Surest Health Plan

(Administered by Surest)

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

Surest Health PPO (Retiree)

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

Effective January 1, 2026

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, 2026. 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

*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

- 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.

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 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.

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** 1-800-531-6329 **Monday – Friday** 6:00 am to 9:00 pm Central **Prescription Drug Questions:** OptumRx (Pharmacy) Member Service Refer to Section 13, Attachment I – Outpatient Prescription Drugs.
Name of the Plan (referred herein as the "Surest Plan")	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 Mailing Address Where to mail medical Claims and written inquiries.	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

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.

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*.

4. When Does My Coverage Begin and End?

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

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 paycheck deductions 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 also referred to as copayments. Your copayments for Covered Health Services are listed in Section 5.1 (Covered Health Services), Section 13 (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 may be responsible for lower copayments and the Provider may not charge you any additional fees. If you use an out-of-network Provider, you may be responsible for (in addition to your higher out-of-network copayment) all amounts that exceed the usual and customary amount, when applicable. Out-of-network Providers may be permitted to bill you for the difference between what the Plan agreed to pay and the full amount charged for a Covered Health Service. This is called "balance billing."

Once your total copayments reach your applicable out-of-pocket maximum, the Surest Plan provides Benefits at 100% of Eligible Expenses for the remainder of the Plan Year, except for amounts you pay for out-of-network Covered Health Services in excess of the usual and customary amount, when applicable. Amounts in excess of usual and customary charges 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's credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of their services. The Providers are independent practitioners and entities that are solely responsible for the care they deliver. 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.

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.

If you receive health care services from an out-of-network Provider and were informed incorrectly by the Claims Administrator prior to receipt of the Covered Health Service that the Provider was an in-network Provider, either through the Surest Plan database, provider directory, or in the Claims Administrator's response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for the same copayment that would apply if the Covered Health Service had been provided from an in-network Provider.

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. 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.

We have agreements in place that govern the relationship between us, our Plan Sponsors and in-network Providers, some of which are affiliated Providers. In-network Providers enter into agreements with us to provide Covered Health Services to Participants. 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.

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

- When Covered Health Services are received from an in-network Provider, Eligible

Expenses are the Claim Administrator's contracted fee(s) with that Provider.

- When Covered Health Services are received from an out-of-network Provider as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable copayment. Surest will not pay excessive charges or amounts you are not legally obligated to pay.

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, except as described below, 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 Expense for reimbursement (plus any applicable copayments). The amount in excess of the Eligible Expense could be significant, and this amount will NOT apply to the out-of-network out-of-pocket maximum. You may want to ask the out-of-network Provider about their billing practices before you receive care.

- For Covered Health Services that are ***Ancillary Services received at certain in-network facilities on a non-Emergency basis from out-of-network Providers***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- For Covered Health Services that are ***non-Ancillary Services received at certain in-network facilities on a non-Emergency basis from out-of-network Providers who have not satisfied the notice and consent criteria as described below***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- For Covered Health Services that are ***Emergency Health Services provided by an out-of-network Provider***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- For Covered Health Services that are ***air ambulance services provided by an out-of-network Provider***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your applicable copayment which is based on the rates that would apply if the service was provided by an in-network Provider.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. 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 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. In-network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage of the published rates allowed by CMS for Medicare for the same or similar service within the geographic market.

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

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

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

  IMPORTANT NOTICE: For Ancillary Services, and for non-Ancillary Services provided without notice and consent, you are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).
- **For Emergency health care services provided by an out-of-network Provider**, the Eligible Expense is based on either:
  - The reimbursement rate as determined by applicable federal or state law or by an applicable state *All Payer Model Agreement.*
  - The initial payment made by us or the amount subsequently agreed to by the out-of-network Provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in Section 12 (Glossary).

- **For air ambulance transportation provided by an out-of-network Provider**, the Eligible Expense is based on either:
  - The reimbursement rate as determined by applicable federal or state law or by an applicable state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator or the amount subsequently agreed to by the out-of-network Provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your copayment which is based on the rates that would apply if the service was provided by an in-network Provider which is based on the Recognized Amount as defined in Section 12 (Glossary).
- **For ground ambulance transportation provided by an out-of-network Provider**, the Eligible Expense, which includes mileage, is a rate agreed upon by the out-of-network Provider and the Claims Administrator, or, unless a different amount is required by applicable law, determined based on the median amount negotiated with in-network Providers for the same or similar service.

  IMPORTANT NOTICE: Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Recognized Amount as defined in Section 12 (Glossary).

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.

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.

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.

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.

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	$10,800
Employee + Spouse; Employee + Child	$5,400	$16,200
Family	$6,850	$20,550

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 (Covered Health Services) 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
	$375 copayment / transport	$375 copayment / transport

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Ambulance Services copayment applies to the in-network out-of-pocket maximum.
- Ground or air ambulance, as the Claims Administrator determines appropriate. Air ambulance is medical transport by helicopter or airplane.
- Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest hospital that offers Emergency health services.
- Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy.
- Ambulance Services Non-Emergency ambulance transportation provided by a licensed ambulance service (either ground or air ambulance) between facilities only when the transport meets one of the following:
  - From an out-of-network Hospital to the closest in-network Hospital when Covered Health Services are required.
  - To the closest in-network Hospital that provides the required Covered Health Services that were not available at the original Hospital.
  - From a short-term acute care facility to the closest in-network long-term acute care facility (LTAC), in-network Inpatient Rehabilitation Facility, or other in-network sub-acute care facility where the required Covered Health Services can be delivered.

- For purposes of this Benefit, the following terms have the following meanings:
  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.
- Non-Emergency air ambulance services 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	$160 copayment / visit
Applied Behavioral Analysis (ABA) Therapy	$20 copayment / visit	$160 copayment / visit
Mental Health Biofeedback	$20 copayment / visit	$160 copayment / visit
Mental Health Habilitative, Cognitive, Occupational Therapy	$15 copayment / visit	$45 copayment / visit
Mental Health Physical Therapy	$10 copayment / visit	$30 copayment / visit
Mental Health Speech Therapy	$15 copayment / visit	$45 copayment / visit
Electroconvulsive Therapy (ECT)	$2110 copayment / visit	$330 copayment / visit
Intensive Outpatient Treatment Program (IOP)	$60 copayment / visit	$180 copayment / visit
Outpatient Alcohol and Drug Treatment Program	$80 copayment / visit	$240 copayment / visit
Partial Hospitalization (PHP)/Day Treatment	$110 copayment / day	$330 copayment / day
Substance Use Disorder Medication Therapy	$35 copayment / visit	$90 copayment / visit
Transcranial Magnetic Stimulation (TMS) Therapy	$110 copayment / visit	$320 copayment / visit
Residential Treatment Facility Care	$1,600 copayment / stay	$4,800 copayment / stay
Outpatient Mental Health	$110 copayment / visit	$330 copayment / visit
Inpatient Hospital	$1,600 copayment / stay	$4,800 copayment / stay
Virtual Care	See Virtual Care section for details.	Not Applicable

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.
  - Methadone maintenance.
  - 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.
- Nutritional Counseling for mental health or substance use disorder does not have visit limits.
- 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.
- Mental Health Occupational Therapy is a visit for therapy focused on regaining daily life skills for a person with a mental health condition, such as autism.
- Mental Health Physical Therapy is a visit for therapy focused on regaining physical function for a person with a mental health condition, such as autism.
- Mental Health Speech Therapy is a visit for therapy focused on regaining speech and communication function for an individual with a mental health condition, such as autism.
- Refer to the Gender Dysphoria section for additional coverage information.

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.
  - 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.

Colonoscopy - Non-Screening	In-Network	Out-of-Network
	$0 to $1,200 copayment / visit	$2,950 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.
- A non-screening colonoscopy is a procedure performed to diagnose disease symptoms.
- Services for preventive screenings are provided under the Preventive Care Services section.

Complex Imaging	In-Network	Out-of-Network
MRI (Magnetic Resonance Imaging)	$150 to $900 copayment / visit	$1,400 copayment / visit
CT (Computed Tomography)	$100 to $725 copayment / visit	$1,725 copayment / visit
Nuclear Imaging	$150 to $1,100 copayment / visit	$3,250 copayment / visit
PET Scan	$150 to $1,400 copayment / visit	$4,200 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, one copayment applies.
- If imaging occurs using different types of imaging machines (e.g., MRI and a CT), on the same date of service, more than one copayment applies.
- 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.

Dental Services: Accidental Dental	In-Network	Out-of-Network
• **Office Visit**	$20 to $105 copayment / visit	$220 copayment / visit
All Other Services		
• **Outpatient Hospital Visit**	$150 to $850 copayment / visit	$2,550 copayment / visit
Inpatient Hospital	$2,000 Copayment / stay	$6,000 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 dentaltreatment. Coverage is limited to facility and anesthesia charges.
- Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.

- Medical Dental Services may require Prior Authorization and Medical Necessity review

Dental Services: Medical Dental	In-Network	Out-of-Network
• **Office Visit**	$20 to $105 copayment / visit	$220 copayment / visit
All Other Services		
• **Outpatient Hospital Visit**	$150 to $850 copayment / visit	$2,550 copayment / visit
• **Inpatient Hospital**	$2,000 copayment / stay	$6,000 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: is a child under age five; is severely disabled; orhas 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 and Oral Services: Oral Surgery	In-Network	Out-of-Network
Oral Surgery (removal of impacted teeth)	$600 Copayment / visit	$1,415 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.

