Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan for Non-Medicare Eligible Retirees

Summary Plan Description

Updated 2023

The Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan Summary Plan Description (SPD) is intended to be read in conjunction with the separate SPD for the Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program. This SPD, when combined with the SPD describing the Comcast NBCU Post-Retirement Health Care & Retiree Reimbursement Account Program, forms a complete SPD as required by the Employment Retirement Income Security Act of 1974, as amended, describing the Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account Program for retirees and eligible dependents.

THE RETIREE HEALTH CARE PROGRAM

Comcast and NBCUniversal (collectively, “Comcast NBCUniversal”), affiliates of Comcast Corporation are proud to offer you valuable benefit programs to support your needs. This Summary Plan Description (also referred to as “SPD”) applies to some or all of the benefits you receive or may choose to receive as a retiree of Comcast NBCUniversal. It has been developed to help you learn about and understand the Independence (Independence) Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan which are benefit components of the Comcast Comprehensive Retiree Health and Welfare Plan (“Plan” or “official Plan Document”). Keep this SPD handy and refer to it when you have questions about your benefits.

If you participate in, or are eligible to participate in, the Post-Retirement Retiree Reimbursement Account, refer to the separate SPD for more information about benefits under this plan. This SPD, when combined with the SPD describing the Post-Retirement Health Care & Retiree Reimbursement Account Program, forms a complete Summary Plan Description as required by the Employment Retirement Income Security Act of 1974, as amended, describing the Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account Program for retirees and eligible dependents.

Many of the benefit programs offered are covered under the federal law known as the Employee Retirement Income Security Act of 1974 (also referred to as “ERISA”.) This document will serve as the SPD for those benefits. Although the plans have been summarized in everyday language, this SPD does not replace the legal documents governing the plans. If there is any information in this SPD that is not in the official Plan document, then this SPD governs. If there is a conflict in language that exists between this SPD and the official Plan document or insurance contracts, the official Plan document will govern. If the official Plan document is silent on a specific issue, then the SPD controls on that issue.

The administration of the benefit plans is the responsibility of the Plan Administrator. The Plan Administrator has the discretionary authority and the responsibility to, among other things, interpret the Plan provisions, and to exercise discretion where necessary or appropriate in the interpretation, administration, and determination of eligibility for benefits under the plans, except to the extent such responsibility has been delegated.

Comcast Corporation reserves the right, by action of the appropriate representative, to amend, modify, suspend, or terminate the plans at any time, in whole or in part, in accordance with Comcast Corporation’s normal operating procedures. These modifications or terminations may be made for any reasons Comcast Corporation or its representatives deem appropriate, or as a result of changes in the laws that govern the plans. Comcast Corporation’s rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers and third party administrators, etc., at any time, and the right to revise the amount of retiree contributions. Nothing in this SPD is intended to guarantee that benefit levels or costs will remain unchanged in future years. By law, retirees will be notified of any material modifications to the Plan.

Comcast Corporation cannot advise you regarding tax, investment, or legal considerations relating to the Plan. Therefore, if you have questions regarding benefit planning, you should seek advice from a personal advisor (e.g., legal counsel, tax advisor, investment advisor.)

Comcast Corporation intends for this plan to be a “retiree-only plan” and exempt from the application of the Patient Protection and Affordable Care Act (ACA).

If you have any questions after reading this SPD, please contact Mercer Marketplace 365+ Retiree[SM*] at 1-866-435-5135. Comcast NBCUniversal has engaged Mercer Marketplace 365+ Retiree[SM] to provide Comcast NBCUniversal retirees and their eligible spouses, domestic partners, civil union partners and dependents with personalized support from knowledgeable, licensed benefits counselors. Mercer Marketplace 365+ Retiree counselors are trained to assist with claims and coverage matters. Where directed to contact Independence, please use the contact information provided.

Retirees, who while employed were represented by a labor union or Guild may, or may not, be eligible for any or all of the benefits, plans or programs described in this document. The eligibility of union-represented former employees for these benefits, plans or programs may be governed by the applicable collective bargaining agreement(s) and/or be subject to collective bargaining.

*Services provided by Mercer Health & Benefits Administration LLC.

THE INDEPENDENCE STANDARD AND MINIMUM PPO PLANS AND CVS/CAREMARK PRESCRIPTION DRUG PLAN

The Independence Standard and Minimum Preferred Provider Organization Plans for Non-Medicare-Eligible Retirees ("Independence Standard and Minimum PPO Plans") cover a broad range of expenses, from hospitalization to doctors' visits to prescription drugs. These plans also include mental health and substance use coverages and prescription drug coverage. This Summary Plan Description contains information on:

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Comcast NBCUniversal Retiree Health Care Program

The Comcast NBCUniversal Retiree Health Care Program ("Retiree Health Care Program") is intended for individuals who retire immediately following their separation of employment from Comcast NBCUniversal and is primarily designed to help bridge these individuals to Medicare eligibility, which occurs at age 65. The Program contains the following two components:

- **Retiree Reimbursement Account or "RRA"** — this account is set up and funded by Comcast NBCUniversal and may be used to reimburse you and your eligible spouse, domestic partner or civil union partner for eligible health care premiums. For more information about the RRA, please see *The Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account SPD*.
- **Retiree health care coverage you choose** — you can access retiree health care coverage through a private health care marketplace (sometimes referred to as a private health care exchange) administered by Mercer Marketplace 365+ Retiree. You may also choose coverage through a public health care exchange. Other coverage options are also available if you meet certain eligibility requirements. See *the Comcast NBCU Post-Retirement Health Care & Retiree Reimbursement Account SPD* for a description of the range of available retiree health care coverage options.

Retirees and their dependents who meet eligibility requirements may participate in the Independence Standard and Minimum PPO Plans and the CVS/Caremark Prescription Drug Plan.

General Provisions

Administration of the Plan

Comcast Corporation's Benefits Fiduciary Committee is the Plan Administrator and, as such, has full charge of the operation and management of the Plan. Comcast Corporation has retained the services of independent third-party Claims Administrators experienced in medical and prescription drug claims review.

Comcast Corporation has designated the following third-party Claims Administrators as the named Claims Fiduciary for appeals involving the Plan benefits.

- Independence Blue Cross (Independence): medical plan benefits
- CVS Caremark: prescription drug benefits

As Claims Fiduciary, the Claims Administrator maintains discretionary authority to review all denied claims for benefits under the Plan for which it has been designated the named Claims Fiduciary, including, but not limited to:

- Denial of certification of hospital or medical services, supplies, and treatment;
- Interpretation of the terms of the Plan; and
- Determination of eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.

Interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

As Claims Fiduciary, the Claims Administrator will have discretionary authority to determine entitlement to Plan benefits as determined by the official Plan document for each claim received and to construe the terms of the Plan. However,

Comcast Corporation has the sole and complete authority to determine eligibility of persons to participate in the Plan. It is also agreed that the Claims Administrators have no other ERISA Fiduciary responsibility under the Plan. Please refer to the Claim Review and Appeal Processes section of this SPD for more information.

Misrepresentation

If the covered person or anyone acting on behalf of a covered person makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the covered person, or any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the covered person in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this Plan null and void.

Pronouns

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

Treatment Outcomes of Covered Services

The Claims Administrators are not a provider of health care services and therefore are not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for CVS Caremark Home Delivery, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of Claims Administrators or their affiliates.

Who is Eligible

Eligibility for the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan is subject to the general eligibility provisions of the Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account Program, including the Standard Eligibility Rule, the Protected Service Rule and the Early Retirement Rule ("Rule of 70"). For these provisions, refer to the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program SPD*, which can be found on the Mercer Marketplace 365+ Retiree website at https://retiree.mercermarketplace.com/comcastnbcu.

The Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan is only available to non-Medicare-eligible retirees and their eligible dependents. Upon reaching Medicare-eligibility, you will no longer be eligible for the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan.

Eligibility for Plan Closed to New Entrants

Note: Beginning January 1, 2018, the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan are closed to new retirees. To participate in these plans, you must have been retired on or before December 31, 2017 and enrolled in one of the plans prior to January 1, 2018 or immediately following retirement. If you are not already enrolled in the Independence Standard or Minimum PPO Plans and CVS/Caremark Prescription Drug Plan, you may be eligible to enroll in a retiree health care plan through the private retiree health care marketplace or other available option. For more information on eligibility for the private retiree health care marketplace or other available options, refer to the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program SPD*, which can be found on the Mercer Marketplace 365+ Retiree website at http://retiree.mercermarketplace.com/comcastnbcu (or, for those not eligible for an RRA, http://retiree.mercermarketplace.com/comcastnbcuaccess).

Who Is an Eligible Dependent

Spouses, Domestic Partners, and Civil Union Partners

Spousal, domestic partner, and civil union partner coverage under the Retiree Health Care Program is only provided if your spouse, domestic partner, or civil union partner was an eligible dependent when you were an active employee.

If you marry or enter into an eligible domestic partnership or civil union partnership after retirement, your spouse, domestic partner, or civil union partner will become eligible to participate at that time on an “access only” basis (i.e., they will be eligible for individual health plan coverage only and not for the RRA).

A spouse is an adult with whom you have a legally valid marriage. This includes individuals residing in states that recognize common law marriages who have satisfied the minimum state requirements to be considered married in common law. If you previously created a common law marriage in a state that recognized this relationship and have moved to another state that does not recognize common law marriages, Comcast NBCUniversal will continue to recognize your established relationship in the state in which you now reside.

A domestic partner is defined as a mentally competent adult who lives with you in the context of a long-term, committed relationship with mutual obligations similar to those of marriage. This does not include platonic roommate relationships, or any relationships prohibited by state law.

The criteria for domestic partnerships are as follows:

- Currently reside together and intend to do so permanently;
- Are not related by blood to a degree of closeness that would otherwise prohibit marriage;
- Have mutually agreed to be responsible for each other’s basic living expenses;
- Be at least the age of consent in the state in which you reside and mentally competent to consent to contract;
- Neither you nor your partner is legally married to another person; and
- Neither you nor your partner is in a domestic partner relationship with anyone else.

An individual cannot be covered as a retiree and a spouse/domestic partner/civil union partner nor can an individual cover both a spouse and a domestic partner/civil union partner.

Note, the Plan will define Domestic Partner consistent with the applicable state or local ordinance definition of Domestic Partner if such definition differs from the definition above.

Civil Union Partner: Eligible under a legally valid existing civil union.

Please note: According to federal tax law, your taxes may be affected when you enroll your domestic partner or civil union partner in an optional retiree health plan made available by Comcast NBCUniversal.

