description for the limitation of action applicable to claims for benefits under this plan.

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.

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9. What are My Rights under ERISA?

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

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10. Continuation of Coverage

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

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11. What Else Do I Need to Know?

11.1 Important Administrative Information

Name of the Surest Plan	Surest Health Plan
Coverage Plan Year	1/1/2023 through 12/31/2023
Plan Sponsor	Lumen Technologies, Inc. 100 Centurylink Dr. Monroe, CA 71203
Plan Sponsor's Employer Identification Number (EIN)	36-2739571
Plan Number (from ERISA 5500 form)	511
Type of Surest Plan	Welfare benefit plan providing group health Benefits.
Funding	The Surest Plan is self-insured, meaning that Benefits are paid from the general assets of the Plan Sponsor and are not guaranteed under a Benefit policy or contract. The Plan Sponsor determines the amount of employee contributions to the Surest Plan, based on estimates of Claims and administrative costs.
Plan Administrator	Lumen Technologies, Inc. 100 Centurylink Dr. Monroe, CA 71203
Agent for Legal Process	If you wish to file suit, legal papers may be serviced on the Plan Administrator at the address listed below: Lumen Technologies, Inc. Chief Privacy Office 931 14th Street, 9th floor Denver, CO 80202 Legal process may also be served on: CT Corporation System 7700 East Arapahoe Road, Suite 220 Centennial, CO 80112

11.2 Coordination of Benefits

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

11.3 Right of Full Restitution (Subrogation) and Reimbursement

The Surest 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

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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 primarycoverage if given a choice when purchasing automobile insurance coverage as the Benefits available underSurest 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 Surest Health Plan, the Surest Health Plan may conditionally advance the payment of the Benefits. **If the Surest Health Plan advances payment of Benefits, the terms of this entire subrogation and reimbursement provision shallapply, and the Surest 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 Surest Health Plan advanced. The Surest 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 Surest 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 Surest Health Plan ID card. His claims are paid by his Claims Administrator under the Surest Health Plan. Once these claims are paid by the Surest 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 Surest 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 Surest 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 Surest 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 Surest Health Plan.

Benefits Conditional Upon Cooperation

By participating in the Surest Health Plan, you and your eligible Dependents acknowledge and agree to the terms of the Surest Health Plan's equitable or other rights to full restitution,

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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 ordocuments needed to enable the Plan Administrator to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree to assign to the Surest Health Plan the right to subrogate and recover Benefits directly from any third party or otherinsurer. A Surest Health Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or

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exercise the Surest 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 thethird 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 toby 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 toletters 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 claimthat 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 Surest Health Plan.

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

Note: The Surest Health Plan is subject to ERISA. –The Surest 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 Surest Health Plan in trust for the sole benefit of the Surest 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 behalfof you or your Eligible Dependent to hold 100% of the Surest 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 Surest Health Plan or its assignee and to comply with and facilitate the reimbursement to the Surest Health Plan of the monies owed it.**

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11.4 General Administrative Provisions

Plan Document

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

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 Surest 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 Surest Health Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Surest 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 Claims Administrator, or the Pharmacy Claim Administrator has the right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits. This applies to all Participants, including Enrolled Dependents whether or not they have signed the enrollment form.

The Surest 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 Surest 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 Surest Health Plan, the Plan Administrator and our related entities may use and transfer the information gathered under the Surest Health Plan, including Claim information for research, database creation, and other analytic purposes.

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Interpretation of the Surest Health Plan

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

- Interpreting Benefits under the Surest 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 Surest Health Plan
- Making factual determinations, finding, and determining all facts related to the Surest Health Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Surest 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.

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 Surest Health Plan to theLumen Plan Design Committee.

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

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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 Surest Health Plan or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other *Plan Document*s.

What Happens to Settlements, Refunds, Rebates, Reversions to the Surest Health Plan

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

Administrative Services

The Plan Administrator may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Surest 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 performance of their responsibilities.

Examination of Participants

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

Workers’ Compensation Not Affected

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

Conformity with Statutes

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

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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 5.4 "Clinical Programs".

Incentives to Providers

The Surest 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 Surest Health Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Surest 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 to impact your access to health care. Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, 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 thismonthly 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 costof 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 anyfinancial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed

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Refund of Benefit Overpayments

If the Surest 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 Surest 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 Surest Health Plan.
- All or some of the payment was made in error.