Dental and Oral Services: Orthognathic Surgery and Temporomandibular Joint (TMJ) Disorder	In-Network	Out-of-Network
Orthognathic (Jaw) Surgery	$2,750 copayment / visit	$8,250 copayment / visit
Temporomandibular Joint (TMJ) Dysfunction Surgery	$800 copayment / visit	$2,400 copayment / visit
All other services:		
• **Office Visit**	$20 to $105 copayment / visit	$220 copayment / visit
• **Outpatient Hospital Visit**	$150 to $850 to copayment / visit	$2,550 copayment / visit
• **Inpatient Hospital**	$2,000 copayment / stay	$6,000 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.

Dialysis Services	In-Network	Out-of-Network
Dialysis	$40 to $270 copayment / visit	$810 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.
- Dialysis Services may require Prior Authorization and Medical Necessity review.

Durable Medical Equipment (DME) and Supplies	In-Network	Out-of-Network
Purchase:		
Tier 1 to Tier 12	$0 to $1,000 copayment	$20 to $1,000 copayment
Rental:		
Tier 1 to Tier 12	$0 to $100 copayment / month	$2 to $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 the following Benefits for durable medical equipment, prosthetics, orthotics, and supplies subject to any limitations noted 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 calling 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, 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. Surest generally follows Centers for Medicare and Medicaid Services (CMS) guidelines on rental vs purchase. 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 regardless of the reason for the hair loss and is limited to a maximum Benefit of $350 per Plan Year for in-network and out-of-network Providers combined.
- Eyeglasses or contacts after cataract surgery or for aphakia is limited to one frame and one pair of lenses and 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. Over-the-counter hearing aids are not covered.
- 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. Speech generating device, digitized speech, and using pre-recorded messages are eligible.
- Purchase of one standard breast pump, either manual or electric, 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	$650 copayment / visit	$650 copayment / visit
Observation Stay	$650 copayment / stay	$650 copayment / stay

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Emergency Room Visit copayment applies to the in-network out-of-pocket maximum.
- Out-of-network Observation Stay copayment applies to the in-network out-of-pocket maximum.

- Copayment applies to Emergency room facility, 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.

Fertility Preservation	In-Network	Out-of-Network
Office Visit	$20 to $105 copayment / visit	$220 copayment / visit
Iatrogenic In Vitro Fertilization	$500 copayment / service	Not Covered
Egg Retrieval for Iatrogenic Infertility	$1,500 copayment / service	Not Covered
Cryopreservation for Iatrogenic Infertility	$500 copayment / service	Not Covered
Storage for Iatrogenic Infertility	$100 copayment / year	Not Covered
Genetic Testing (PGT) for Iatrogenic Infertility	$500 copayment / visit	Not Covered

Notes:

- Refer to the Surest mobile app for additional coverage information.
- There is a combined lifetime maximum of $25,000 per Participant for covered medical fertility preservation and fertility services and a combined lifetime maximum of $15,000 for prescription medications for fertility preservation and fertility services.
- This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Participant during the entire period of time he or she is enrolled for coverage under the Plan.

Fertility Preservation for Iatrogenic Infertility:

- Benefits are available for fertility preservation for medical reasons that cause irreversible infertility, such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:
  - Collection of sperm.
  - Cryopreservation of sperm.
  - Ovulation stimulation, retrieval of eggs and fertilization.
  - Oocyte cryopreservation.
  - Embryo cryopreservation.
  - Storage up to one year.
- Benefits for medications related to the treatment of fertility preservation are provided as described in Section 13 (Attachment I – Outpatient Prescription Drugs).
- Benefits are not available for elective fertility preservation.
- Benefits are not available for embryo transfer.
- Benefits are not available for long-term storage costs (greater than one year).

Preimplantation Genetic Testing (PGT) and Related Services:

- Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:
  - PGT must be ordered by a Physician after Genetic Counseling.
  - The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).

  - Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryopreservation and short-term embryo storage (less than one year).
- Benefits are not available for long-term storage costs (greater than one year).
- You must enroll in the Fertility Solutions Program for fertility preservation coverage. Refer to Section 5.4 (Clinical Programs) for information on how to enroll in the Fertility Solutions Program.
- Dependent children are not eligible for this coverage.

Fertility Services	In-Network	Out-of-Network
Office Visit	$20 to $105 copayment / visit	$220 copayment / visit
Artificial insemination	$100 copayment / service	Not Covered
Egg Retrieval	$1,500 copayment / service	Not Covered
Embryo Transfer	$750 copayment / service	Not Covered
Cryopreservation	$500 copayment / service	Not Covered
Storage	$100 copayment / year	Not Covered
Thawing	$150 copayment / service	Not Covered
Genetic Testing (PGT)	$500 copayment / visit	Not Covered
Donor Services (Egg)	$1,200 copayment / service	Not Covered
Donor Services (Sperm)	$300 copayment / service	Not Covered

Notes:

- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one service is performed during a visit.
- There is a combined lifetime maximum of $25,000 per Participant for covered medical fertility preservation and fertility services and a combined lifetime maximum of $15,000 for prescription medications for fertility preservation and fertility services.

The Surest Plan provides Benefits for fertility services and associated expenses for Participants enrolled in the Surest plan including:

- Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Fertility Treatment 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.
- Therapeutic services for fertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:
  - Assisted Reproductive Technologies (ART), including but not limited to, egg ooctye retrieval, fresh or frozen embryo transfer, intracytoplasmic sperm injection (ICSI), gamete intrafallopian transfer (GIFT), in-vitro fertilization (IVF), pronuclear stage tubal transfer (PROST), tubal embryo transfer (TET), and zygote intrafallopian transfer (ZIFT).
  - Ovulation induction and controlled ovarian stimulation.
  - Cryopreservation, and storage of embryos for up to 12 months.
  - Frozen embryo transfer cycle including the associated cryopreservation and storage of embryos for up to 12 months.
  - Insemination procedures (artificial insemination [AI] and intrauterine insemination [IUI]).
  - Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) – male factor associated surgical procedures for retrieval of sperm.

  - Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
  - Electroejaculation.
  - Pre-implantation Genetic Testing (PGT) is a biopsy 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 and PGT-SR for structural rearrangements).
- If a Participant is bypassing reversal of sterilization and requesting direct fertility treatment (IVF), the IVF would be covered.
- A cycle is defined as one partial or complete fertilization attempt extending through the transfer phase only.
- Participant must use Center of Excellence in order for services to be covered. Services with any other provider will not be covered unless a GAP exception is allowed. If there is no COE within 60 miles, a GAP exception is allowed for a Participant to go to a non-COE and have claims paid at the COE benefit level.
- Please refer to other sections of the SPD for Covered Health Services for diagnosis and treatment of underlying medical condition which may cause infertility such as surgical procedures: laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, and ovarian cystectomy. These are described under Laboratory Services, X-Rays, and Diagnostic Test – Outpatient, Office Visit, Diagnostic Visit, and Treatments / Tests / Therapies.
- The medical Plan provides Benefits for certain prescription medications or products, including specialty medications, for the treatment of infertility that are administered by a medical Provider on an outpatient basis in a hospital, alternate facility, physician's office, or in your home.
- Fertility Benefits for prescription medications or products for outpatient use that are filled by a prescription order or refill are described in Section 13 (Attachment I - Outpatient Prescription Drugs).

Donor Coverage:

- The Surest Plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The Surest Plan will not pay for donor charges associated with compensation, administrative services or any non-medical expenses.

Criteria to be Eligible for Benefits:

- To be eligible for fertility services, you must be an enrolled employee or spouse/domestic partner, enrolled in the Fertility Solutions Program and receive services from a Designated Provider. Refer to Section 5.4 (Clinical Programs) for information on how to enroll in the Fertility Solutions Program.
- You do not need to have a diagnosis of Infertility in order to be eligible to receive fertility services.
- This benefit is not available to dependent children.
- To be eligible for Benefits, the Covered Person must
  - Must be under age 44, if female and using own eggs / oocytes
  - Must be under age 55, if female and using donor eggs / oocytes

  For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

Gender Dysphoria Services	In-Network	Out-of-Network
Mental Health Office Visit	$20 copayment / visit	$160 copayment / visit
Gender Dysphoria Voice Therapy	$15 copayment / visit	$45 copayment / visit
Gender Dysphoria Surgery	$110 to $1,600 copayment / visit	$330 to $4,800 copayment / visit
Gender Dysphoria Reconstructive Services	$20 to $110 copayment / visit	$160 to $330 copayment / visit

Notes:

- Refer to the Surest mobile app for additional coverage information.
- The following services are covered for Gender Affirming Services:
  - Psychotherapy for Gender Affirming 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.
  - Members must be 18 years of age or older for the surgical treatment of Gender Dysphoria.
- Surgery treatment for Gender Dysphoria, includes the surgeries listed below:
  - Procedures that may be performed in support of a gender affirming surgery, including skin grafts or flap surgery.
  - Abdominoplasty and body contouring
  - Dermatology
  - Hair removal
  - Hair transplantation
  - 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:
    - Blepharoplasty (eyelid lift).
    - Brow lift.
    - Forehead lift.