If Both You and Your Spouse/Domestic Partner/Civil Union Partner are Retired from Comcast

Neither of you can be covered both as retiree and a dependent under retiree health care benefits. Each of you may be covered as either a retiree or a dependent, but not both.

Termination of Relationship

Spouse/domestic partner/civil union partner eligibility for the optional retiree health care plans ends upon death, divorce or termination of domestic partnership or civil union partnership. You must notify Mercer Marketplace 365+ Retiree at 1-866-435-5135 within 31 days after the death of the spouse, domestic partner or civil union partner or the date on which any of the criteria of marriage or domestic partnership/civil union partnership is no longer met.

Termination of a domestic partnership also requires completion of an *Affidavit of Termination of Domestic Partnership Form* within that 31-day period.

Dependent Children

Dependent children may be covered under the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan through end of the month in which the child reaches age 23.

If You Enroll in a GE Retiree Medical Plan

Pre-65 retirees who enroll in a GE retiree medical plan will permanently forfeit eligibility for the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan. If you are a pre-65 retiree enrolled in a GE retiree medical plan, you must dis-enroll from the GE retiree healthcare plan to maintain eligibility under the Comcast NBCUniversal Retiree Health Care Program. If you do not dis-enroll from the GE retiree healthcare plan, you will continue to have access to individual plan options available through Mercer Marketplace 365+ Retiree but you will permanently forfeit eligibility for the Independence Standard and Minimum PPO Plan and CVS/Caremark Prescription Drug Plan.

When You Can Change Your Coverage

Enrolling for Coverage

Participation in an optional retiree health care plan is voluntary. Enrollment in an optional health care plan is not automatic upon retirement. If you are eligible for coverage, you and your eligible dependents must enroll in order to receive it.

You are able to make separate elections for the following:

- Independence Standard or Minimum PPO Plans
- CVS Caremark Prescription Drug plan

Open enrollment periods are generally held in the fall of each year. The benefit choices you make during each year's open enrollment period take effect on January 1 of the following year and remain in effect until December 31.

If you are already enrolled in coverage and you do not take any action during an annual open enrollment period, your coverage for the new plan year usually defaults to your current election. You will be charged based on the new plan year retiree contributions.

If you are already enrolled in the Independence Standard or Minimum PPO Plans and/or the CVS/Caremark Prescription Drug Plan, you may also change the plan enrollment between eligible plans. Your eligibility for the optional retiree health care plan will remain so long as you maintain coverage in at minimum either the Independence Standard or Minimum PPO Plans and/or the CVS/Caremark Prescription Drug Plan. Comcast NBCUniversal may conduct an active enrollment period and require all retirees to re-enroll for coverage if they want to participate in any of the Comcast NBCUniversal benefits programs. If this is the case, you will be notified.

If you have already retired prior to age 65, as you approach age 65, you will receive information from Mercer Marketplace 365+ Retiree about your retiree health care coverage options and how to enroll. For more information about how to enroll in coverage, contact Mercer Marketplace 365+ Retiree at 1-866-435-5135.

Please note: If you and your spouse, domestic partner or civil union partner are both pre-Medicare eligible, the retiree must be enrolled in one of the optional retiree health care plans, in order for their spouse, domestic partner or civil union partner to enroll in coverage.

You may request to cancel your coverage at any time. If you cancel coverage and have not reached age 65, your cancellation of coverage will be effective for *all* covered dependents. If you cancel coverage because you have become Medicare-eligible, your cancellation of coverage will be effective for yourself and your pre-65 covered dependents may continue their coverage in their current health care plan.

You may terminate coverage during the plan year by contacting Mercer Marketplace 365+ Retiree at 1-866-435-5135. If you terminate coverage mid-year, you will not be able to participate again.

Changes must be reported by contacting Mercer Marketplace 365+ Retiree at 1-866-435-5135.

Entitlement to Governmental Benefits

If you, or your spouse, domestic partner or civil union partner becomes entitled to Medicaid or certain other governmental group medical programs, you may drop coverage under this plan.

Change in Address, Family Status or Mid-Year Election Change Event

To ensure timely and accurate processing of claims, it is important that you notify Mercer Marketplace 365+ Retiree by phone at 1-866-435-5135 of any change in your address, family status change event such as marriage, divorce, termination of domestic partnership/civil union partnership and death of a spouse. Notice of events and election changes must be made within 31 days of the event. The Plan Administrator will then update your participation information (and that of your spouse, domestic partner, or civil union partner if applicable) as well as any optional health care plan made available by Comcast NBCUniversal that you elect, as appropriate.

For Pre-Medicare Eligible Retirees: If You Enroll in a Health Care Plan through the Public Exchange

If you or your spouse/domestic partner/civil union partner wishes to enroll in a health care plan through a public exchange and you are eligible for a federal subsidy due to your income, you should decline the optional retiree healthcare coverage. If you or your spouse/domestic partner/civil union partner is covered under a Comcast NBCUniversal Pre-Medicare eligible retiree health care plan, you will not be eligible for a federal subsidy for coverage purchased on the public exchange, even if your household income would otherwise qualify you for a subsidy. Failure to decline Comcast NBCUniversal coverage will jeopardize your eligibility for the federal subsidy.

Please note that by declining retiree health care plan coverage made available by Comcast NBCUniversal, you are ineligible for future participation in the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan (which is closed to new participants as of the timing referenced above) and the RRA. Please refer to the *Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Program SPD* for more information.

Paying For Coverage

Retirees who retired from Comcast or NBCUniversal Groups 4, 5 and 6 pay the full cost of the optional retiree health care plan coverage. Retirees from NBCUniversal Groups 1, 2 and 3 share the cost of optional retiree health plan coverage with Comcast.

Note: If you are a Comcast or NBCUniversal Group 5 participant, you can use your RRA, if you are eligible to receive one, to receive reimbursement for some or all of the cost of this coverage. The cost of coverage for a domestic partner or civil union partner is the same as the cost for a spouse. For more information, see *The Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program SPD*.

When Optional Health Care Coverage Ends

Retirees

Coverage under the optional health care plans made available by Comcast NBCUniversal will automatically terminate on the last day of the month in which any of the following occurs:

- The Plan is discontinued;
- You voluntarily stop your coverage;
- The group contract ends;
- You are no longer eligible for coverage;
- You do not pay the required contributions;
- You are rehired by Comcast as an active employee (including, but not limited to, regular full-time employee, part-time employee, temporary employee, benefit eligible or benefit ineligible employee),
- If you enroll in the pre-65 GE retiree healthcare plan, or
- You die.

Dependents

Your spouse, domestic partner's, civil union partner's or dependent child(ren)'s coverage will automatically terminate if:

- Your coverage ends for any of the reasons listed above *except* your death;
- He or She is no longer eligible for spouse, domestic partner, civil union partner or dependent child(ren) coverage;
- He or She does not pay the required contribution toward the cost of spouse, domestic partner coverage, civil union partner coverage or dependent child(ren); or
- Spouse, domestic partner, civil union partner, or dependent child(ren) coverage is no longer available under the plan.

Continuing Coverage

If your dependent's Comcast Retiree Health Care Program coverage ends, your dependents may be able to continue that coverage at their own expense under a federal law known as COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. See the Continuation of Coverage — COBRA section in this SPD for more information.

Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan for Non-Medicare Eligible Retirees

How the Medical Plans Work

The Independence Standard and Minimum PPO Plans offer health care services to participants through the Claims Administrator's network of facilities and doctors, but you do not have to use providers associated with the network. When you receive health care through an in-network provider, your out-of-pocket expenses are lower, and there are no claim forms to fill out. When you receive care from a provider who is not a member of the PPO network, you still receive benefits, but your out-of-pocket expenses will be greater. You also may be required to file a claim form.

To see if your provider participates in the PPO network or to find one who does, see *PPO Network Directories*. The PPO plan is administered by Independence.

See *Administrative Information* section for Claims Administrator names, addresses, Member Services phone numbers, and web site addresses.

How PPOs Work

In-Network Benefits

To receive in-network benefits, simply visit a provider in the applicable PPO network. Each time you receive services from an in-network provider, the Plan pays for the majority of your care after your deductible. For other services, the Plan pays a percentage of the network participating provider fee schedule after a deductible. You do not have to submit any claim forms when you use an in-network provider; the provider will submit them on your behalf.

Out-of-Network Benefits

For all out-of-network services you must meet an annual deductible (separate from the in-network deductible) before the Plan pays any benefits. Once you've met the required deductible, the Plan pays a percentage of the charges, up to the Plan's maximum allowable charges for those services. See *Maximum Allowable Charge (Out-of-Network)* for more information.

When you receive services from an out-of-network provider, you are responsible for submitting a claim for benefits. Unlike in-network providers, an out-of-network provider may require that you pay the full cost of the services up front.

Maximum Allowable Charge (Out-of-Network)

Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Independence, and the actual charge of the provider. This amount may be significant. Claim payments for Non-Preferred Professional Providers (physicians) are based on the lesser of the 90th percentile of the FHTM Benchmarks database, or the Providers' charges for Covered Services. For covered services where FHTM Benchmarks pricing is not available, the amount is determined by reimbursing 90% of the Professional Providers' charges for Covered Services. Under Independence contracts with hospitals and other facility providers, Independence pays using bulk purchasing arrangements that save money at the end of the year, but do not produce a uniform discount for each individual claim. Therefore, the amount paid by Independence at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

Out-of-network facility maximum allowable charges incurred only at a hospital are the lesser of:

- Provider's charges
- 50% of Medicare Allowable Payment
- Reasonable and Customary Charge for the Covered Services

Annual Deductible

The annual deductible is the amount you must pay each calendar year **before** the medical plan pays any benefits. You may not have to meet an annual deductible for preventive care.

The annual deductibles for the PPO Medical Plans are as follows:

	Minimum PPO	Standard PPO
Per Individual	$1,000	$200
Two Participants	$2,000	$400
Per Family	$3,000	$600

Coinsurance

Coinsurance is a percentage of the covered expenses that must be paid by you or your covered dependent; it is applied after the deductible is met, if any applies. The Independence Minimum PPO Plan covers most services at 70%, so your coinsurance is 30%. The Independence Standard PPO Plan covers most services at 80%, so your coinsurance is 20%.