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

Your Relationship with the Claims Administrator and the Surest Health Plan

In order to make choices about your health care coverage and treatment, the Surest 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 whichyou are enrolled. The Claims Administrator does not provide medical services or make treatment decisions.

This means:

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

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

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Relationship with Providers

The relationships between the Surest 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 Surest Health Plan and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, the Surest 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 Surest Health Plan and the Claims Administrator do not have any other relationship with Network Providers such as principal-agent or joint venture. The Surest 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 Surest Health Plan.

The Plan Administrator is responsible for:

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

Your Relationship with Providers

The relationship between you and any Provider is that of Provider and patient. Your Provider is solelyresponsible 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, includingCopayments 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 towhom 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 acceptingnew patients. If a Provider leaves the Network or is otherwise not available to you, you must choose anotherNetwork Provider to get In-Network Benefits.

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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 CoveredHealth Services. Some Network Providers choose to be a Network Provider for only some products. Contact the Claims Administrator for assistance.

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.

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.

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Rebates and Other Payments

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

Review and Determine Benefits with Surest 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 ordeterminations that the Surest 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 Surest 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 for yourself or to share with your out-of-network Physician or Provider by calling the telephone number on your ID card.

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12. 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 Surest 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 Surest Plan.

Term	Definition
Addendum	Any attached written description of additional or revised provisions to the Surest 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.
Adverse Benefit Determination	An Adverse Benefit Determination is a denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity.
Alternate Facility	A health care facility that is not a Hospital and that provides one or more of the followingservices 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 outpatientbasis or inpatient basis (for example a Residential Treatment Facility).
Amendment	Any attached written description of additional or alternative provisions to the Plan/Surest Health Plan. Amendments are subject to all conditions, limitations, and exclusions of the Plan/Surest Health Plan, except for thosethat the Amendment is specifically changing.
Annual Enrollment	A period of time where eligible persons are able to enroll, disenroll, and make Surest Plan changes without a life status change.
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 indaily 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).
Authorized Representative	A person you appoint to assist you in submitting a Claim or appealing a Claim denial. You will be required to designate your Authorized Representative in writing. This could also be a Provider for urgent care Claims and expedited appeals. The appointment of an Authorized Representative is revocable by you.

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Term	Definition
Autism Spectrum Disorder	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 Surest Plan approved by the Plan Administrator as Covered Health Services, as explained in this SPD and any amendments.
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; pre-service request for Benefits and appeals; urgent care request for Benefits and appeals; concurrent care request for Benefits and appeals; and post-services Claims.
Claim Administrator	Also known as a third-party administrator, or TPA, provides Surest certain claim administration and other services for the Plan.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time. 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.
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 Service	Health care services, including supplies or Pharmaceutical Products, which are determined 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. • Not excluded in this SPD.
Custodial Care	Services that are any of the following non-skilled care services: • Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating. • Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence..
Dependent	An individual who meets the eligibility requirements specified in the Surest Health Plan, as described in the**Retiree General Information SPD**. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

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Designated Facility	A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Surest 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 Provider	A provider and/or facility that: • Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or • The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures. A Designated Provider may or may not be located within your geographic area. Not all network hospitals or network physicians are Designated Providers.
Designated Virtual Network Provider	A provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only, and/or through federally compliant secure messaging applications. These Providers services are provided exclusively or primarily though virtual communication methods.
Domestic Partner	An individual of the same or opposite sex with whom you have established a domesticpartnership as described in the **Retiree General Information SPD**.
Domiciliary Care	Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.
Effective Date	The first day of the Plan Year if you have timely completed all applicable enrollment requirements.
Eligible Charge	A charge for health care services, subject to all of the terms, conditions, limitations, and exclusions for which the Surest Plan, or Participant will pay.

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Term	Definition
Eligible Expenses	Charges for Covered Health Services that are provided while the Surest Plan is in effect and determined by the Claims Administrator. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies: • As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS). • As indicated in the most recent editions of the *Healthcare Common Procedure Coding System (HCPCS)*, or *Diagnosis-Related Group (DRG) Codes.* • 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 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, except as required under the No Surprises Act, which is a part of the Consolidated Appropriations Act of 2021.
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. 3. Serious dysfunction of any bodily organ or part.
Employee	Meets the eligibility requirements specified in the **Retiree General Information 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 anyclassification 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.
Employer	Lumen Technologies, Inc.
ERISA	The Employee Retirement Income Security Act of 1974 as amended from time to time. The federal law that regulates retirement and employee welfare benefit plans maintained by employers.
E-Visit and Telephone Consult with Your Physician	Care provided by a Physician performed without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal messages.