- Facial bone remodeling.
- Facial feminization and masculinization.
- Lip reshaping.
- Rhinoplasty (nose reshaping).
- Thyroid cartilage remodeling / thyroid chondroplasty / tracheal shave (remodeling of the Adam's apple).
- Face lift.
- Neck tightening.
- Voice modification surgery.

- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Gender Affirming 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.

Home Health Services	In-Network	Out-of-Network
• **Home Health Care Visit**	$60 copayment / visit	$180 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	$60 copayment / visit	$180 copayment / visit
Inpatient Hospice Care	$2,000 copayment / stay	$6,000 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.

Hospital Services - Other	In-Network	Out-of-Network
Outpatient Hospital Visit	$150 to $850 copayment / visit	$2,550 copayment / visit
Inpatient Hospital	$2,000 copayment / stay	$6,000 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 services such as radiation device placement, outpatient pulmonary function testing, esophageal dilation, and hip dysplasia treatment.
- 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 Tests	$20 to $1,250 copayment / visit	$150 to $2,500 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 Tests 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:
    - Angiography (Arteriography).
    - Cardiac Event Monitoring.
    - Coronary Calcium Score (Heart Scan).
    - Cystometrogram (CMG).
    - Diagnostic Hearing Exams and Testing.
    - Echocardiogram Exercise Stress Test.
    - EKG Exercise Stress Test.
    - Electroencephalogram (EEG).
    - Electromyography (EMG) and Nerve Conduction Studies (NCS).

    - Gastrointestinal Motility Testing.
    - Genetic Testing.
    - Home Sleep Test & Unattended Sleep Study.
    - Attended Sleep Study (Polysomnography).
    - Non-cardiac Angiography, Arthrography, and Myelography.
    - Pulmonary Function Tests.
    - 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.
- The following categories of Genetic Testing services are covered:
  - Genetic tests for cancer susceptibility.
  - Genetic tests for hereditary diseases.
  - Unspecified molecular pathology.
  - Fetal aneuploidy testing.
- 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	$160 copayment / visit
Amniocentesis	$500 copayment / test	$1,500 copayment / test
Chorionic Villus Sampling (CVS)	$550 copayment / test	$1,650 copayment / test
Inpatient Delivery	$900 to $2,000 copayment / stay	$6,000 copayment / stay
Home Birth/Delivery	$900 copayment / visit	$2,700 copayment / visit
Newborn Nursery Care	$0 copayment / test	$0 copayment / test
Elective Abortion – Non-Surgical	$90 copayment / visit	$270 copayment / visit
Elective Abortion - Surgical	$160 copayment / visit	$480 copayment / visit
Abortion – Non-Surgical (Medically Necessary)	$90 copayment / visit	$270 copayment / visit
Abortion – Surgical (Medically Necessary)	$160 copayment / visit	$480 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.
- Inpatient deliveries do not require Prior Authorization or notification unless the mother is hospitalized more than 48-hours following a normal vaginal delivery and 96-hours following a normal cesarean section delivery. Stays beyond these time periods may require Prior Authorization and Medical Necessity review.
- **Dependent Child’s Pregnancy:** Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness, or Injury for certain Participants. However, direct, or indirect expenses incurred for a Dependent Child’s Pregnancy are not covered. **Please Note:** This exclusion does **not** apply to pre-natal services for which Benefits are provided under the Preventive Care Services Benefit, including certain items and services under the United States Preventive Services Task Forcerequirements or the Health Resources and Services Administration (HRSA) requirement or care to save the life of the mother. If you reside in the State of Massachusetts, the benefit coverage for a Dependent Child’s Pregnancy is different, and the Bind Health Plan covers additional Benefits. If you have questions on which pre-natal services for a Dependent Child’s Pregnancy are covered, please contact Surest Member Services.

Medical Infusions, Injectables, and Chemotherapy	In-Network	Out-of-Network
Cancer Chemotherapy	$25 to $650 copayment / visit	$225 to $1,950 copayment / visit
Provider Administered Drugs	$40 to $2,600 copayment / visit	$450 to $7,800 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, and cancer chemotherapy administered on an outpatient basis in a hospital facility, alternate facility, in a Physician’s office, or in the home. This includes intravenous chemotherapy or other intravenous infusion therapy.
- 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.
- 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.
- Supportive drugs that are often unplanned for your diagnosis and treatment, such as IV fluids or antibiotic injections, have a $0 copayment.
- Provider Administered Drugs and Cancer Chemotherapy that are typically for planned administration have their own copayments when given in a non-emergent outpatient setting. If a mixture of drugs is needed for a chemotherapy visit, the copayment of the highest cost drug will apply to that visit.
- 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.
- 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 [Outpatient Prescription Drugs]).
- Select Medical Infusions, Injectables and Chemotherapy 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 $105 copayment / visit	$220 copayment / visit
Mental Health Office Visit (including Telehealth Visit)	$20 copayment / visit	$160 copayment / visit
Allergy Injection Visit	$0 copayment / visit	$160 copayment / visit
Allergy Testing and Treatment	$110 copayment / visit	$330 copayment / visit
Convenience Care / Retail Visit	$25 copayment / visit	Not Covered
Cor Medical Onsite Clinic: Office Visit and Mental Health Office Visit	$0 copayment / visit	Not Applicable
Cor Medical Onsite Clinic Preventive (Wellness)	$0 copayment / visit	Not Applicable
Cor Medical Onsite Clinic Physical Therapy Visit	$0 copayment / visit	Not Applicable
E-Visit and Telephone Consult with Your Physician	$20 copayment / visit	$220 copayment / visit
Outpatient Anticoagulant Management	$20 copayment / visit	$60 copayment / visit
Naturopathic Professional Visits	$35 copayment / visit	$130 copayment / visit
Virtual Care	See Virtual Care 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.
- Multiple copayments may apply if a treatment or procedure is also performed during a visit.
- Hearing Services – Assessments with your Provider.
- 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.
- Preventive Nutritional Counseling – Focuses on preventing chronic diseases and promoting overall health before any symptoms or diagnoses appear. Generally, as part of a wellness visit.
  - Counseling to prevent obesity, type 2 diabetes, heart disease, or high cholesterol.
  - Dietary guidance for individuals at risk due to family history of lifestyle factors.
- Non-Preventive Nutritional Counseling – Focuses on managing or treating existing health conditions.
  - Nutrition therapy for diabetes management, kidney disease, eating disorders, or recovery from surgery.
  - Counseling for patients already experiencing symptoms or complications.
- Nutritional counseling does not have visit limits.
- Virtual Care refers to a visit with a Designated Virtual Network Provider such as Doctor on Demand or K Health. See Virtual Care 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.
- Naturopathic Professional Services limited to 20 visits per Participant per Plan Year for Network and out-of-network Providers combined. If your Provider refers you for a test or service within a hospital or other facility, the Outpatient Hospital copayment may apply.
- Returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Palliative Care	In-Network	Out-of-Network
Office Visit	$20 to $105 copayment / visit	$220 copayment / visit
Home Health Care Visit	$60 copayment / visit	$180 copayment / visit
Outpatient Hospital Visit	$150 to $850 copayment / visit	$2,550 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.
- See Hospice Care notes for services related to Hospice.

Preventive Care Services	In-Network	Out-of-Network
Preventive Care Services	$0 copayment / visit	$160 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.
- 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. This includes mammography, breast ultrasounds and breast MRIs.
  - 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 (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
	$40 to $2,100 copayment / visit	$210 to $6,300 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 for Radiation Therapy and Other High Intensity Therapy 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:
  - Actinotherapy.
  - Apheresis.
  - Blood Transfusion.
  - Brachytherapy.
  - Conventional External Beam Radiation Therapy (EBRT).
  - Hyperbaric Oxygen Therapy (HBOT).
  - Non-Oral Radiopharmaceutical Therapy.
  - Oral Radiopharmaceutical Therapy.
  - 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.
- See Dialysis Services for services for dialysis and home.

Reconstructive Surgery	In-Network	Out-of-Network
Office Visit	$20 to $105 copayment / visit	$220 copayment / visit
Outpatient Hospital	$150 to $850 copayment / visit	$2,550 copayment / visit
Inpatient Hospital	$2,000 copayment / stay	$6,000 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.

Rehabilitative/Habilitative Services and Other Low Intensity Therapy	In-Network	Out-of-Network
Acupuncture Visit	$50 copayment / visit	$150 copayment / visit
Biofeedback	$60 copayment / visit	$180 copayment / visit
Aural Therapy – Post Cochlear Implant	$20 to $140 copayment / visit	$220 copayment / visit
Cardiac Rehabilitation Therapy	$60 copayment / visit	$180 copayment / visit
Chiropractic Visit	$25 copayment / visit	$75 copayment / visit
Cognitive Therapy	$15 to $105 copayment / visit	$185 copayment / visit
Occupational Therapy	$15 to $105 copayment / visit	$185 copayment / visit
Physical Therapy	$10 to $75 copayment / visit	$225 copayment / visit
Speech Therapy	$15 to $105 copayment / visit	$185 copayment / visit
Pulmonary Rehabilitation Therapy	$80 copayment / visit	$240 copayment / visit
Vision Therapy	$20 copayment / visit	$220 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 40 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 40 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 do not have visit limits.
  - Cognitive rehabilitation therapy following traumatic brain injury or cerebral vascular accident is covered when Medically Necessary.
- Physical therapy does not have visit limits.
- Pulmonary Rehabilitation does not have limits.
- Speech therapy does not have visit limit.
- 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.
- Note that Occupational Therapy and Physical Therapy are different types of services and the copayment varies based on how the claim is billed.
- Therapies related to the treatment of a mental health condition, such as autism disorder, are provided under Behavioral Health – Mental Health and Substance Use Disorder services section and do not apply to limits in this section.