As a reminder, if you use a network provider, the coinsurance is based on a percentage of the Claims Administrator's s negotiated rate for the service(s). If you use an out-of-network provider, the coinsurance is based on a percentage of the "maximum allowable charge", and could result in balance billing to you. For more information, refer to the *Maximum Allowable Charge (Out-of-Network)* section.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most coinsurance you, your spouse, domestic partner, civil union partner, or dependent child(ren) will have to pay out of your pocket for covered medical services in an entire calendar year. Once the out-of-pocket maximum is reached, the medical plan pays 100% of the eligible expenses incurred for the rest of the year.

The annual out-of-pocket maximum for the Independence Minimum and Standard PPO Plans are as follows:

	Minimum PPO	Standard PPO
Per Individual	$3,000	$2,000
Per Family	$6,000	$4,000

Exceptions to the Annual Out-of-Pocket Maximum

In most cases the coinsurance you pay will count toward the medical plan's annual out-of-pocket maximum; however, some expenses will not count toward the out-of-pocket maximum. This includes:

- Charges applied to deductibles;
- Copayments;
- Charges in excess of Maximum Allowable Charges;
- Charges in excess of maximum benefit amounts or other special limits, such as:
    - Charges for hearing aid;
    - Charges for wigs/hairpieces;
- Charges when you do not follow pre-admission review procedures;
- Precertification penalties, and
- Any other expenses not covered by the medical plan.

Transition of Care

You may currently be receiving services from physicians or other health care providers or at hospitals or facilities that are not part of the Independence network. An approved Transition of Care request allows you, as a new member, to continue

care for a medical condition, under certain circumstances and for a specified period of time (up to 90 days), with a specialist or at a hospital or facility outside of your selected health care vendor's network. Transition of Care is for members who are in active, ongoing treatment with a non-participating provider and whose treatment will continue for a specific period of time following their enrollment in their new plan (for example, if you are pregnant and in your third trimester).

PPO Network Directories

The PPO Claims Administrator selects and manages the group of health care professionals and facilities in their networks. Listings of providers can be obtained from the Independence website at www.ibx.com. When searching for providers, you should choose to search from the "National Blue Card" PPO network directory.

The Claims Administrator make reasonable efforts to validate that the lists of providers displayed on their websites are up to date and accurate; however, it is a member's responsibility to contact the provider prior to scheduling an appointment to verify the provider continues to be part of the PPO network. Certain services such as Mental Health Care are covered only when received by providers with certain credentials. Contact the Claims Administrators to verify that the provider you select meets those requirements.

Covered Health Services

The PPO option will only pay benefits for medically necessary services or supplies that are covered health services under the Plan and are not specifically excluded by the Plan.

Medically Necessary or Medical Necessity health care services and supplies or prescription drugs that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

a) In accordance with generally accepted standards of medical practice;

b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;

c) Not primarily for the convenience of the patient, physician, other health care provider; and

d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical community, or otherwise consistent with physician or specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Covered health services must be provided as follows:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this SPD; and;
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

Covered health services also do not include experimental or investigational services or unproven services, which are defined in the following section. Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies.

Experimental, Investigational and Unproven Services

A drug, biological product, device, medical treatment or procedure, or diagnostic test which meets any of the following criteria:

- Is the subject of: Ongoing clinical trials;
- Is the research, experimental, study or investigational arm of an ongoing clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or
- Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.
- Any drug, biological product, device, medical treatment or procedure, or diagnostic procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:
- When required the drug, biological product, device, medical treatment or procedure, or diagnostic test must have final approval from the appropriate governmental regulatory bodies (e.g. FDA);
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test leads to measurable improvement in health outcomes (That is, the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.
- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in the previous bullet, is possible in standard conditions of medical practice, outside clinical investigatory settings.
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure, or diagnostic test is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

Any approval granted as an interim step in the FDA regulatory process (For example: An Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of a drug or biological product (e.g., infusible agent) for another diagnosis or condition shall require that

one or more of the established reference Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

Care Management Program and Notice Requirements

Prior Notification (Precertification/Care Coordination)

Prior notification is required for certain covered health services, which means you must contact the Claims Administrator for approval in advance of receiving the services. Other services require notification to the Claims Administrator within prescribed time periods. Failure to comply with these requirements may result in a penalty — the Plan may apply a flat $500 penalty (both in-network and out-of-network services). If the charge is less than $500, you may be responsible for the full amount (where applicable as this may vary based on provider or facility where services are rendered).

To notify the Plan, contact the Claims Administrator at the phone number listed on your PPO identification card. In general, you must notify the Claims Administrator for the following types of care:

- Inpatient hospital stays, except inpatient hospital services for 48-hour maternity stays for vaginal deliveries, and 96-hour maternity stays for cesarean sections
- Emergency Room admissions that result in hospital admission; notification must be made after admission to the hospital
- Outpatient private duty nursing
- Skilled nursing facility services
- MRI/MRA/CAT/CT/PET scans
- Bariatric Surgery
- Transplants
- Radiation treatment
- Selected durable medical equipment (DME) (threshold of $500 for rental and $1,500 for purchase)
- Prosthetics ($1,000 threshold)
- Home health care
- Non-emergency ambulance transportation
- Office-based opioid treatment
- Transcranial Magnetic Stimulation for Depression

For a complete listing of all services that require precertification, please contact Independence at 1-800-898-3556.

You must notify the Claims Administrator whether you are using either an in-network or out-of-network provider. If you are using an in-network provider, the provider may notify the Claims Administrator for you, but you have the responsibility of ensuring that this is done. The Claims Administrator will inform you or your doctor whether the proposed service or treatment suggested by your doctor is a covered health service. Note that notification does not ensure payment of benefits — as with all coverage, the provisions of the Plan will determine benefits.

Regardless of what the Claims Administrator recommends or what the Plan will pay, it is always up to the patient and his or her doctor to decide what, if any, care the patient should receive. The Plan and the Claims Administrator do not provide medical advice. See *Administrative Information* section for Claims Administrator names, addresses, Member Services phone numbers, and web site addresses.

Emergency Care

In an emergency, the first thing to do is get help. As required by the Patient Protection and Affordable Care Act of 2010, coverage for medical emergency services will be provided without the need for prior authorization, even if the emergency services are provided on an out-of-network basis. A "medical emergency" is the sudden and unexpected onset of a

medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the Member's health, or in the case of a pregnant Member, the health of the unborn child, in jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Since emergency hospitalization cannot be reviewed in advance, you must contact the Claims Administrator within 48 hours after the emergency admission to receive full benefits.

If you are admitted to the hospital within three days for the same medical reason as your emergency room visit your ER copay will be waived. Please call the number on the back of your ID card to have the second emergency copayment waived.

Concurrent Review

The Claims Administrator will assign an estimated length of stay for all approved inpatient hospital admissions. It also approves admissions to skilled nursing facilities and other types of care provided by facility and professional providers as provided for in this *Care Management* section. Concurrent review of an approved admission or plan of treatment may result in an approval of a request for an extension of approved care. The Claims Administrator will inform the provider of the approval of any additional care as a result of the concurrent review. It will also continue to monitor extensions of care to determine whether further covered services are medically necessary/ medically appropriate. The written determination, by both the Claims Administrator and the attending physician, that covered services are no longer medically necessary and medically appropriate will result in the termination of benefits payable for the treatment of the illness or injury.

Case Management

If you or a covered family member suffers from a serious or complex medical or mental health and substance use condition, you may be a candidate for Case Management (CM). CM is designed to help the covered person or his or her physician coordinate quality and cost-effective treatment options based on the covered person's needs.

CM is available if all of the following criteria are met:

- The Claims Administrator determines that, without CM, the covered person will have to remain in a more costly setting to receive the appropriate quality or intensity of care;
- The attending physician determines that the alternative course of treatment or services is responsive to the needs of the covered person; and
- The Claims Administrator, the attending physician, the covered person, and the covered person's family, where applicable, all agree on the alternative plan of treatment.

Second Surgical Opinions for Elective Surgery (Voluntary)

Consultations for surgery to determine the medical necessity of an elective surgical procedure are covered. Elective surgery is that surgery which is not associated with an emergency or life-threatening condition.

These services must be performed and billed by a doctor other than the one who initially recommended performing the surgery. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances, you will be eligible for a maximum of two consultations involving the elective surgical procedure in question in addition to the original recommendation but limited to one consultation per consultant.

What Your Medical Plan Covers

	Minimum PPO Plan	Standard PPO Plan
Preventive Care		
Routine physical exams (adult and child)[1]	Covered 70% after deductible	Covered 80% after deductible
Well child exams[1]	Covered 70% after deductible	Covered 80% after deductible
Immunizations (includes pediatric, adult and travel immunizations)	Covered 70% after deductible	Covered 80% after deductible
Routine gynecological exam[1]	Covered 70%, no deductible applies	Covered 80%, no deductible applies
Routine pap and pelvic smears[1]	Covered 70%, no deductible applies	Covered 80%, no deductible applies
Mammograms (includes routine and diagnostic)	Covered 70%, no deductible applies	Covered 80%, no deductible applies
Routine colonoscopy, sigmoidoscopy and similar routine procedures done for preventive reasons	Covered 70%, no deductible applies	Covered 80%, no deductible applies
Routine hearing exam (limited to 1 exam every 24 months)	Covered 70%, after deductible applies	Covered 80%, after deductible applies
Physician Care		
Physician office visits (includes telehealth consultations with Independence)	Covered 70% after deductible	Covered 80% after deductible
Specialist	Covered 70% after deductible	Covered 80% after deductible
Urgent care facility visit	Covered 70% after deductible	Covered 80% after deductible
Inpatient Hospitalization		
Inpatient room and board[1]	Covered 70% after deductible	Covered 80% after deductible
Inpatient professional services	Covered 70% after deductible	Covered 80% after deductible