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

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

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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.
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 NursingFacility, 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.
Long-term Acute Care Facility (LTAC):	A facility or Hospital that provides care to people with complexmedical 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.

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Medically Necessary / Medical Necessity	A health care service is deemed Medically Necessary when it is delivered or supervised by a licensed health care 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 Surest Coverage with Evidence Development Policy. Surest ensures Medical Necessity through Utilization Management processes.
Medicare	Parts A, B, C and D of the insurance program established by Title XVIII, United States SocialSecurity 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 *InternationalClassification 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 isa 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 Surest 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

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Network/In-Network (Provider)	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 CoveredHealth 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 ofProviders 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 **"Network and Out-of-Network Benefits and Providers** (for those residing in a Network area) and Section 6 ". Providers" for details about how Network Benefits apply.
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 **"Out-of-Area Members"** (for those residing in an Out-of-Network area) and Section 6 **"Providers"** for details about how Network Benefits apply.
Out-of-Pocket Maximum	The maximum amount you pay every Calendar Year. Refer to Section 5 **"Copayments**" for the Out-of-Pocket Maximum amount. See Section 5 **"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 eligible employee or dependent properly enrolled in the Surest Plan under the eligibility rules and only while such person(s) is enrolled and eligible for Benefits under the Surest Plan.
Payroll Deductions	Premium contributions are paid by reducing the Participant's pay, typically on a pre-taxbasis, as allowed by the IRS guidelines.
Pharmacy Benefit Manager (PBM)	A third-party administrator of prescription drug programs for commercial health plans and self-insured employer plans.
Pharmacy Claims Administrator	Also known as the Pharmacy Benefit Manager, or PBM, which provides administrative services for 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. Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Surest Plan.

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Plan	Lumen Technologies, Inc. Health and Welfare Benefit Plan. Surest Health Plan is a plan offered as part of the Plan.
Plan Administrator	The person or entity, as defined under Section (3)(16) of ERISA, that has the exclusive, final, and binding discretionary authority to administer the Surest Plan, to make factual determinations, to construe and interpret the terms of the SPD, the Surest 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 Surest Plan-connected administrative services.
Plan Sponsor	Lumen Technologies, Inc. The entity that establishes and maintains the Surest Plan, has the authority to amend and/or terminate the Surest Plan and is responsible for providing funds for the payment of Benefits.
Plan Year	The period following the Effective Date of the Surest Plan and each subsequent period (generally 12 months) the Surest Plan remains in force.
Pre-Admission Notification	Process whereby the Provider or you inform the Surest Plan that you will be admitted to the inpatient hospital, Skilled Nursing Facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization, or Residential Treatment Facility. This notice is required in advance of being admitted for inpatient care for any type of non-Emergency admission and for partial hospitalization. All contracted facilities are required to provide Pre-Admission Notification to you.
Primary Physician	A Physician who has a majority of his or her practice in general pediatrics, internalmedicine, 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 PrimaryPhysician.
Prior Authorization	Pre-service, urgent care request, concurrent care benefit coverage decision for a service, procedure, or test that has been subject to an evidence-based review resulting in a Medical Necessity determination.
Private Duty Nursing	Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or an office/home setting when any of the following are true: • No skilled services are identified. • Skilled nursing resources are available in the facility. • The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. • 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 an inpatient or 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 otherwise specified.
Reconstructive	Surgery or procedure to restore or correct: • A defective body part when such defect is incidental to or follows surgery resulting from illness, injury, or other diseases of the involved body part. • A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician. • A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the Claim Administrator to be Medically Necessary.