Skilled Nursing Facility Services	In-Network	Out-of-Network
Skilled Nursing Facility	$1,500 copayment / stay	$4,500 copayment / stay
Inpatient Rehabilitation Facility	$1,500 copayment / stay	$4,500 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	$2,100 copayment / visit	Not Covered
Corneal Transplant	$2,200 copayment / visit	Not Covered
CAR T and Non-Genetic Cellular Therapy	$2,100 copayment / visit	Not Covered
Cellular and Gene Therapy	$2,100 copayment / visit	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.
- 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 available for CAR T and non-genetic cellular therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility. Note this Benefit excludes the gene therapies as described in Section 6 (What Is Not Covered). Benefits for CAR T therapy for malignancies are provided as described above.
- 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 5.3 (Clinical Programs and Resources) 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 Transplant Resource Services program provides Benefits for travel and lodging expenses. for the patient, and a companion. up to a maximum of $10,000 per transplant procedure. See Complex Medical Conditions Travel and Lodging Assistance Program in Section 5.3 (Clinical Programs and Resources) for more information.

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., biofeedback, needle biopsy, pain management procedures, etc.)	$35 to $2,850 copayment / visit	$210 to $8,550 copayment / visit
• **Level 2:** Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, etc.)	$0 to $2,950 copayment / visit	$620 to $8,850 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.)	$170 to $3,000 copayment / visit / stay	$1,500 to $9,000 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.)	$300 to $2,750 copayment / visit / stay	$6,000 to $9,000 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.)	$1,100 to $3,000 copayment / visit / stay	$6,300 to $9,000 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 $105 copayment / visit	$220 copayment / visit
• **Outpatient Hospital Visit**	$150 to $850 copayment / visit	$2,550 copayment / visit
• **Inpatient Hospital**	$2,000 copayment / stay	$6,000 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.
  - 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 Designated Provider.
- Bariatric surgery does not have a limit.
- 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.
- 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	$60 copayment / visit	$180 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 Care – Designated Provider	In-Network	Out-of-Network
Virtual Primary and Urgent Care	$0 copayment / visit	Not Covered
Virtual Mental Health & Substance Use Disorder	$20 to $60 copayment / visit	Not Covered
Virtual Specialty Care	$0 to $105 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 care is for 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 care provides 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 Designated Virtual Network Provider, see the Office Visit section for additional Telehealth Visit copayment information. Benefits are available only when services are delivered through a Designated Virtual Network 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 Network Provider.
- No virtual care coverage for out-of-network Providers.
- Please note that not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which in-person Physician contact is needed.

Travel and Lodging for Covered Health Services

For Travel and Lodging related to complex medical conditions, see Section 5.4 (Clinical Programs and Resources).

The Plan provides a Participant with a travel and lodging allowance related to the Covered Health Service that is not available in the Participant's state of residence due to law or regulation when such services are received in another state, as legally permissible.

Travel and Lodging provides support for the Participant under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Participant and travel companion when the Participant must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Participant. An allowance of up to $2,000 per Participant per year will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per day for the Participant, or $100 per day for the Participant with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, see Benefits.Surest.com or contact Surest Member Services.

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.

5.2 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. 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
- 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

5.3 Clinical Programs and Resources

Surest Care Management

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

Surest 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 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.

The Transplant Resource Services provides Benefits for travel and lodging expenses. See Complex Medical Conditions Travel and Lodging Assistance Program for more information.

Complex Medical Conditions Travel and Lodging Assistance Program

This is the travel and lodging assistance program for the complex medical conditions described below.

The Plan provides you with Travel and Lodging assistance for certain Covered Health Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the necessary distance from your home address to the facility is at least 50 miles. Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call Surest Member Services.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Participant and a travel companion as follows:

- Transportation of the Participant and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below.
- The eligible expenses for lodging for the Participant (while not a hospital inpatient) and one companion.

- If the Participant is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Participant resides at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Participant and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Participant for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, combined for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

  Examples of items that are not covered:
  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the in-network Provider or Designated Provider.
- Taxi, Uber/Lyft fares (not including limos or car services / rental cars).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Surest Digital Health Solutions

Surest Digital Health Solutions are programs offered by 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. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services, or go to www.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.

Ardynn (formerly known as MyCancerJourney)

Ardynn, 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. Ardynn'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 Benefits.Surest.com website or call Surest Member Services, or go to www.ardynn.com/surest.

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

Well Connected Incentive Program and Resources to Stay Healthy

See Attachment II.

2nd.MD

If you're planning a non-emergency knee, hip, shoulder, or spine surgery, consider getting a second opinion through 2nd.MD to explore your options before moving forward.

Cor Medical

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

Calm Health

Calm Health provides digital support techniques designed to help you relax, shift perspectives or cope with stressful situations.

Calm Health provides tools and support, such as:

- Mood and health data tracking over time.
- Integrated goal-setting and progress assessments.
- Relaxation techniques.

Calm Health can be accessed through Benefits.Surest.com or the Surest mobile app.

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 with cancer-related services* ***received at a Designated Facility****.*

To receive Benefits under the CRS program, **you must obtain Prior Authorization from** Well Connected **PRIOR** to obtaining Covered Health Services. The 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.
- 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.

Fertility Solutions

When you enroll in the Fertility Solutions Program, you will be able to work with fertility nurses who can provide support and encouragement throughout your experience, help answer your questions, and assist you with things like:

- Getting information about the causes of infertility and treatment options.
- Helping you find doctors, clinics, and facilities within the designated facilities participating in the Fertility Solutions (FS) Program.

Navigating the health care system and how to best use your health benefit.

- Fertility Solutions Provides education and counseling through individualized case management, utilization management and access to a highquality Fertility Centers of Excellence (COE) network. Fertility Solutions offers comprehensive support to employees throughout the treatment process. For more information, or call 1-866-774-4626.

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.

MD LIVE – Virtual Visits

MD LIVE 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 MD LIVE 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. MD LIVE'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 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 (HDHP or Surest) under the Lumen Health Care Plan and
2. you are:
   - an Retired 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 MD LIVE benefit.

Services are provided either through phone, video or mobile app. You can register by calling MD LIVE toll free at **888-632-2738**, going to lumen.com/mdlive or through the MD LIVE Mobile App. If you are an HDHP member, the co-pay is $52 for medical services and $59 for dermatology services.

You can use MD LIVE 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. MD LIVE doctors provide prescriptions only if they deem it is necessary and MD LIVE does not prescribe DEA medications.

Quit Genius: Confidential, digital support to quit or cut back on drinking

Quit Genius is an app and virtual program to help explore and improve your relationship with alcohol. It includes one-on-one virtual coaching with a licensed counselor, 24/7 access to self-guided activities and ways to track your progress in the app, and (optional) medication to help with cravings, shipped discreetly to your home. This program is free for all Lumen employees, spouses and dependents 18+ on a Lumen medical plan. Visit lumen.com/quitgenius to get started. Questions? Contact the Quit Genius team at 877-349-7755 or members@quitgenius.com.

Visana Health

Visana Health's virtual women's health clinic offers expert women's healthcare with unlimited virtual visits, prescription medications, and personalized treatment plans with ongoing support. Our OBGYNs, Nurse Practitioners, and health coaches are experts in the treatment and management of a wide range of women's health conditions, including those that cause pelvic pain, period pain, and painful periods such as fibroids, endometriosis, and more.

Get the time you need to discuss your history, concerns, and treatment goals with intake appointments that last up to 45 minutes. Appointments are available after-hours and on the weekends. Visana Health offers an unprecedented level of care coordination; our care coordinators are available on-demand to support you with any follow-up testing, appointments, or pharmacy needs. Get automatic enrollment in personalized care programs that will help address chronic pain, menopause symptoms, and other issues.

In addition to clinical care, our care programs include 1-1 access to our care teams and include health coaching, pelvic floor exercise, nutrition, and mental health support.

For more information, call 612-424-0844 or visit visanahealth.com/lumen

Wondr Health

Wondr Health™ is a digital behavioral change program focused on weight management that helps participants improve their physical and mental wellbeing through simple, interactive, and clinically-proven skills and tools. By treating the root cause of obesity through behavioral science, Wondr reduces risk factors to prevent chronic diseases like diabetes and hypertension, helps enhance employee productivity and engagement, decreases claims costs, and improves overall physical and mental wellbeing.

A master class of sorts, Wondr Health's team of renowned doctors and scientists teaches practical, data- backed skills that empower participants to stress less, sleep better, and feel better. The highly personalized program has helped hundreds of thousands of people by flipping diet culture upside down and teaching employees the science of eating the foods they love so they can still lose weight. Through the app, online community, certified coaches, and series of weekly videos that offer a new perspective on better health, participants enter a world

where weight loss is a science, small steps lead to big changes, perspectives are flipped, possibilities are infinite, and good habits last.

Wondr is a full 52-weeks of support (three phases):

- WondrSkills™: learn simple, repeatable skills through personalized weekly lessons tailored to unique eating and activity behaviors.
- WondrUp™: Practice and build on foundational skills to prevent weight regain.
- WondrLast™: Maintain progress and keep the weight off with weekly episodes on participant- requested and seasonal topics based on the latest research.