	Minimum PPO Plan	Standard PPO Plan
Emergency room care	Covered 70% after deductible	Covered 80% after deductible
Ambulance (non-emergent ambulance requires precertification)	Covered 70% after deductible	Covered 80% after deductible
Skilled nursing facility (limited to 120 days per calendar year)[2]	Covered 70% after deductible	Covered 80% after deductible
Maternity Care		
Inpatient room & board	Covered 70% after deductible	Covered 80% after deductible
Inpatient professional services	Covered 70% after deductible	Covered 80% after deductible
Pre-/post-natal care	Covered 70% after deductible	Covered 80% after deductible
Infertility (diagnosis & treatment of underlying medical condition only)	Covered 70% after deductible	Covered 80% after deductible
Outpatient Services		
Outpatient Surgery	Covered 70% after deductible	Covered 80% after deductible
X-ray and laboratory	Covered 70% after deductible	Covered 80% after deductible
Advanced Imaging	Covered 70% after deductible	Covered 80% after deductible
Chemotherapy	Covered 70% after deductible	Covered 80% after deductible
Radiation Therapy	Covered 70% after deductible	Covered 80% after deductible
Infusion Therapy	Covered 70% after deductible	Covered 80% after deductible
Cardiac rehabilitation therapy	Covered 70% after deductible	Covered 80% after deductible
Physical therapy (limited to 60 visits per calendar year)[2]	Covered 70% after deductible	Covered 80% after deductible
Occupational therapy (limited to 30 visits per calendar year)[2]	Covered 70% after deductible	Covered 80% after deductible
Speech therapy (limited to 30 visits per calendar year)[2]	Covered 70% after deductible	Covered 80% after deductible
Spinal manipulation (limited to 40 visits per calendar year)[2]	Covered 70% after deductible	Covered 80% after deductible
Acupuncture (limited to 30 visits per calendar year)[2]	Covered 70% after deductible	Covered 80% after deductible
Dialysis	Covered 70% after deductible	Covered 80% after deductible

	Minimum PPO Plan	Standard PPO Plan
Home health care (limited to 100 visits per calendar year) [2]	Covered 70% after deductible	Covered 80% after deductible
Private Duty Nursing (limited to 800 hours per calendar year)	Covered 70% after deductible	Covered 80% after deductible
Hospice (includes respite care and bereavement limit of 7 days for every 6 months)[2]	Covered 70% after deductible	Covered 80% after deductible
TMJ (includes surgery, appliances, and adjustments)	Covered 70% after deductible	Covered 80% after deductible
Mental Health and Chemical Dependency Care		
Inpatient	Covered 70% after deductible	Covered 80% after deductible
Outpatient	Covered 70% after deductible	Covered 80% after deductible
Other services		
Routine foot care (limited to diagnosis of diabetes only)	Covered 70% after deductible	Covered 80% after deductible
Orthotics	Not covered	Not covered
Vision care[3]	Not covered	Not covered
Hearing aids ($1,000 lifetime maximum per ear)[2]	100% covered	100% covered
Durable Medical Equipment (DME) & prosthetics	Covered 70% after deductible	Covered 80% after deductible
Wigs if medically necessary (one per calendar year, up to a $500 maximum benefit)	100% covered	100% covered
Outpatient obesity treatment	Covered 70% after deductible	Covered 80% after deductible
Organ Transplantation Performed at a Center of Excellence		
Inpatient room & board	Covered 70% after deductible (no coverage for services provided outside of the Center of Excellence provider network)	Covered 80% after deductible (no coverage for services provided outside of the Center of Excellence provider network)
Outpatient surgery (includes professional and facility services)		

[1]Maximum per benefit limit of $300 calendar year maximum for certain wellness preventive benefits (OB/GYN routine exam, pap smear, routine exam and routine tests, labs, and x-rays; limit excludes mammogram and routine prostate exam). Well-baby/well-child care included in limit for PPO plan only.

[2]Limit is combined for in-network and out-of-network services

[3]Medically diagnosed vision care is covered at the benefit levels described in the above chart for each respective plan. Routine vision screening and comprehensive routine eye exams are not covered under this plan as administered by Independence.

Waiver of Certain Participant Charges in Connection with COVID-19

Effective as of March 18, 2020, the Plan will waive certain charges related to the testing of Novel Coronavirus Disease known as COVID-19, that would ordinarily apply to certain services and prescriptions under the Plan. Effective January 15, 2022, the Plan will also provide access to over-the-counter tests for COVID-19 at pharmacies that are part of the CVS Caremark network or online. This will be effective for the duration of the declared public health emergency. The Plan Administrator will then have the authority to determination whether to waive charges. Waivable charges during the declared public health emergency include:

- Copayments;
- Coinsurance charges;
- Out-of-network charges, including out-of-network deductible charges;
- Emergency room charges;
- Precertification requirements and related charges;
- Other charges that are required to be waived pursuant to legislation enacted by Congress or other state and local legislation that is determined to apply to the Plan

Acupuncture Services

Acupuncture is considered medically necessary and covered for the following conditions:

- Headache (migraine and tension)
- Post-operative nausea and vomiting
- Chemotherapy – induced nausea and vomiting
- Nausea of pregnancy
- Low back pain
- Chronic neck pain
- Pain from osteoarthritis of the knee/hip

Ambulance Services

- **Ground ambulance** covered expenses include charges for transportation:
  - To the first hospital where treatment is given in a medical emergency;

- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles;
- When during a covered inpatient stay at a hosptial, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

▪ **Air or water ambulance** covered expenses include charges for transportation to a hospital by air or water ambulance when:
  - Ground ambulance transportation is not available; and
  - Your condition is unstable, and requires medical supervision and rapid transport; and
  - In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; *and* the two conditions above are met.

▪ *Not* covered under this benefit are charges incurred to transport you:
  - If an ambulance service is not required by your physical condition; or
  - If the type of ambulance service provided is not required for your physical condition; or
  - By any form of transportation other than a professional ambulance service.

In the event emergency ambulance transport is called and you receive treatment and are not transported, the plan will process the claim at the emergency ambulance benefit level.

Dental Services, Accident Only

Dental services when all of the following are true:

▪ Treatment is necessary because of accidental damage;
▪ Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."; and
▪ The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

▪ A virgin or unrestored tooth; or

- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.

Important Reminder: Complex imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply.

Durable Medical Equipment

The Claims Administrator will provide coverage for the rental or, at the option of the Claims Administrator, the purchase of Durable Medical Equipment when:

- Prescribed by a Professional Provider and required for therapeutic use; and
- Determined to be Medically Necessary by the Claims Administrator.

Although an item may be classified as Durable Medical Equipment it may not be covered in every instance. Durable Medical Equipment includes equipment that meets the following criteria:

- It is durable and can withstand repeated use. An item is considered durable if it can withstand: repeated use, (That is, the type of item that could normally be rented). Medical Supplies of an expendable nature are not considered "durable"
- It customarily and primarily serves a medical purpose;

- It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the Member's illness, injury, or to improvement of a malformed body part; and
- It is appropriate for home use.

Replacement and Repair: The Claims Administrator will provide coverage for the repair or replacement of Durable Medical Equipment when the equipment does not function properly; and is no longer useful for its intended purpose, in the following limited situations:

- Due to a change in a Member's condition: When a change in the Member's condition requires a change in the Durable Medical Equipment the Claims Administrator will provide repair or replacement of the equipment;
- Due to breakage: When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Claims Administrator will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Claims Administrator.

Breakage under warranty: If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of:

- The Claims Administrator in the case of rented equipment; and
- The Member in the case of purchased equipment.

Breakage during reasonable useful lifetime: The Claims Administrator will not be responsible if the Durable Medical Equipment breaks during its reasonable useful lifetime for any reason not covered by warranty. (For example, the Claims Administrator will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.)

Cost to repair vs. cost to replace: The Claims Administrator will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment:

- Replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning;
- A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage or defect.

Emergency Health Services

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Eye Examinations

Eye examinations received from a health care provider in the provider's office but only in conjunction with a Physician's office visit for a medical condition or accidental injury.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Family Planning

Covered Health Services for family planning when provided by or under the direction of a Physician. Benefits will be paid for:

- Diaphragm or intrauterine device and related Physician services
- Voluntary sterilization by either vasectomy or tubal ligation
- Depo Provera
- Norplant

Oral contraceptives are covered under the Prescription Drug program. Infertility benefits are described under *Infertility Services* in this section.

Foot Care

Covered Health Service if done as the result of an infection or disease. Treatment covered for:

- Any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
- Physician's office visit for diagnosis of bunions.
- Treatment of bunions when an open cutting operation or arthroscopy is performed
- Corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease

Hearing Examinations and Hearing Aids

Hearing examinations received from a health care provider in the provider's office. Benefits for hearing examinations are limited to one examination every two calendar years.

Benefits for hearing aids are limited to $1,000 per ear during the entire period of time you are covered under the medical plan and are not subject to the Annual Deductible. Charges for hearing aids are not included in the Out-of-Pocket Maximum.

Home Health Care Covered Services

The Claims Administrator will provide coverage for the following services when performed by a licensed Home Health Care Provider:

- Professional services of appropriately licensed and certified individuals;
- Intermittent skilled nursing care;
- Physical Therapy;
- Speech Therapy;
- Well mother/well baby care following release from an Inpatient maternity stay; and

- Care within 48 hours following release from an Inpatient Admission when the discharge occurs within 48 hours following a mastectomy.

Regarding well mother/well baby care

With respect to well mother/well baby care following early release from an Inpatient maternity stay, Home Health Care services must be provided within 48 hours if:

- Discharge occurs earlier than 48 hours of a vaginal delivery; or
- Discharge occurs earlier than 96 hours of a cesarean delivery. No cost-sharing shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.
- Regarding other medical services and supplies: The Claims Administrator will also provide coverage for certain other medical services and supplies, when provided along with a primary service. Such other services and supplies include:
    - Occupational Therapy;
    - Medical social services; and
    - Home health aides in conjunction with skilled services and other services which may be approved by the Claims Administrator.
- Regarding Medical Necessity: Home Health Care benefits will be provided only when prescribed by the Member's attending Physician, in a written Plan Of Treatment and approved by the Claims Administrator as Medically Necessary.
- Regarding the issue of being confined: There is no requirement that the Member be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.
- Regarding being Homebound: With the exception of Home Health Care provided to a Member, immediately following an Inpatient release for maternity care, the Member must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider. This means that leaving the Home could be harmful to such person, would involve a considerable and taxing effort, and that the Member is unable to use transportation without another's assistance.

Hospice Care

The Claims Administrator will provide coverage for palliative and supportive services provided to a terminally ill member through a Hospice program by a Hospice Provider. This also includes Respite Care. The Member will be eligible for Hospice benefits if both of the following occur:

- The member's attending physician certifies that the member has a terminal illness, with a medical prognosis of six months or less; and
- The member elects to receive care primarily to relieve pain.

Hospice care provides services to make the member as comfortable and pain-free as possible. This is primarily comfort care and includes the following:

- Pain relief;
- Physical care;
- Counseling; and
- Other services that would help the member cope with a terminal illness, rather than cure it.

When the member elects to receive hospice care the benefits for treatment provided to cure the terminal illnesses are no longer provided and the member can also change their mind and elect not to receive hospice care anymore.