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Residential Treatment	Treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements: • Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee. • Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation. • Provides at least the following basic services in a 24-hour per day, structured setting: – Room and board. – Evaluation and diagnosis. – Counseling. – Referral and orientation to specialized community resources. A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.
Residential Treatment Facility	A facility that is licensed by the appropriate state agency, has, or maintains a written, specific, and detailed treatment program requiring full-time residence and participation, and provides 24-hour-a-day care in a structured setting, supervision, food, lodging, rehabilitation, or treatment for an illness related to mental health and substance use related disorders.
Semi-private Room	A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.
Shared Savings Program	A program in which the network partner may obtain a discount to a non-network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network Provider. When this happens, you may experience lower out-of-pocket amounts. Surest Plan out-of-network copayments would still apply to the reduced charge. Sometimes the Surest Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the network partner, such as: • A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services* (CMS) for the same or similar service within the geographic market. • An amount determined based on available data resources of competitive fees in that geographic area. • A fee schedule established by a third party vendor. • A negotiated rate with the Provider. In this case the non-network Provider may bill you for the difference between the billed amount and the rate determined by the network partner. If this happens you should call the number on your medical member 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, carefollowing 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 SubstanceUse Disorder.

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Term	Definition
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 aSpecialist Physician.
Specialty Drugs	Infusions, injectables and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics: • Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes. • Intensive patient training and compliance assistance are required to facilitate therapeutic goals. • There is limited or exclusive product availability and/or distribution. • There are specialized product handling and/or administration requirements. • Are produced by living organisms or their products.
Spinal Treatment	The therapeutic application of chiropractic and/or Spinal Treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function in the management of an identifiable neuromusculoskeletal condition.
Spouse	An individual to whom you are legally married, or a Domestic Partner as defined in the **Retiree General Information SPD**.
Sub-Acute Facility	A facility that provides intermediate care on a short-term or long-term basis.
Summary Plan Description (SPD)	The document describing, among other things, the Benefits offered under the Surest Health Plan and your rights and obligations under such benefit option as required by ERISA.
Surest Plan	Refers to the Lumen Technologies, Inc. Retiree and Inactive Health Plan, Surest Option, as used in this SPD.
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.
Telehealth Visit	A visit with a Provider who uses a secure audio-video or audio-only telecommunications system allowing evaluation, assessment, and management of health care services.
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.

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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 supervisedapartments 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.
Unproven / Unproven Services	Health services, including medications that are not determined to be effective for treatment of the medical condition or not determined 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. Surest has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time Surest issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can contact Surest Member Services for additional information. **Please note:** If you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment), Surest may, at its discretion, consider an otherwise Unproven service to be a Covered Health Service for that illness or condition. Prior to such a consideration, Surest must first establish that there is sufficient evidence to conclude that, albeit Unproven, the service has significant potential as an effective treatment for that illness or condition.
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.

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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 allowed 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 Surest to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, 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	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). Virtual Visits may be with a Designated Virtual Provider or a non-Designated Virtual Provider. There are different Copays for a Designated Virtual Provider and a non-Designated Virtual Provider.
Well Connected	Programs that focus on prevention, education, and closing the gaps in care designed toencourage 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 assignto 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.

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13. Attachments

Attachment I – Outpatient Prescription Drugs

The Plan includes coverage for Prescription Drugs dispensed at Network pharmacies with the Copaymentslisted 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 theinformation found in Section 11.2, "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
Tier 4	$200 Copayment	Not Covered	$500 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
Tier 4	$400 Copayment

Note: The Coordination of Benefits provision described in Section 1.1, "Quick Reference" 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 Pharmacyor you must provide the Network Pharmacy with identifying information that can be verified by the ClaimsAdministrator during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you will be required topay 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 thetoll-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 "**J. Prior Authorization/Medical Necessity Requirements**". The Plan pays Benefits for certaincovered 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 onsupply 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 theCopayment 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 forExperimental 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 "**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. Pleasehave 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 toask 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 onsupply 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 PrescriptionDrugs.

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. Besure 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 "**Prescription Drug Glossary**" for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the tables at the beginning of "**A. Specialty Drug Tiers**" for detailson 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 PDLManagement 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 wasprescribed.

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 isappropriate 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 amongthe 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 coveredand 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 aredefined in "**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 Necessityapproval. The Pharmacy Claims Administrator will determine if the Prescription Drug, is in accordance withapproved guidelines:

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

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

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 responsiblefor 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 "**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 PharmacyClaims 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-free number on your ID card.