Wondr is covered 100% by Lumen sponsored health plan as a preventive care benefit so there is no out-of-pocket cost for you. Employees, spouses, and covered dependents over age 18 enrolled in the Lumen medical plan are eligible to apply to the program.

How to get signed up:

- Visit: Lumen.com/wondrhealth
- Click Apply Now: complete the short online application form
- Acceptance: once you're accepted, you may begin the program or select your start date
- Welcome Kit: a welcome kit complete with information and resources will arrive via mail
- Participant questions and support, visit: https://support.wondrhealth.com

5.4 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.

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

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.

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.
- **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 or 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 or 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 or 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 or 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 for medical services,
  - Up to 90 days from the effective date of coverage for new members for behavioral health services,
  - 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.

6. What Is Not Covered

The Surest Plan does not provide Benefits for the following services, treatments, or supplies (including items or services that are related to the services, treatments, or supplies listed below, but which are not specifically listed below) 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 Spectrum Disorders.
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, pyromania, kleptomania, and paraphilic disorder.
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*

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 accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental and Medical in Section 5.1 (Covered Health Services). This exclusion does not apply to dental care (oral exam, x-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan.
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 (Covered Health Services) under Durable Medical Equipment (DME) and Supplies. Examples of not covered items include iPads and Android tablets.
36. Devices used specifically as safety items or to affect performance in sports-related activities.
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 (under the medical plan)

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 13 (Outpatient Prescription Drugs).
54. Certain new prescription medications or products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

    This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening sickness or condition, under such circumstances, Benefits may be available for the new prescription medications or product to the extent provided in Section 5.1 (Covered Health Services).
55. A pharmaceutical product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year.
56. A pharmaceutical product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year.
57. A pharmaceutical product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. For the purpose of this exclusion a "biosimilar" is a biological pharmaceutical product approved based on showing that it is highly similar to a reference product (a biological pharmaceutical product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
58. Certain pharmaceutical products for which there are therapeutically equivalent (having essentially the same efficacy to adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six time during a calendar year.
59. Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
60. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Participants for self-administration.
61. Vitamin or dietary supplements, except as specified in Section 13 (Outpatient Prescription Drugs).

Experimental or Investigational or Unproven Services

62. Intracellular micronutrient testing.

63. 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

64. Routine foot care. Examples include:
    a) Cutting or removal of corns and calluses.
    b) Nail trimming, nail cutting, or nail debridement.
    c) Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

    This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
65. Treatment of flat feet.
66. Treatment of subluxation of the foot.
67. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.
68. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.
69. Shoe inserts.
70. Arch supports.

Gender Dysphoria Services

71. Cosmetic procedures related to a diagnosis of Gender Dysphoria including:
    a) Buttock lift.
    b) Calf implants or augmentation.
    c) Chemical peels.
    d) Dermabrasion.
    e) Ear reduction (Otoplasty).
    f) Fertility preservation services.
    g) Gluteal augmentation.
    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

72. Enteral feedings and other nutritional and electrolyte formulas, including infant formula, blenderized food, 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) This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 5.1 (Covered Health Services).
73. 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).
74. Nutritional education that is non-disease specific, such as general good eating habits, calorie control or dietary preferences (e.g., vegetarian, macro-biotic).

Physical Appearance

75. 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.
76. Excision or removal of hanging skin on any part of the body, unless Medically Necessary. Examples include plastic surgery procedures called abdominoplasty, brachioplasty and panniculectomy.
77. Physical conditioning programs such as athletic training, bodybuilding, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
78. 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.

79. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic procedure.
80. Medical and surgical treatment of excessive sweating (hyperhidrosis).
81. Treatment of benign gynecomastia (abnormal breast enlargement in males).
82. 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 5.3 (Clinical Programs and Resources).

Procedures and Treatments

83. Chelation therapy, except to treat heavy metal toxicity and overload conditions.
84. Helicobacter pylori (H. pylori) serologic testing.
85. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
86. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
87. 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.
88. 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.
89. Rehabilitation services for speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or Autism Spectrum Disorder.
90. 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

91. Services ordered or delivered by a Christian Science practitioner.
92. 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.
93. Services performed by a Provider with your same legal residence.
94. Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.

Reproduction

95. The following fertility treatment-related services, except as described in Section 5.1 (Covered Health 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) Assisted reproductive technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
d) Cloning.
e) Storage and retrieval of all reproductive materials. Examples includes eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT-M and PGT-SR) and related services in Section 5.1 (Covered Health Services).
f) Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
g) Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
h) The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
    a. Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. This refers to purchasing a donor egg that has already been retrieved and is frozen.
    b. Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
i) Embryo or oocyte accumulation, defined as a fresh oocyte (egg) retrieval prior to the depletion of previously banked frozen embryos or oocytes (eggs).
j) In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to In vitro fertilization for which Benefits are provided as described under Preimplantation Genetic Testing (PGT-M and PGT-SR) and related services in Section 5.1 (Covered Health Services).
k) Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
l) Ovulation predictor kits.
m) Reversal of voluntary sterilization.
n) Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
o) Fertility treatment following unsuccessful reversal of voluntary sterilization.
p) Fertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).
q) Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

r) Services for partners, spouses, and the maternity expenses of gestational carriers not covered by the Surest Plan.
s) Treatments considered Experimental by the American Society of Reproductive Medicine.
t) Services and supplies not received from a designated provider or by an out-of-network Provider.

96. Fertility services for a female who has either:
a) attained age 44 and using your own oocytes (eggs); or
b) attained age 55 and using donor oocytes (eggs).

97. Note: for treatment initiated prior to the pertinent birthday, fertility services will be covered to completion of the initiated cycle.

Services Provided Under Another Plan

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

Transplants

99. Health services for transplants involving permanent mechanical or animal organs.

100. 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

101. Health services provided in a foreign country, unless required as Emergency Health Care Services.

102. Travel or transportation expenses, even if ordered by a Physician, except as identified under Ambulance Services and transplant in Section 5.1 (Covered Health Services) or in Section 5.4 (Clinical Programs and Resources) for Complex Medical Conditions Travel and Lodging Assistance Program.

Types of Care

103. Custodial Care.

104. Domiciliary Care.

105. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
106. Private Duty Nursing.
107. Respite care, except as defined under Hospice Care in Section 5.1 (Covered Health Services).
108. Rest cures.
109. Services of personal care attendants.
110. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision, Hearing and Voice

111. Implantable lenses used only to correct a refractive error such as radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
112. Refractive surgery (e.g., Lasik) for ophthalmic conditions that are correctable by contact lenses or glasses.
113. Routine eye exams (including refractions), Eyeglasses, contact lenses and any fittings associated with them, except as identified in Section 5.1 (Covered Health Services).
114. 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.
115. Over-the-counter hearing aids.
116. 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.
117. 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.
118. Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or any other language assistive devices.

All Other Exclusions

119. Autopsies and other coroner services and transportation services for a corpse.
120. Charges for:
    a) Completion of Claim forms.
    b) Missed appointments.
    c) Record processing.
    d) Room or facility reservations.

121. Charges prohibited by federal anti-kickback or self-referral statutes.
122. Direct-to-consumer retail genetic tests.
123. 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, or caused by services in the armed forces 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 the Recognized Amount when applicable, or any specified limitation in this SPD.
124. Foreign language and sign language services.
125. Health care services that Surest determines are not Medically Necessary.
126. Long-term (more than 30 days) storage of blood, umbilical cord, or other material (e.g., cryopreservation of tissue, blood, and blood products).
127. 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.
128. Physical, psychiatric, or psychological exams, testing, and all forms of vaccinations and immunizations, or treatments when:
    a) Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 5.1 (Covered Health Services).
    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.
129. 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.

    In the event an out-of-network Provider waives, does not pursue, or fails to collect, copayments or other amount owed for a particular health care service, no Benefits are provided for the health care service when the copayments are waived, not pursued, or not collected.

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.

Regular Post-Service Pharmacy Claims

See Section 13 (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.

- 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.

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

If your Pharmacy Claim is Denied

See Section 13 (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
   Consumer Affairs (Member Appeals)
   P.O. Box 31270
   Salt Lake City, UT 84131

Review of a Medical Appeal

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

You can send written comments, documents, records, and any other information you think will help 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 Surest reviews your medical Claim appeal, Surest will take into account all comments, documents, records, and other information you give, 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.

- 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, we will give you the identification of any medical expert who gave 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.

- **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.

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. Surest will notify you if Surest determines 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. Surest will notify you if Surest determines that the additional time is needed before the 30 days expires.	
You must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination

Appeals (Post-Service)	Appeals Timing
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.

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).

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.

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

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

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

You cannot bring any legal action against the Plan Administrator or Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your Claim have been completed.

Claim for Payroll Adjustment and Deadlines

There is a separate claims process if you dispute the deductions from your paycheck for your Surest Health PlanBenefits.

Reminder to Review Your Paycheck Deductions

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

- Confirm your medical bi-weekly premium deductions based on your medical plan election and how you answered the enrollment questions for the tobacco-free discount and the working spouse/domestic partner surcharge.