Benefits for hospice services shall be provided until whichever occurs first:

- The member's discharge from hospice care; or
- The member's death.

Hospital Inpatient Stay

Inpatient Stay in a Hospital. Benefits are available for:

- Services and supplies received during the Inpatient Stay
- Room and board in a Semi-private Room (a room with two or more beds)

The term hospital means an approved facility that provides inpatient, as well as outpatient care, and that meet the requirements listed below:

- The term hospital specifically refers to a short-term, acute care, general hospital which has been approved by The Joint Commission on Accreditation of Healthcare Organizations; and/or by the American Osteopathic Hospital Association or by the Claims Administrator, and which meets the following requirements:
  - Is a duly licensed institution;
  - Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians;
  - Has organized departments of medicine;
  - Provides 24-hour nursing service by or under the supervision of registered nurses;
  - Is not, other than incidentally, any of the following:
    - Skilled Nursing Facility;
    - Place for treatment of mental illness
    - Nursing home;
    - School;
    - Place for treatment of alcohol or drug use;
    - Custodial Care home;
    - Health resort;
    - Place for provision of rehabilitation care;
    - Spa or sanitarium;
    - Place for treatment of pulmonary tuberculosis;

- Place for rest;
- Place for aged;
- Place for provision of hospice care.

Infertility Services

Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility

Injections Received In a Physician's Office

Benefits are available for injections received in a Physician's office, for example allergy immunotherapy.

Maternity Services

Benefits for pregnancy will be paid at the same level as Benefits for any other condition, sickness or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Birthing centers and nurse midwives are covered.

Benefits will be paid for an inpatient stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery
- 96 hours for the mother and newborn child following a cesarean section delivery

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Medical Supplies and Wigs

Medical supplies when prescribed by a Physician, including:

- Elastic stockings
- Ace bandages
- Gauze and dressings
- Ostomy supplies

Benefits are provided for one wig or hairpiece per year when prescribed by a Physician for hair loss due to injury, sickness or the treatment of a sickness, including but not limited to:

- Burns (2nd degree full thickness or 3rd degree burns with resulting permanent alopecia)
- Lupus
- Chemotherapy
- Radiation therapy

Wigs or hairpieces for male or female pattern alopecia are not covered under the medical plan.

Benefits for wigs or hairpieces are limited to $500 per calendar year and are not subject to the annual deductible. Charges for wigs or hairpieces are not included in the Out-of-Pocket Maximum.

Nutritional Counseling

Covered Health Services provided by a registered dietician in an individual session for Covered Persons.

Obesity Treatment

Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for non-surgical treament of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam; and
- Prescription drugs.

Covered expenses include one morbid obesity surgical procedure, within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided under the plan.

Oral Surgery

Covered Health Services for the diagnosis and surgical and adjunctive treatment of disease, injuries and defects of the mouth, jaws and associated structures when ordered by a Physician. You should contact Independence in advance to verify that the surgical procedure is a Covered Health Service.

Benefits are provided for the treatment of temporomandibular joint disease (TMJ).

Benefits are also provided for dental anesthesia and associated hospital and facility charges provided to an enrolled dependent child if any of the following criteria apply:

- The child has a physical, mental or medically compromising condition;
- The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
- The child is extremely uncooperative, unmanageable or uncommunicative with dental needs deemed sufficiently important that the dental care cannot be deferred; or
- The child has sustained extensive orofacial and dental trauma.

Outpatient Surgery, Diagnostic, and Therapeutic Services

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Surgery and related services

- Lab and radiology/X-ray
- Mammography testing and pap smears
- Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy)

Benefits under this category include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* in this section.

When these services are performed in a Physician's office, benefits are described under *Physician's Office Services* in this section.

Physician's Office Services

Covered Health Services received in a Physician's office including:

- House calls
- Treatment of a Sickness or Injury
- Preventive medical care; $300/calendar year limit
- Voluntary family planning
- Well-baby and well-child care (under age 7 is covered under Standard PPOPPO plan only)
- Routine physical examinations, except that vision and hearing examinations are only covered as described under *Eye Examinations* and *Hearing Examinations* in this section
- Routine well woman examinations — $300/calendar year limit
- Routine mammograms
- Routine prostate specific antigen (PSA) test and digital rectal exam (DRE)
- Immunizations
- Growth hormone therapy

Private Duty Nursing Services

The Claims Administrator will provide coverage up to the number of hours as specified in the Schedule of Covered Services for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician and which are Medically Necessary as determined by the Claims Administrator.

- Limitations for Private Duty Nursing services in connection with the following:
  - Nursing care which is primarily custodial in nature; such as care that primarily consists of bathing, feeding, exercising, homemaking, moving the patient and giving oral medication;
  - Services provided by a nurse who ordinarily resides in the Member's home or is a member of the Member's Immediate Family; and
  - Services provided by a home health aide or a nurse's aide

- Inpatient Private Duty Nursing services.

Professional Fees for Surgical and Medical Services

Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Eligible Expenses for assistant surgeon services for surgical, radiological, and other diagnostic services and procedures performed on the same day, the industry guidelines are to allow the full Maximum Allowable Charge for the primary procedure and a percentage of the Maximum Allowable Charge for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed. A separate charge will not be allowed under the Plan.

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Eligible Expenses for multiple surgical procedures are limited as follows:

- Eligible Expenses for a secondary procedure are limited to 50% of the Eligible Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session;
- Eligible Expenses for any subsequent procedure are limited to 25% of the Eligible Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session; and
- When these services are performed in a Physician's office, benefits are described under *Physician's Office Services* in this section.

Prosthetic Devices

Prosthetic devices that replace a limb or body part including:

- Artificial limbs
- Artificial eyes
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998

If more than one prosthetic device can meet your functional needs, coverage will be based on medical necessity.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits are provided for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device no more than once every three calendar years.

Reconstructive Procedures

Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target 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.

Cosmetic Procedures

Services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This medical plan does not provide benefits for Cosmetic Procedures.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Woman'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 Covered Health Service. You can contact Independence for more information about benefits for mastectomy related services.

Rehabilitation Services, Outpatient Therapy

Short-term outpatient rehabilitation services for:

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Benefits are limited as follows:

- 60 visits of physical therapy per calendar year
- 30 visits of occupational therapy per calendar year
- 30 visits of speech therapy per calendar year

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Benefits will be paid for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Note: Aquatic Therapy is included as part of PT/OT, including in 60 visit calendar year maximum. One on one restorative therapy covered as part of physical therapy.

The medical plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Skilled Nursing Facility Services

The Claims Administrator will provide coverage for a Skilled Nursing Facility:

- When Medically Necessary as determined by the Claims Administrator; and
- Up to the Maximum days specified in the Schedule of Covered Services.

The member must require treatment by a skilled nursing personnel, which can be provided only on an inpateint basis in a Skilled Nursing facility.

In computing the number of days of benefits the Claims Administrator will count the day of the Member's admission, but not the day of the Member's discharge. If the Member is admitted and discharged on the same day, it will be counted as one day.

The Claims Administrator will only provide coverage for days spent during an uninterrupted stay in a Skilled Nursing Facility. It will not provide coverage for:

- Time spent outside of the Skilled Nursing Facility, if the Member interrupts their stay and then stays past midnight on the day the interruption occurs;
- Time spent if the Member remains past midnight of the day on which the interruption occurred; or
- Time spent in the Skilled Nursing Facility after the discharge hour that the Member's attending Physician has recommended that further Inpatient care is not required.

Limitations for Skilled Nursing facility services in connection with the following:

- When confinement in a Skilled Nursing Facility is intended solely to assist the Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
- For the treatment of Alcohol And Drug Use Or Dependency, and Mental Illness; or
- After the Member has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care.

Sleep Disorders

Covered at home only unless medically necessary to be performed elsewhere (such as in a hospital setting).

Spinal Treatment, Chiropractic, and Osteopathic Manipulative Therapy

Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits for Spinal Treatment are limited to 40 visits per calendar year.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Please note that the medical plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Transplant Services

In order for these services to be covered under the Plan, **members must receive treatment from a designated COE network provider and facility, as defined by the heath care vendor**. There is no benefit reimbursement if these procedures are performed by a provider or facility that does not participate in the health care vendor's COE provider network.

When a covered person is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all inpatient and outpatient transplants, which are beyond the experimental/investigative stage. Benefits are also provided for those services to the covered person, which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of blood provided to a covered person during the following scenarios:

- When both the recipient and the donor are covered persons, the payment of their respective medical expenses shall be covered by their respective benefit programs.
- When only the recipient is a covered person, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under this Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or coverage by the carrier or any government program. When only the recipient is a covered person and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding as no benefits are provided to the donor under this Plan.
- When only the donor is a covered person, the donor is entitled to the benefits of this Plan for all related donor expenses, subject to the following additional limitations:
    - The benefits are limited to only those benefits not provided or available to the donor from any other source for funding or coverage in accordance with the terms of this Plan; and
    - No benefits will be provided to the donor recipient.

If any organ or tissue is sold rather than donated to the covered person recipient, no benefits will be payable for the purchase price of such organ or tissue.

Travel Benefit - A travel benefit is available for transplant services received from the Independence BDC COE program and for care for covered medical and mental health/substance use services and/or procedures are not available within

50 miles of the member's home. The plan will reimburse for up to three trips during the course of treatment, including diagnostic visits, surgery and follow up visits.

The benefit is limited $4,000 per trip to a total of $10,000 (amounts greater than $4,000 per trip will be allowed on an exception basis to a total of $10,000 per course of treatment).

The following expenses are covered for the member and one companion:

- Airfare and travel allowance for member and one companion,
- Lodging for the member awaiting hospitalization and lodging for the companion for their entire stay, and
- Round-trip transportation between the airport and the hotel;
- Standard IRS mileage reimbursements are also available when traveling more than 50 miles to a COE facility and using your own vehicle.

Certain covered travel benefits may be taxed if it is not considered an eligible medical care expense under Internal Revenue Code section 213.

You can contact Member Services at the phone number on your ID card for additional details on the travel benefit.

Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* in this section.

Mental Health and Substance Use Care

Treatment of Mental Disorders and Substance Use

Benefits for the treatment of mental illness are based on the services provided and reported by the provider. When a provider renders medical care, other than mental health care, for a covered individual with mental illness, payment for such medical care will be based on the medical benefits available instead of the mental health care benefits.

Inpatient Treatment

Benefits are provided, subject to the coinsurance requirements stated in the chart in this section, for an inpatient admission for treatment of mental illness. Benefits include facility and professional services during the inpatient admission.