The Prescription Drugs requiring notification are subject to the Pharmacy Claims Administrator's periodic review and modification. Benefits may not be available for the Prescription Drug after the Pharmacy Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a CoveredHealth 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 ClaimsAdministrator 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 isa 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 futurepharmacy 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 mayrestrict 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-namedrug may change. As a result, your Copayment may change. You will pay the Copayment applicable for the tierto 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 treatmentregimens 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 Attachment II, **"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 wasprescribed by a Specialist Physician. You may access information on which Prescription Drugs are subject toBenefit 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 arerequired 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 therapyrequirements 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 medicationsinclude: 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 ScriptRewardsprogram.

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 thePharmacy 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 pharmaceuticalmanufacturers 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 varietyof messages, including information about Prescription Drugs. These mailings may contain coupons or offersfrom pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discountor 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 appropriatefor 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.

EXCLUSIONS: PRESCRIPTION DRUGS NOT COVERED

The exclusions listed below apply to "**PRESCRIPTION DRUGS**". In addition, exclusions from coverage listed in Section 6 "**Drugs**" also apply to this section.

When an exclusion applies to only certain Prescription Drugs, contact the Pharmacy Claims Administrator forinformation 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. PrescriptionDrugs 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 duringa 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 aprescription 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 suppliesand inhaler spacers specifically stated as covered);
7. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosedmedical 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 ManagementCommittee;
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 notmeet the definition of a Covered Health Service;
16. Prescription Drugs that contain an approved biosimilar or a biosimilar and Therapeutically Equivalent (havingessentially 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 "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.

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, butnot 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 yourPhysician 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 Physicianmay 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 ClaimsAdministrator (UHC).

Pharmacy Benefit Manager: A Third-Party Administrator of Prescription Drug programs for commercial healthplans 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 usingits 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 Drugdispensed 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 whichtier a particular Prescription Drug has been assigned by contacting the Pharmacy Claims Administrator at thephone 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 approvalthrough the Claims Administrator (UHC) to determine if the drug meets certain criteria or conditions before thedrug can be prescribed. Such criteria may include but are not limited to the medication; dose and duration; labresults; 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 effectprofile.

Usual and Customary Charge: The usual fee that a pharmacy charges individual for a Prescription Drugwithout reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Attachment II – 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, theGenetic 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 andbehaviors 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.

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 forBenefits in any way. Lumen does not receive the results or data from your survey.

Alternatives to Succeed. If you are unable to complete an activity, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternativestandard 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.

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 ormanagers 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 vendorsand 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 youservices 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 separatefrom 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. Appropriateprecautions 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 andretaliation, 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 andthe 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.

Additional Incentive Program Details

Weight Watchers Program

Weight Watchers offers a scientifically proven program for weight loss and wellness, with Digital, Studio andPersonal coaching solutions to help meet your goals. For more than 55 years, Weight Watchers has helpedmillions 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 aWeight 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 personWeight Watchers coaching, or lifetime members can receive the $50 reward after they complete 3 monthlyweigh ins. Once completed, confirm you've done so in Rally to receive your $50 reward.

Travel and Lodging

Well Connected will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments (CRS).
- For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility or Centers of Excellence.

The Plan coverage expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows.

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by an in-network Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- Eligible Expenses include lodging for the patient (while not a hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to:
    - $50 per day for the patient or up to $100 per day for the patient plus one companion; or
    - If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Facility or Center of Excellence. The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- Airfare at coach rate;

- Taxi or ground transportation; or
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility

A combined overall maximum Benefit of $10,000 per Participant applies for all travel and lodging expense reimbursed under this Plan in connection with the related treatments and procedures during the entire period that person is covered under the Plan.

Attachment III – Health Reimbursement Account (HRA) and Surest

If you elect the Surest 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 Surest 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 Surest Health Plan, you will have access to your HRA accountbalance. You can then use the money to pay yourself back for eligible Surest 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 theexpenses 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 informationas it relates to the FSA)*

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

Health Care Account Service CenterPO Box 981506

El Paso, TX 79998-1506

See the Health Reimbursement Account SPD for more information.

If you are enrolled in the Surest 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 undera 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.

Flexible Spending Accounts and Rollover HRA

Which Account Will Pay First

For eligible medical and Prescription Drug expenses, the HRA balance should always be accessed **first** until itis 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 besubmitted manually by filling out a manual Claim form found on UHCs website at myuhc.com. The prior year 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 whichyou are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

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 usedthroughout 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 standardregulations 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 enrolledin 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.