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

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

1. within 180 days of an adverse 1st level decision by the Plan Administrator, or
2. the earlier of **(a)** within 180 days of the Effective Date of an election that is later claimed to be erroneous, or **(b)** by the last day of the Plan Year of when the election error is claimed to have occurred.

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

The Required Forum for Legal Disputes

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

9. What are My Rights under ERISA?

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

10. Continuation of Coverage

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

11. What Else Do I Need to Know?

11.1 Important Administrative Information

Name of the Surest Plan	Surest Health Plan
Coverage Plan Year	1/1/2026 through 12/31/2026
Plan Sponsor	Lumen Technologies, Inc. 100 Centurylink Dr. Monroe, LA 71203
Plan Sponsor's Employer Identification Number (EIN)	72-0651161
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, LA 71203
Agent for Service of Process	If you wish to file suit, legal papers may be serviced on the Plan Administrator at the address listed below: Lumen Technologies, Inc. Associate General Counsel/ERISA 931 N. 14th Street Denver, CO 80202 Legal process may also be served on: Lumen Technologies, Inc. 214 East 24th Street Vancouver, WA 98663

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 example, an auto accident). This includes, but is not limited to, any claim for damages or entitlement to recover from your or another party's:

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

No-fault insurance benefits and auto medical payments coverage should always be selected as the primary coverage if given a choice when purchasing automobile insurance coverage as the Benefits available under Surest 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 shall apply, 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 alleged comparative fault or contributory negligence in causing the Injury(ies) or accident for which the Plan advanced medical benefits.**

Example:

Mr. Jones is a participant in the 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 are electronically sent to Cotiviti, 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 information regarding the accident (auto carrier/attorney/ etc.) and contacts the involved parties putting them on notice of the Surest Health Plan's interest. The recovery services administrator follows the case until a settlement is made between Mr. Jones and the at fault auto carrier and/or any uninsured/underinsured auto insurance. The 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, 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 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 or its delegated recovery vendor and you must provide the information requested. **If you retain legal counsel, your counsel must also contact the Plan Administrator or its delegated recovery vendor;** and,
7. Inform the Plan Administrator or recovery vendor in advance of any settlement proposals advanced or agreed 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.**

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.

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 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.

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 any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

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 Physician make 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.

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, including Copayments and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Provider, the cost of any non-Covered Health Service;
- must decide if any Provider treating you is right for you (this includes Network Providers you choose and Providers to whom you have been referred); and
- must decide with your Provider what care you should receive.

It is possible that you might not be able to obtain services from a particular Network Provider. The Network of Providers is subject to change. Or you might find that a particular Network Provider may not be 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.

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.

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.

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.

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.
Ancillary Services	Items and services provided by out-of-network Physicians at a Network facility that are any of the following: • Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; • Provided by assistant surgeons, hospitalists, and intensivists; • Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary; • Provided by such other specialty practitioners as determined by the Secretary; and • Provided by an out-of-network Physician when no other Network Physician is available.
Annual Enrollment	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.
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	Plan payments for Covered Health Services, subject to the terms and conditions of the Plan as explained in this SPD and any addendums and/or 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.
Claims Administrator	Provides 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 they are 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.
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 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 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.
Durable Medical Equipment (DME)	Medical equipment that is all of the following: • Ordered or provided by a Physician for outpatient use primarily in a home setting. • Used for medical purposes. • Not consumable or disposable except as needed for the effective use of covered DME. • Not of use to a person in the absence of a disease or disability. • Serves a medical purpose for the treatment of a sickness or injury. • Primarily used within the home.
Effective Date	The first day of the Plan Year if you have timely completed all applicable enrollment requirements.

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 health of the Participant (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. 2) Serious impairment to bodily functions. 3) Serious dysfunction of any bodily organ or part.

Emergency Health Care Services	With respect to an Emergency: • An appropriate medical screening exam (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and • Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)). • Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation or an inpatient stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met: a) The attending Emergency Physician or treating Provider or facility, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition. b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. c) The patient is in such a condition to receive information as stated in b above and to provide informed consent in accordance with applicable law. d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law. e) Any other conditions as specified by the Secretary. The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.
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	Services 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.

Experimental / Investigational Service(s)	A procedure, study, test, drug, equipment, or supply will be considered Experimental and/or Investigational if 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.
Gender Dysphoria	A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
Home Health Agency	A program or organization authorized by law to provide health care services in the home.
Hospital	An institution, operated as required by law, which: • Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, Mental Health, Substance Use Disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and • has 24-hour nursing services. A Hospital is not primarily a place for rest, Custodial Care, or care of the aged and is not a Skilled Nursing Facility, convalescent home, or similar institution.

Independent Freestanding Emergency Department	A health care facility that: • Is geographically separate and distinct and licensed separately from a hospital under applicable state law; and • Provides Emergency Health Care services
Infertility	A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.
Injury	Damage to the body, including all related conditions and symptoms.
Inpatient Rehabilitation Facility	A long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.
Inpatient Stay	An uninterrupted confinement, following formal admission to a Hospital, Skilled 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.

Medically Necessary / Medical Necessity	Health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee. • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your sickness, injury, mental illness, substance-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms. *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator. The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Participants, Physicians and other health care professionals on Benefits.Surest.com. Participants may also call the telephone number on your ID card.
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
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 Covered Health Services, or to be a Network Provider for only some products. In this case, the Provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and an out-of-network Provider for other Covered Health Services and products. The participation status of Providers will change from time to time.
Network/In-Network (Benefits)	Description of how Benefits are paid for Covered Health Services provided by Network Providers. Refer to Section 5 **"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, naturopath, or other Provider who acts within the scope of their license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes 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.
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: • Services exceed the scope of intermittent care in the home. • Skilled nursing resources are available in the facility. • The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. • 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.
Recognized Amount	The amount which the copayment is based on for the below Covered Health Services when provided by out-of-network Providers: • Out-of-network Emergency Health Care Services. • Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary. The amount is based on one of the following in the order listed below as applicable: 1) An All Payer Model Agreement if adopted; 2) Applicable state law; or 3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility. The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider. Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.
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.

Residential Treatment	Treatment in a facility which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services treatment. The facility must meet all of the following requirements: • It is established and operated in accordance with applicable state law for Residential Treatment programs. • It provides a program of treatment under the active participation and direction of a Physician. • It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services: – 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.
Secretary	As that term applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*. This definition encompasses the secretary of HHS, DOS and Treasury.
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.
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 Substance Use Disorder.
Skilled Care	Skilled nursing, teaching, and rehabilitation services when: • they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; • a Physician orders them; • they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair; • they require clinical training in order to be delivered safely and effectively; and • they are not Custodial Care, as defined in this section.

Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law. Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.
Specialist Physician	A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.
Specialty Drugs	Infusions, injectables and non-injectable prescription drugs, as determined by the 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 ancillaryphysiologic 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 Surest health plan 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	Live interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Participant's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.
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.

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	Services, including medications and devices regardless of *U.S. Food and Drug Administration (FDA)* approval, 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. (Two or more treatments are compared to each other, and the patientis not allowed to choose which treatment is received. • Well-conducted cohort studies from more than one institution. (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 sickness 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 sickness or condition. Prior to such a consideration, Surest must first establish that there is sufficient evidence to conclude that, even though Unproven, the service has significant potential as an effective treatment for that sickness 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.

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 Care	Virtual care is for 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 care provides communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).
Well Connected	Programs that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.
Well Connected Nurse	The primary nurse (Personal Health Nurse) that the Claims Administrator may 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.

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 the information 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 Home Delivery Pharmacy**	**Out of Network Pharmacies**
Preventive	$0 Copayment	Not Covered	$0 Copayment	Not Covered
Tier 1	$15 Copayment	Not Covered	$37.50 Copayment	Not Covered
Tier 2	$60 Copayment	Not Covered	$150 Copayment	Not Covered
Tier 3	$180 Copayment	Not Covered	$450 Copayment	Not Covered
Tier 4	$360 Copayment	Not Covered	$900 Copayment	Not Covered
Appetite Suppression/Weight Control Medications	$500 Copayment	Not Covered	$1,250 Copayment	Not Covered

A. Specialty Drug Tiers

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

Specialty Pharmacy	
	30-Day Supply
Tier 1	$260 Copayment
Tier 2	$285 Copayment
Tier 3	$360 Copayment
Tier 4	$460 Copayment

B. Identification Card (ID Card) — Network Pharmacy

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

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you will be required 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.

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 Home Delivery Network Pharmacy, you are responsible for paying the lower of:

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

D. Retail

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

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

- as written by a Physician;
- up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits; A 90-day supply at retail may be obtained and pay a copay per month's supply.
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 30-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 for Experimental or Investigational, or Unproven Services.*

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

E. Price Edge Cost List

The Price Edge Cost (PEC) List is a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes when a Prescription Drug Product is obtained from a retail Network Pharmacy or a mail order Network Pharmacy. This

list is subject to the Claims Administrator review and may change from time to time. When a Generic Prescription Drug Product is included on the PEC List and is dispensed by a retail Network Pharmacy or a mail order Network Pharmacy, the PEC List price will only apply when the PEC List price is the lowest cost option for the Covered Person. You may access the amount you will pay for Prescription Drug Products to be dispensed by a retail Network Pharmacy or a mail order Network Pharmacy by contacting the Claims Administrator at the toll-free number on your ID card or by logging onto optumrx.com.