Partial hospitalization and plan-approved facility based day/night care and intensive outpatient treatment programs are eligible as part of the inpatient benefit. For maximum benefits, an in-network doctor must perform inpatient visits for the treatment of mental illness. Covered services include medically necessary treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing, psychopharmacologic management

In the event of a hospital admission for mental health reasons, the covered person and/or his or her provider is responsible for contacting Independence to do the pre-certification. Independence will then make sure the provider is a preferred provider and work with the preferred provider to design a plan of treatment. The covered person should call 1-800-688-1911 to ensure that pre-certification has been accomplished. After ensuring that pre-certification has been accomplished, the covered person is not required to take any further action concerning the pre-certification process.

Emergency care is exempt from the requirements for pre-certification; however, emergency admissions or services must be reviewed and authorized within 48 hours of the admission or services, or as soon as possible as determined by the Claims Administrator.

Outpatient Treatment

Benefits will be provided to you subject to the coinsurance requirements shown in the charts in this section, for medically necessary outpatient treatment of mental illness performed by licensed mental health providers.

Covered services include professionally billed treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing, psychopharmacologic management.

Covered mental health and substance use care providers are psychologists, psychiatrists or masters-prepared clinicians licensed by the state to provide psychotherapy or medication management.

Benefits are not payable for the following services:

- Vocational or religious counseling
- Activities that are primarily of an educational nature
- Treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire ad determined by broad-based professional consensus, such as primal therapy, rolfing or structural integration, bioenergetic therapy and obesity control therapy
- Medical facility charges for family counseling services

Chemical Dependency Treatment

Chemical dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in a psychological dependency evidenced by physical tolerance or withdrawal.

Benefits are payable for the care and treatment of chemical dependency provided by a hospital or medical facility, and according to the provisions outlined below. For maximum benefits, treatment must be received from a network provider.

Inpatient Detoxification and Rehabilitation

In the event of a hospital admission for chemical dependency reasons, the covered person and/or his or her provider is responsible for contacting the plan to do the pre-certification. To notify the plan, contact the Claims Administrator at the phone number listed on your identification card. The Claims Administrator will then make sure the provider is a preferred provider and work with the preferred provider to design a plan of treatment. The covered person should call the Claims

Administrator to ensure that pre-certification has been accomplished. After ensuring that pre-certification has been accomplished, the covered person is not required to take any further action concerning the pre-certification process.

Emergency care is exempt from the requirements for pre-certification; however, emergency admissions or services must be reviewed and authorized within 48 hours of the admission or services, or as soon as possible as determined by the Claims Administrator.

Hospital and Non-Hospital Residential Treatment

Benefits that are provided by a hospital or non-hospital residential treatment medical facility must be licensed by the appropriate state or federal government agency. The medical facility may be accredited by the following organization(s): Joint Commission of Accreditation of Health Care Organizations (JCAHO); Bureau of Healthcare Facilities Accreditation, American Osteopathic Association (AOA); Accreditation for Ambulatory Healthcare (AAAHC); Council on Accreditation of Services for Families & Children, Inc. (CARF); or Council on Accreditation of Rehabilitation Facilities (COA).

Covered services include medically necessary:

- Lodging and dietary services
- Physician, psychologist, nurse, certified addictions counselor and trained staff services
- Rehabilitation therapy and counseling
- Psychiatric, psychological and medical laboratory testing
- Drugs, medicines, use of equipment and supplies billed by a professional provider

Outpatient Chemical Dependency Treatment

Medically necessary outpatient chemical dependency treatment services shall be covered subject to the coinsurance and deductibles shown in the chart in this section.

Covered services include:

- Physician, psychologist, nurse, certified addictions counselor and trained staff services
- Rehabilitation therapy and counseling
- Family counseling and intervention
- Psychiatric, psychological and medical laboratory testing
- Drugs, medicines, use of equipment and supplies

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the

What Your Medical Plan Covers section. Charges made for the following are not covered except to the extent listed under the *What Your Medical Plan Covers* section or by any amendment to this SPD.

Allergy

Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Charges

- Any charges in excess of the benefit, dollar, day, visit or supply limits stated under the plan;
- Charges which are submitted for services or supplies that are not rendered;
- Charges which are submitted for a person who is not eligible for coverage under the plan;
- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Contraception

Except as specifically described in the *What Your Medical Plan Covers* section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic Services and Plastic Surgery

Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons (unless such services are deemed medically necessary) including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as or chin implants); except removal of an implant will be covered when medically necessary;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;

- Breast augmentation (only as the result of a mastectomy);
- Otoplasty.

Counseling

Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

Dental Services

Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- Services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- Non-surgical treatments to alter bite, or
- the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable Outpatient Supplies

Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, Medications and Supplies

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under the plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient prescription drugs;
- Self-injectable prescription drugs and medications;
- Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and

- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational Services

Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;

Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and

Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations

Any health examinations:

- Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- Any special medical reports not directly related to treatment except when provided as part of a covered service.
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What Your Medical Plan Covers* section.

Experimental, Investigational Services or Unproven Services

Any services or supplies related to experimental, investigational or unproven services, including clinical trials.

Facility Charges

Facility charges for care services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums; or
- Infirmaries at schools, colleges, or camps.

Food Items

Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot Care

Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes;
- Palliative foot care
- Trimming of nails, corns or calluses when there is not a metabolic disease and;
- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.

Growth/Height

Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a stay in a hospital or other facility;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under *Covered Medical Services* section.
- Plan does not cover Replacement parts or repairs.

Home and Mobility

Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;

- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home Births

Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility

Except as specifically described in the *What Your Medical Plan Covers* section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;

- Home ovulation prediction kits or home pregnancy tests; and
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a physician's practice;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public hospital or other facility is required to provide; or
  - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Independence, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
- Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in the *What Your Medical Plan Covers* section.
- Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
  - Surgical procedures to alter the appearance or function of the body;
  - Hormones and hormone therapy;

   - Prosthetic devices; and
   - Medical or psychological counseling.
- Services provided by a spouse, domestic partner, civil union partner, parent, child, step-child, brother, sister, in-law or any household member.
- Services of a resident physician or intern rendered in that capacity.
- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
   - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
   - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
- Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account SPD*.
- Services that are not covered under the plan.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.
- Speech therapy for treatment of delays in speech development, except as specifically provided in the *What Your Medical Plan Covers* section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.
- Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What Your Medical Plan Covers* section.
- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
   - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
   - Drugs or preparations to enhance strength, performance, or endurance; and
   - Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Maternity Care

- Home care delivery

Mental Health and Substance Use Services

- Alcoholism or substance use rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance use that is specifically provided in the *What Your Medical Plan Covers* section;
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field;
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use;
- Treatment of antisocial personality disorder;
- Treatment in wilderness programs or other similar programs;
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What Your Medical Plan Covers* section.

Miscellaneous

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *What Your Medical Plan Covers* section;
- Alternative/Complimentary Treatment: Holistic or homeopathic medicine, hypnosis, and other alternative treatment that is not accepted medical practice as determined by the plan
- Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Plan, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal;
- Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs;
- Blood, biofeedback, blood pressure cuffs/monitors, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered;
- Court ordered services, including those required as a condition of parole or release;

- Enteral Formulae: Enteral Feedings; Supplies including feeding tubes, pump, bags and products; and Supplemental feedings, over-the-counter nutritional and electrolyte supplements
- Experimental or investigational drugs, devices, treatments or procedures, including clinical trials;
- Growth hormones;
- Home uterine activity monitoring;
- Insulin: excluded unless administered at an inpatient setting
- Massage Therapy
- Panniculectomy/Abdominoplasty
- Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Independence when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Therapies and Tests

Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;

- Sleep therapy;
- Thermograms and thermography.
- Tobacco addiction services

Transplant

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by Independence;
- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the *What Your Medical Plan Covers* section.

Vision

Vision-related services and supplies, except as described in the *What Your Medical Plan Covers* section. The plan does not cover:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight

Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as provided by the plan, including but not limited to:

- Liposuction
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work Related

Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source.

If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Wrong surgery

Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery.

Filing Medical Claims

You or the health care provider must file a claim in order for the program to pay benefits for covered charges.

Your provider can choose to file your claim for you. If he or she will not file a claim for you, then you will have to file a claim yourself. You can obtain information on filing a claim by contacting Independence at 1-800-ASK-BLUE (1-800-275-2583)

Be sure to complete the following information:

- Your name and Social Security Number, if required;
- The amount charged;
- The diagnosis;
- Your medical plan ID number;
- The person incurring the expense if a dependent;
- The date the expense was incurred (if different from the date of the bill);
- The name of the supplier of medical services; and
- The type of service.

The Claims Administrator may not accept a claim more than 12 months after the date of service.

Note: The federal government has extended certain timeframes for employee benefit plans, participants, and beneficiaries affected by the National Emergency for the COVID-19 outbreak. Therefore, the date within which individuals may file a benefit claim will be disregarded during the "Outbreak Period." The "Outbreak Period" is defined as March 1, 2020 until 60 days after the announced end of the National Emergency.

For instructions on how to file a claim, you can contact the Claims Administrator at the telephone number shown on your prescription drug plan ID. This number can also be found in the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account SPD*.

When you reach age 65, Medicare becomes the primary health plan. All claims must be submitted to Medicare first. The Comcast NBCUniversal medical plan will be the secondary payer.

The Claims Administrator is responsible for evaluating all benefit claims under the medical plan. They will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The medical plan has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide the status of your claim.

You also have certain rights regarding claims and appeals. For more information, see the *Claims Review and Appeals Processes* section in the *Comcast NBCUniversal Post-Retirement Health Care and Retiree Reimbursement Account SPD*.

Newborns' and Mothers' Health Protection Act

Under federal law, the plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. The plan also may not require the provider to obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). The covered individual, however, may still be subject to certain precertification requirements to avoid a reduction in the dollar amount covered by the plan. Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours following delivery (or 96 hours following cesarean section).

Women's Health and Cancer Rights Act Of 1998

A federal law requires health plans that provide mastectomy benefits to also provide certain related benefits and to tell participants that they are available. In the case of a participant or beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, reconstructive surgery coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The reconstructive benefits are subject to any annual plan deductibles and coinsurance provisions like other medical and surgical benefits covered under the Plan.

Standard Prescription Drug Plan

How the Standard Prescription Drug Plan Works

The Standard Prescription Drug Plan is administered by CVS/Caremark, and is available for non-Medicare retirees only. The plan offers prescription drug benefits through a designated network of participating pharmacies. You are encouraged to use pharmacies affiliated with the Claims Administrator's provider network. A listing of providers is available by contacting the Claims Administrator at the telephone number or the web site address found in the *Administrative Information* section of the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account SPD*. When you fill your prescription at a network retail pharmacy, you pay 50% of the cost of your prescription, and the prescription drug plan pays the rest. The maximum you'll pay to fill a prescription is $100. You also have the option to fill prescriptions through the mail-order program, which is ideal for a chronic condition that requires ongoing treatment, such as arthritis, high blood pressure, diabetes, or allergies. If you fill a prescription through mail order, you'll pay a $20 copay for a 90-day generic supply, or a $50 copay for a brand name supply. The maximum the prescription drug plan will pay for prescription costs per individual in a calendar year is $2,000 (retail and mail-order combined).

For most health plans, prescription drugs should be purchased through CVS/Caremark. The PPO plan prescription drug benefits are:

PRESCRIPTION DRUG – CVS CAREMARK	
Retail – 30 day supply	50%, up to a maximum out of pocket expense of $100/script
Mail Order – 90 day supply	$20 (generic)/$50 (brand)
Specialty Drugs – member enrolled in PrudentRx*	$0
Specialty Drugs – member not enrolled in PrudentRx*	30%
Prescription Drug Annual Benefit Maximum**	$2,000/calendar year (retail and mail order combined)

*The PrudentRx Program is designed to lower your out-of-pocket costs by assisting you with enrollment in any drug manufacturer copay assistance programs that are available to you. When enrolled in PrudentRx, your out-of-pocket cost will be $0 for specialty medications (exclusions may apply, please refer to the *PrudentRx Program for Specialty Medications* section for additional detail). If you opt-out of the program or do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for 30% of the medication's cost. Specialty HIV and specialty fertility medications are excluded from the PrudentRx Program but are covered at no cost to you.

Specialty medications on the PrudentRx Drug List for members enrolled in the PrudentRx Program will not be applied towards satisfying your out-of-pocket maximum. Please see the PrudentRx Specialty list at https://www.prudentrx.com/Comcast. Select specialty medications that do not qualify as "essential health benefits" under the Affordable Care Act (for members not enrolled in PrudentRx) also do not apply to the out-of-pocket maximum.

PrudentRx Program for Specialty Medications

Comcast NBCUniversal has contracted with CVS/Caremark to offer the PrudentRx Program for certain specialty medications. The PrudentRx Program helps you and your eligible dependents enroll in manufacturer copay assistance programs that will reduce your out-of-pocket costs for specialty medications covered under the PrudentRx Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Program will assist you in obtaining copay assistance from drug manufacturers to reduce your cost share for eligible medications, thereby eliminating out-of-pocket expenses. Participation in the PrudentRx Program requires certain data to be shared with the administrators of these copay assistance programs, which will be done in compliance with HIPAA.

- Specialty medications included on the PrudentRx Program drug list will be subject to 30% coinsurance.
- If you and your eligible dependents enroll in the PrudentRx Program for your specialty medication, there will be no cost for your specialty medication.
- If you or your eligible dependents opt-out, elect to not participate in the PrudentRx Program or do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be subject to the 30% coinsurance for specialty medications and this cost share amount will not count toward your prescription drug annual out-of-pocket maximum.
- Specialty medications included on the PrudentRx Program drug list and not filled at a CVS Specialty Pharmacy are not covered. If a drug on the PrudentRx Program drug list is a Limited Distribution Drug that is unavailable to CVS Specialty, that drug will not be covered unless it is filled at an exclusive specialty pharmacy that provides that Limited Distribution Drug. You will be responsible for the full cost share and this amount will not count toward your prescription drug annual out-of-pocket maximum if you are not enrolled in the PrudentRx Program.

Steps to enroll:

- If you currently take one or more specialty medications included on the PrudentRx Program drug list *(for access to the complete PrudentRx Program drug list please visit https://www.prudentrx.com/Comcast) or call 1-800-578-4403,* you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your specialty medication.
- If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Program.

You are encouraged to call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications.

If you **choose to opt out of the PrudentRx Program** you must call 1-800-578-4403 and you will be required to pay 30% coinsurance for your specialty medication listed on the PrudentRx Specialty Drug List. PrudentRx will also contact you if you are required to enroll in the copay assistance for any specialty medication that you take. Eligible members who choose to decline enrollment in an available manufacturer copay assistance program will be responsible for the full amount of the 30% coinsurance on specialty medications that are eligible for the PrudentRx Program and this cost share amount will not count toward your prescription drug annual out-of-pocket maximum.

Specialty HIV and specialty fertility medications are excluded from the PrudentRx Program but are covered at no cost to you. For a full list of specialty drugs covered under the PrudentRx Program please visit *https://www.prudentrx.com/Comcast* (the drug list may be updated periodically by PrudentRx).

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, your cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count toward the Plan's prescription drug annual out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Program.

Purchasing Prescriptions through a Pharmacy

You will receive an ID card for your prescription drug plan benefits separate from your medical plan ID card (if applicable). When you or a covered dependent need to have a prescription filled, follow these steps:

- Present your prescription drug plan ID card to the pharmacist along with your prescription,
- Sign the voucher the pharmacist gives you, and
- Pay your portion of the cost to the pharmacy.

You do not have to submit a claim form for reimbursement. Your cost-share applies each time a prescription is filled or refilled.

If you purchase your prescription from a non-member pharmacy or if you do not have your card with you at the time of purchase, you must pay the entire cost of the prescription and submit a claim form for reimbursement.

Purchasing Prescriptions through Mail Order

Mail order is an easy and convenient way to purchase medication if you have a chronic condition that requires ongoing treatment – such as arthritis, high blood pressure, diabetes, or allergies. There are several advantages to mail order, including:

- ***Save money*** — Prescriptions for ongoing medication are less expensive when receiving them via Mail Order.
- ***Delivered to your mailbox*** — With mail order, your prescriptions come to you. You don't have to make a special visit to the pharmacy.
- ***Easy to use*** — Once you've filled out your first mail order application, you can usually order refills by phone and pay with most major credit cards.

For details on how to fill a prescription through mail order, contact the Claims Administrator directly.

Covered Prescription Drugs

In general, coverage is provided for drugs that require a prescription and are furnished in accordance with medical technology assessment guidelines. These include birth control drugs and certain drugs used on an off-label basis (e.g., drugs used to treat cancer and HIV/AIDS). This also includes:

- Diaphragms
- Injectable insulin and disposable syringes and needles needed for its administration
- Materials to test for the presence of sugar when ordered by a network physician
- Prescription prenatal vitamins and pediatric vitamins with fluoride
- Nicotine gum or nicotine patches (or other smoking cessation aids that require a prescription by law) when prescribed by a network physician. You are not required to complete a smoking cessation program in order to receive coverage for smoking cessation aids. Smoking Cessation is covered under HCR with no member cost share.
- Levonorgestrel
- Drugs used in the treatment of infertility (i.e., clomid, follistim)

Prescription Drug Utilization Management

Certain classes of prescription drugs may be subject to Utilization Management (UM) policies. UM is required to ensure safe and appropriate dispensing of medications that may present significant health risks, have strict dosing or duration guidelines, are indicated only for use in the presence of specific clinical criteria, require close monitoring, or are shown to have a potential for abuse.

One of three following UM programs may be applicable to appointed drug classes — Prior Authorization, Step Therapy, Drug Limitations Group I or Drug Limitations Group II.

Prior Authorization

Approval from the prescription drug plan is required before the drug can be obtained through the prescription drug plan. Drug classes requiring Prior Authorization include Growth Hormones and Anti-Obesity agents, Interferons and certain Rheumatoid Arthritis, Crohns Disease, Asthma/Allergy, Psoriasis and Anemia medications.

Step Therapy

Drugs in this group can be obtained only after one or more “prerequisite” medications — clinically appropriate and cost-effective alternative drugs — are tried first. The drug class included in this group is certain Asthma/Allergy medications (Leukotriene Modifiers).

Drug Limitations Group I

Prior approval is not required to obtain the drug through the prescription drug plan but the quantity that may be obtained is limited. Drug classes subject to Drug Limitations include certain Opioid Analgesics (pain medications) and Intranasal Corticosteriods/Antihistamines.

Drug Limitations Group II (Post-Limit Prior Authorization)

Prior approval is not required to obtain a limited quantity of the drug through the prescription drug plan but quantities in excess of the initial limit require prior authorization from the prescription drug plan. Drug classes subject to Drug Limitations with Post-Limit Prior Authorization include Migraine medications (5-Ht1 agonists/triptans, migranal nasal spray) and certain Opioid Analgesics (pain medications).

Prior Authorization, Step Therapy and Post-Limit Prior Authorization determinations are made by the Claims Administrator based on recognized clinical guidelines.

Prescription Drugs Not Covered

The following prescription charges are not covered by the prescription drug plan:

- Therapeutic devices or appliances, support garments and other non-medicinal substances
- Prescriptions filled by a person not licensed to fill them
- Prescriptions filled after your coverage under the prescription drug plan terminates
- Drugs considered experimental by federal law
- Charges for giving or injecting drugs
- Drugs given while confined in a hospital, nursing home or similar place that has its own drug dispensary. These expenses are covered under the health care plan as part of the cost of your or a dependent's hospital stay.
- Drugs for injuries or illnesses not covered under the prescription drug plan
- Any refill in excess of the number specified by the physician or dispensed more than one year after the prescription was written
- Over-the-counter medications, except insulin and certain diabetic supplies
- Drugs available without charge under Workers' Compensation laws
- Biological sera, blood or blood plasma
- Anti-wrinkle agents (e.g., Renova)
- Dermatologicals, hair growth stimulants
- Cosmetic hair removal products
- Certain bulk powders, bases, kits, patches and miscellaneous formulations as part of a compound prescription
- Fertility medications
- Erectile Dysfunction drugs

Filing Prescription Drug Claims

If you visit a participating pharmacy, you do not have to submit a claim form for reimbursement. You are subject to a portion of the cost each time a prescription is filled or refilled. If you forget your ID card and need to file a claim, contact the Claims Administrator at the telephone number shown on your ID card for instructions on how to file a claim.

If you purchase your prescription from a non-member pharmacy or if you do not have your card with you at the time of purchase, you must pay the entire cost of the prescription and submit a claim form for reimbursement.