F. Home Delivery

You may (but are not required to) use OptumRx Home Delivery pharmacy for most maintenance medications.Through OptumRx Home Delivery 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**".

G. Getting Started

Option 1: Call OptumRx at 1-800-531-6329.

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

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

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

- Mail in your written prescriptions along with a completed order form.; or
- Ask your doctor to call 1-800-791-7658 with your prescriptions or to fax them to 1-800-491-7997.

Option 3: Log on to optumrx.com. You

can get started by:

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

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

The Plan pays Home Delivery 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 Home Delivery Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drugs.

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

H. 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.

I. Specialty Prescription Drugs

You must fill a prescription for Specialty Prescription Drugs at the Designated Pharmacy. 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 andDesignated Pharmacy. Refer to the tables at the beginning of "**A. Specialty Drug Tiers**" for details on Specialty Prescription Drug supply limits.

Note: To lower your out-of-pocket Prescription Drug costs:

Consider Tier 1 Prescription Drugs, if you and your Physician decide they are appropriate.

J. Assigning Prescription Drugs to the PDL

The Pharmacy Claims Administrator Prescription Drug List Pharmacy and Therapeutics

(P&T) Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the Pharmacy and Therapeutics (P&T) Committee takes into account a number of factors including, but not limited to, clinical and economic factors.

Clinical factors may include:

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

Economic factors may include:

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

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

When considering a Prescription Drug for tier placement, the Pharmacy and Therapeutics (P&T) Committee reviews clinical and economic factors regarding Participants as a general population. Whether a particular Prescription Drug is appropriate for an individual Participant is a determination that is made by the Participant and the prescribing Physician.

The Pharmacy and Therapeutics (P&T) Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six times per Calendar Year and may occur without prior notice to you.

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

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined in “**Prescription Drug Glossary**”.

Prescription Drug List (PDL)

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

K. Prior Authorization/Medical Necessity Requirements

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

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

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

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

L. 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.

M. Out-of-Network Pharmacy Prior Authorization

The plan does not cover Prescription Drugs that are dispensed at an out-of-network Pharmacy

N. Prescription Drug Benefit Claims

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

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

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

O. Limitation on Selection of Pharmacies

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

P. Supply Limits

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

Note: *Some products are subject to additional supply limits based on criteria that the Plan*

Administrator and the Pharmacy Claims Administrator have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

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

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

R. Special Programs

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

S. 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.

T. Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug was prescribed by a Specialist Physician. You may access information on which Prescription Drugs are subject to Benefit enhancement, reduction, or no Benefit by calling the telephone number on your ID card.

U. Step Therapy

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

You may determine whether a particular Prescription Drug or Pharmaceutical Product is subject to step therapyrequirements by visiting optumrx.com or by calling the number on the back of your ID card.

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 offers from 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 Home Delivery 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.

X. Claims and Appeals Procedure

The Claims and Appeals Procedures for Outpatient Prescription Drug Claims are the same as those set forth in Sections 7 and 8 above. However, Claims and Appeals must be submitted to:

OptumRx
P.O. Box 29077
Hot Springs, AR 71903

If your Outpatient Prescription Drug Claim is Denied

If a Claim for Benefits is denied in part or in whole, you may call Surest at the number on your ID card before requesting a formal Appeal. If Surest cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal Appeal as described in Section 8.

Your Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by the Claims Administrator, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information, please visit www.uhcprovider.com under the following path: Resources Drug Lists and Pharmacy Additional Resources_Patient Protection and Affordable Care Act $0 Cost-Share Preventive Medications Exemption Requests (Commercial Members).

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 for information on which Prescription Drugs are excluded. This listing is subject to change and is updated from time to time and over time.

Medications that are:

1. for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
2. any Prescription Drug for which payment or benefits are provided or available from the local, state, or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
3. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. 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 supplies and inhaler spacers specifically stated as covered);
7. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition;
8. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
9. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
10. certain Prescription Drugs that have not been prescribed by a Specialist Physician;
11. certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee
12. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the Pharmacy and Therapeutics (P&T) Committee;
13. prescribed, dispensed, or intended for use during an Inpatient Stay;
14. weight loss drugs excluded except those covered by the Plan and prescribed by a qualified Provider;

15. Prescription Drugs, including new Prescription Drugs or new dosage forms, that OptumRx determines do 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 or convenience 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/OptumRx) as a Brand-name drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

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

Designated Pharmacy: A pharmacy that has entered into an agreement with the Claims Administrator (UHC/OptumRx) 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/OptumRx) 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/OptumRx).

Network Pharmacy: A retail or Home Delivery pharmacy that has:

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

NON FORMULARY - Non-formulary drugs are not covered by your Plan, however may be filled at a Tier 4 cost share if certain criteria is met.

PDL: See Prescription Drug List (PDL).

Pharmacy and Therapeutics (P&T) Committee: See Prescription Drug List (PDL) Management Committee of the ClaimsAdministrator (UHC/OptumRx).

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/OptumRx) 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/OptumRx) 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/OptumRx) 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.

Prior Authorization/Medical Necessity: Some non-life-threatening Prescription Drugs require prior approvalthrough the Claims Administrator (UHC/OptumRx) 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.

Vital Medication List: Products on the Vital Medication List are covered at no out-of-pocket cost to you. This list includes certain preferred insulins. Log on to optumrx.com for more information or call the number on your ID card.

Attachment II – Well-Being Rewards Program

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

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

Well-being Rewards Program

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

Participation is Voluntary. Participation is completely voluntary and without charge. If you choose to participate in the well-being rewards program, you will be asked to complete a voluntary Health Survey that asks a series of questions about health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the Health Survey. For details on how the incentive program works, visit lumen.com/wellbeing.

The Incentive. Employees and their eligible spouses/domestic partners may earn up to a maximum of $600 each per calendar year by completing eligible wellness activities. Activities must be completed by the applicable deadline for each plan year to be eligible for rewards. Unless otherwise specified, most activities must be completed by December 31 of the plan year; however, certain activities may have an earlier deadline. Although you are not required to complete the Health Survey, the Health Survey is the gatekeeper to unlock your wellness rewards. **Once you complete** this activity, you will be eligible to earn and redeem rewards for all other rewardable activities.

Note: You will see your reward options outlined in Optum Engage along with how to redeem rewards after earning them.

In addition to the rewards, you can earn Optum Engage points for specific wellness activities as indicated. Optum Engage points are accumulated and can be used to enter sweepstakes for prizes, auctions, and discounts for merchandise and services, or you can donate points earned to charities listed on Rally. ***Note:*** *Sweepstakes winners will be taxed (and receive a 1099) only if the prize value exceeds $599.*

Alternatives to Succeed. If you are unable to complete an activity, you may be entitled to reasonable accommodation or an alternative standard. You may request reasonable accommodation or an alternative standard by contacting the Wellness Support Team at **877-370-1130**.

Use of Health Information. Information obtained through your Health Survey and other reward activities 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 additional services such as coaching or condition management. You also are encouraged to share your results or concerns with your own healthcare provider. Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way. Lumen does not receive the results or data from your survey.

Protections from Disclosure of Medical Information
The Claims Administrator (UHC) is required by law to maintain the privacy and security of your personally identifiable health information. Although the Well-being 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-being 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-being Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Well-being Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

In addition, all medical information obtained through the Well-being Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Well-being Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and the event of a data breach involving information you provide in connection with the Well-being 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-being Program, nor may you be subjected to retaliation if you choose not to participate.
If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Integrity Line at **800-333-8938** or email at integrityline@lumen.com.

Reward Redemption. Rewards may be redeemed as deposits to your Health Savings Account (HAS) or as gift cards, subject to applicable terms and conditions. You have up to 120 days after the end of the plan year to request your rewards. Once you are no longer an active employee or eligible for the Plan for any reason (i.e. termination, retiree, LTD, COBRA, leave

the US, etc.) or your eligible Spouse/Domestic Partner are no longer covered by the Plan, your wellness rewards cannot be redeemed after the last day of the month in which you or your Spouse/ Domestic Partner's coverage or employment with Lumen ends.

Gift Cards. Rewards are earned and redeemed for a variety of gift cards that are displayed online. You can either request an eGift Card or a plastic Visa gift card. You are taxed on the value of the card at the time the card is redeemed not at the time you actually use it as a transaction. Except where prohibited by law, a Monthly Fee of $2.50 per month will be applied to the remaining balance of this Card after the 12th month following the date of activation.

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

Tax Implications. Employees will continue to have the option to receive earned wellness rewards as a deposit to their Health Savings Account (HSA) or through gift cards. The IRS considers Wellness Rewards taxable income **EXCEPT** for wellness rewards deposited into an HSA.

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

Note: For a current list of eligible wellness activities and details on how to earn and redeem rewards, please visit the well-being rewards program page on InsideLumen or lumen.com/wellbeing.

Attachment III – Spenddown Health Reimbursement Account (HRA) for Surest Plans

If you elect one of the Surest Health Plans and have a balance in your CDHP Health Reimbursement Account (HRA) these funds will follow you. Your prior HRA funds will become available after a run-out period of 45 days. Once the funds are available you will receive a new Health Care Spending Card.

The Spenddown HRA funds will be used to reimburse medical and pharmacy expenses. Claims will automatically roll over to your Spenddown HRA.

Forty-five (45) days after your coverage starts on one of the Surest Health Plans, you will have access to your Spenddown HRA account balance. If you received eligible health care services during the run-out period, you can use the funds once available to pay yourself back by manually submitting a claim.

To be reimbursed from your available HRA funds submit a reimbursement form, called Request for Withdrawal Form which is available online at myuhc.com. You must include proof of the expenses incurred such 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.

To make sure the Claim is processed promptly and accurately, a completed claim form must be attached

and mailed to UnitedHealthcare HRA claims submittal address:

Health Care Account Service Center

PO Box 981506

El Paso, TX 79998-1506

Qualified Life Event (QLE) – Midyear

If you are enrolled in any of the Medical Health Plans and experience a Qualified Life Event (QLE) which may allow you to change your benefit options and you have a balance in either the Post Deductible HRA or the Spenddown HRA, refer to the applicable HRA account information above.

Flexible Spending Accounts and Spenddown HRA

Which Account Will Pay First

For eligible Medical and Prescription Drug expenses, the Spenddown HRA balance will always be accessed **first** until it is depleted before your 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.

HRA Glossary

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

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

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

Attachment IV – Additional Programs

Cariloop

Caring for a spouse. Helping aging parents. Supporting friends. Starting a self-care journey. Caregiving takes many forms. That's why you now have access to Cariloop®, a caregiving benefit provided at no cost by Lumen. Access to coaches and tools is just a few steps away:

1. Activate your account: Go to www.cariloop.com/register and click Get Started. Sign up with your work email. (You can add a personal email or phone later.)
2. Confirm your email: Cariloop will send you a 6-digit code to your work email. Enter that code to finish activating your account.
3. Access your benefits: Once activated, you have access to the extensive features of the Caregiver Support Platform®, where you can:
    a. Explore free tools and resources, including: notes, medication tracker, community channels to connect with like-minded individuals, and many more
    b. Connect with a Cariloop Coach for hands-on guidance and support, to answer any questions you have
    c. Browse articles and guides written by Cariloop Coaches designed to support you through every stage of your journey

Prefer to talk with someone directly? Call Cariloop at 972-232-7561 (English or Spanish). Need technical help? Email us at support@cariloop.com.

Hinge Health Virtual Physical Therapy

Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their MSK needs. The programs include:

(a) Prevention - This is a software only program (no coaching, sensors or other hardware). This Program is designed to increase education regarding key strengthening and stretching activities around healthy habits.

(b) Chronic - evidence-based care for joint pain in a program that includes the following: personalized exercise therapy sessions guided by motion tracking technology, 1:1 access to personal health coach, personalized educational content, and behavioral health support. The Chronic Program consists of (i) the Hinge Health proprietary exercise band systems and technologies; (ii) coaching and alert features; and (iii) Cloud-based data capture and reporting capabilities; and (iv) personalized analytics capabilities. Participants in the Chronic Program may also be offered the non-invasive ENSO High Frequency Impulse TherapyTM pain treatment device and service, as appropriate, for symptomatic relief and management of pain.

(c) Acute - Program designed to address recent injuries which includes live virtual sessions with a dedicated licensed Physical Therapist along with software guided rehabilitation and education.

(d) Surgery - Program provides members with access to a physical therapist, a health coach, and motion-guided exercise therapy, and covers both pre-and post-surgical rehabilitation for the most common MSK surgeries and is designed as a continuation of the Chronic Program.

(e) Expert Medical Opinion - Service offering second opinions focused on elective MSK procedures.

For applicable programs a participant may obtain up to six virtual physical therapy sessions per episode prior to in-person healthcare provider or physical therapy care (additionally, other state laws may limit access without a physician's referral).

Eligibility
To be eligible for the Hinge Health programs, you, and your eligible dependents must meet each of the following requirements: (i) be enrolled in a UHC or Surest medical plan (ii) be age 18 or older (iii) be located in the United States, and (iiii) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

Cost
If you are eligible, Hinge Health is offered at no cost to you.

Hinge Health Contact Information
To get started with Hinge Health, visit lumen.com/hingehealth to enroll.
If you have any questions regarding Hinge Health, email help@hingehealth.com or call (855) 902-2777.

MD Live – Virtual Visits

MD Live 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 MD Live 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. MD Live'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 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.

Eligibility

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

1. you are enrolled in the Lumen HDHP medical 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 MD Live benefit.

How to Access MD Live

Services are provided either through phone, video or mobile app. You can register by calling MD Live toll free at **888-910-8622**, going to lumen.com/mdlive or through the MD Live Mobile App. If you are an HDHP member, care visits through MD Live will have the following charges:

- Urgent Care/Medical - $58
- Primary Care, Annual Wellness or Routine Care visit -$106 - $159
- Behavioral Health - $47 - $258
- Dermatology - $75

When to use MD Live

You can use MD Live 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. MD Live doctors provide prescriptions only if they deem it is necessary and MD Live does not prescribe DEA medications.

MD Live will be implementing a policy for virtual primary care appointments to include a $25 fee for patients who either miss or cancel their appointment within 24 hours of their appointment time.

Pelago

Pelago: Confidential support for alcohol, tobacco/nicotine, cannabis and opioid use.

Pelago is a digital health benefit available to you and your covered family members through Lumen that helps you build a healthier relationship with substances like alcohol, nicotine (including vaping and smokeless tobacco), cannabis, and opioids. Whether you want to quit, cut back, or simply check in on your habits, Pelago offers care that fits your goals.

Key features of Pelago:

- One-on-one guidance from licensed coaches or counselors
- Tools to track your habits and view insights
- Mindfulness sessions and self-guided exercises
- 24/7 access on your own schedule

Pelago is available at no cost to Lumen employees, spouses/domestic partners, and dependents ages 15+ enrolled in a Lumen medical plan.

Visit lumen.com/pelago to get started. Questions? Contact the Pelago team at **877-349-7755** or members@pelagohealth.com.

Real Appeal Program

UnitedHealthcare provides the Real Appeal program which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support employees over the age of 18.
This intensive, extremely interactive weekly online group coaching sessions that combines video with live coaching to drive small behavior changes week-by-week for 26 weeks and then monthly for the remaining 26 weeks (52-week virtual approach). The experience will be personalized for each employee though an introductory call and may include, but not limited to, the following:

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

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional

information regarding the program, please call Real Appeal at 844-344-REAL (7325) Or visit lumen.com/realappeal.

Visana

Visana Health's virtual women's health clinic offers expert women's healthcare with unlimited virtual visits, prescription medications, and personalized treatment plans with ongoing support. Our OBGYNs, Nurse Practitioners, and health coaches are experts in the treatment and management of a wide range of women's health conditions, including those that cause pelvic pain, period pain, and painful periods such as fibroids, endometriosis, and more.

Get the time you need to discuss your history, concerns, and treatment goals with intake appointments that last up to 45 minutes. Appointments are available after-hours and on the weekends. Visana Health offers an unprecedented level of care coordination; our care coordinators are available on-demand to support you with any follow-up testing, appointments, or pharmacy needs. Get automatic enrollment in personalized care programs that will help address chronic pain, menopause symptoms, and other issues.

In addition to clinical care, our care programs include 1-1 access to our care teams and include health coaching, pelvic floor exercise, nutrition, and mental health support.

Weight Watchers Program

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

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

Employees and spouses/domestic partners who are enrolled in a UHC or Surest Health Plan medical plan will be eligible to receive up to $55/month for participating in Weight Watchers. A prescription from your doctor to participate in the Weight Watchers program is required to receive this reimbursement along with a receipt and a Weight Watchers Reimbursement Form which can be found on the Company Intranet.

Wondr Health

Wondr Health™ is a digital behavioral change program focused on weight management, that helps participants improve their physical and mental wellbeing through simple, interactive, and clinically-proven skills and tools. By treating the root cause of obesity through behavioral science, Wondr reduces risk factors to prevent chronic diseases like diabetes and hypertension, helps enhance employee productivity and engagement, decreases claims costs, and improves overall physical and mental wellbeing.
A master class of sorts, Wondr Health's team of renowned doctors and scientists teaches practical, data-backed skills that empower participants to stress less, sleep better, and feel

better. The highly personalized program has helped hundreds of thousands of people by flipping diet culture upside down and teaching employees the science of eating the foods they love so they can still lose weight. Through the app, online community, certified coaches, and series of weekly videos that offer a new perspective on better health, participants enter a world where weight loss is a science,small steps lead to big changes, perspectives are flipped, possibilities are infinite, and good habits last.

Wondr is a full 52-weeks of support (three phases):

- **WondrSkills™:** learn simple, repeatable skills through personalized weekly lessons tailored to unique eating and activity behaviors.
- **WondrUp™:** Practice and build on foundational skills to prevent weight regain.
- **WondrLast™:** Maintain progress and keep the weight off with weekly episodes on participant- requested and seasonal topics based on the latest research.

Wondr is covered 100% by Lumen sponsored health plan as a preventive care benefit so there is no out of pocket cost for you. Employees, spouses, and covered dependents over age 18 enrolled in a Lumen medical plan are eligible to apply for the program.
How to get signed up:
Visit: Lumen.com/wondrhealth

Click Apply Now: complete the short online application form

Acceptance: once you're accepted, you may begin the program or select your start date

Welcome Kit: a virtual welcome kit will be sent to you complete with information and resources you can use throughout the program.

Participant questions and support, visit: support.wondrhealth.com

Quit For Life Program

The Claims Administrator provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.
If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.

- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card.