You have certain rights regarding claims and appeals. For more information, see the *Comcast NBCU Post-Retirement Health Care & Retiree Reimbursement Account SPD.*

Other Important Information

Coordination of Benefits and Subrogation

This Plan has been designed to help you meet health care costs for you and your family. It is not intended that you receive greater benefits than the actual expenses incurred. Therefore, the amount paid by the Plan will take into account any coverage you or your covered dependents have under any other group health care or government program, including any automobile no-fault coverage (where permitted by law). Coordination of benefits will generally apply to only the medical plans.

Effect of Other Health Care Benefits

The Plan will coordinate the benefits it pays with those benefits provided by other medical plans so that the total benefit provided by both plans combined is not greater than the total benefit that would have been provided under the Plan if it were the only plan providing coverage. Coordination of benefits is not provided under the prescription drug plan.

COB requires determining which plan is "primary." Eligible expenses are paid first by the primary plan. If the Independence Standard or Minimum PPO Plan is secondary, it then pays the difference between what was paid under the primary plan and what the Independence Standard and Minimum PPO Plans would have paid.

To administer the COB rules described in this section, the plan (or its duly authorized delegates) reserves the right to exchange information with other plans involved in paying claims and to require you or your medical care provider to furnish any necessary information.

If this Plan should have paid benefits that were paid by another medical plan, this Plan may reimburse the other plan as appropriate under the plan. An amount paid in this way will be considered to be a benefit paid under the Independence Standard and Minimum PPO Plans, and the Plan will be fully discharged from any liability it may have to the extent of that payment.

To obtain the entire benefits available, file a claim under each plan that covers the person for the expenses incurred. Please remember that any person claiming benefits under this Plan must provide the Plan Administrator, or the applicable plan insurer, with information about any other coverage the person may have.

Group Health Plans

If you and your eligible dependents are covered under more than one group health plan, the primary plan (the one responsible for paying benefits first) needs to be determined. If this Plan is paying secondary, your Plan coverage will ensure that, in total, you receive benefits up to what you would have received with this Plan as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount. A summary of the coordination rules (how the Plans coordinate coverage with another group health plan to ensure nonduplication of benefits) is provided below. If you have questions, contact the Claims Administrator for help.

Here is an example of how this Plan coordinates benefits with other group health plans. Assume your spouse has a medically necessary procedure with a reasonable and customary (R&C) charge of $100. If your spouse's plan is primary and pays 70% for that procedure, your spouse will receive a $70 benefit (70% of $100). Also assume that this Plan is secondary and pays 80% for this medically necessary procedure. In this case, your spouse normally would receive

an $80 benefit (80% of $100) from this Plan. Because your spouse already received $70 from his or her primary plan, he or she would receive the balance ($10) from this Plan.

Determining Primary Coverage

In order to pay claims, the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan must determine which health plan is primary and which plan is secondary. You will have to give information about any other plans when you file a claim.

There are rules to determine which plan is primary and which plan is secondary. The rules are used until one is found that applies to the situation. They are always used in the following order:

- A plan that has no coordination of benefits provision will be primary to a plan that does have a coordination of benefits provision.
- A plan that covers the person as a retiree will generally be primary to a plan that covers the same person as a dependent. However, if the person is a Medicare beneficiary and, as a result of the Medicare Secondary Payer rules, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (for example, a retiree), then the order of benefits is reversed so that the plan covering the person as a retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.
- The following ordering rules are used to determine which plan is primary and which plans are secondary when a person is covered as a dependent child under two or more medical plans of parents who either 1) are married or are living together (whether or not they have ever been married), or 2) have a court decree that either awards joint custody without specifying that one parent has the responsibility to provide medical coverage, or specifies that both parents are responsible for the dependent child's medical care expenses and coverage:
  - The plan that covers a child of the parent whose birthday is earlier in the calendar year will generally be primary to a plan that covers a child of a parent whose birthday is later in the calendar year. For example, if your birthday is in May and your spouse's birthday is in October, your plan is considered primary for your child, regardless of which spouse is older in actual years.
  - If both parents have the same birthday, the plan that covered one of the parents longer will be primary to the plan that covered the other parent for a shorter period of time.
- For a dependent child whose parents are divorced, if a court decree states that one of the parents is responsible for the dependent child's medical care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no medical care coverage for the dependent child's medical care expenses, but the parent's spouse does, the parent's spouse's plan is primary. This provision will not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- The following ordering rules are used to determine which plan is primary and which plans are secondary when the parents are divorced, and there is no court decree allocating responsibility for the child's medical care services or expenses:
  - The plan of the parent with custody will pay benefits first.
  - The plan of the stepparent with custody will pay benefits next.
  - The plan of the parent without custody will pay benefits next.
  - The plan of the stepparent without custody will pay benefits next.
- A plan that covers you as an active worker, or as a dependent of that active worker, is primary to any plan that covers the person as a laid-off or retired worker, or as a dependent of that laid-off or retired worker.
- A plan that covers a person as an active or retired worker, or as a dependent of that active or retired worker, is primary to any plan that covers that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law.
- If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan.
- If none of the preceding rules determines the order of benefits, the allowable expenses will be shared equally between the plans.

After it is determined which plan pays benefits first, you will need to submit your initial claim to that plan. After the first plan pays your benefits (up to the limits of its coverage); you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You will need to include a copy of the written explanation of benefits (EOB) from your primary plan.

If the Plan pays more than the required amounts under this coordination of benefits provision, the plan has the right to recover the excess payment from the individual for whom the benefit was paid, the insurance company, or the other benefit plan.

Coordination with Medicare

Benefits for Individuals Who Are Entitled to Medicare

The Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan pay secondary and Medicare is the primary payer if you (or your covered family member) are entitled to Medicare (meaning eligible and enrolled), you (or your covered family member) do not have end-stage renal disease and you do not have current employment status with Comcast/NBCUniversal.

Medicare is also the primary payer if you or your eligible dependent become entitled to Medicare due to age or disability while enrolled in COBRA coverage. In this situation, Medicare pays primary and COBRA pays secondary. If Medicare entitlement is due to end-stage renal disease while enrolled in COBRA coverage, COBRA will be the primary payer for the first 30 months of Medicare entitlement and Medicare will be pay secondary. At the end of the 30-month period, Medicare will become the primary payer. See the Continuing Coverage under COBRA section for additional information on COBRA coverage.

Please note that you must enroll in both Parts A and B of Medicare coverage when you are first eligible; otherwise the Plan or Medicare may not cover the expenses. If you do not enroll in Medicare Part B when first eligible, you may face late enrollment penalties and Medicare can apply this penalty for as long as you are enrolled in Part B.

Please note: if you are receiving subsidized COBRA, the end of your subsidized COBRA coverage is not a special enrollment period that would allow you to enroll in Medicare. You will not be able to enroll in Medicare when subsidized COBRA coverage ends unless you are first eligible for Medicare at that time, e.g., you are just turning 65. Otherwise, you will have to wait for the Medicare Annual Enrollment period, between January 1 and March 31, and your coverage will not begin until July 1.

How the Plan Pays When Medicare Is Primary

If Medicare pays benefits first, the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan pay benefits as described below. This method of payment only applies to a Medicare-eligible person. Medicare statements are required before payment can be made.

First, the Standard and Minimum PPO Plans determine the amount payable according to the benefits payable under the plan; however, the amount of covered expenses is based on the amount of charges allowed under Medicare rules instead of the allowable charges as defined by the Standard and Minimum PPO Plans. Then, the Standard and Minimum PPO Plans subtract the amount payable under Medicare for the same expenses. The Plan pays only the difference (if any) between Plan benefits and Medicare benefits.

The amount payable under Medicare that is subtracted from the Standard and Minimum PPO Plans benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare + Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all the rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

The Plan will coordinate its prescription drug coverage with Medicare Part D according to Medicare coordination of benefits rules under federal law. If you are or will become eligible for Medicare Part D while covered under this plan, ask the Plan Administrator for more information.

Medicaid

If you or your dependents are covered under a state Medicaid program, the Independence Standard and Minimum PPO Plans are primary and pays benefits before Medicaid. The Plan does not reduce or deny benefits for you or your covered dependent(s) to reflect eligibility to receive medical assistance under a state Medicaid program. In addition, the Plan reimburses any state Medicaid program for the cost of any items and services provided under the state program that should have been paid for by the Plan, and honors any subrogation rights that a state has in order to recoup such mistaken payments.

Other Government Health Plans

If you are also covered under a government plan, this Plan does not cover any services or supplies to the extent that those services and supplies, or benefits for them, are available under the government plan. This provision does not apply to any government plan that by law requires this plan to pay primary.

A government plan is any plan, program, or coverage other than Medicare or Medicaid, that is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Effect of No-Fault Motor Vehicle Coverage

If you (or your dependent) has coverage for health care services or loss of income available to you under any no-fault motor vehicle coverage required by law, the no-fault motor vehicle coverage has financial liability for losses.

The Independence Standard and Minimum PPO Plans do not provide coverage for health care services covered by no-fault motor vehicle coverage. Where permitted, the Plan will pay the claims up-front and collect from the auto insurance company later (see Acts of Third Parties). Where subrogation is not permitted, the Claims Administrator will request additional information-on about accident-related services prior to paying benefits.

The above description applies to no-fault motor vehicle coverage other than in the state of Michigan. The following applies with respect to motor vehicle injuries for residents of Michigan:

For a participant who is a Michigan resident, benefits are not payable under the Comcast health plan for injuries received in an accident involving a motor vehicle. For purposes of this exclusion, the term “motor vehicle” means an automobile, truck, motor driven trailer, or other vehicle which is the type of vehicle normally intended for use on paved roads or highways. Motor vehicle does not include a motorcycle or other two-wheel vehicle. Motor vehicle also does not include a snowmobile, motor boat, all-terrain vehicle, or similar type of motor-driven vehicle which is not intended for use on paved roads and highways. This applies to Michigan residents only. However, this exclusion will not apply to a Participant who is a Michigan resident, who is injured in a motor vehicle accident, where no-fault motor vehicle benefits are not legally payable, such as an accident involving a motor vehicle where the accident occurs outside of North America.

Effect of Workers’ Compensation

If you suffer a work-related injury or sickness covered under Workers’ Compensation law, that coverage has primary financial liability for losses.

The Independence Standard and Minimum PPO Plans do not provide benefits for health care services covered under Workers' Compensation law. The Plan will pay benefits subject to its right to recover those payments if and when it is determined that Workers' Compensation law covers them.

Refund of Overpayments

Whenever payments have been made by the Independence Standard and Minimum PPO Plans that at any time total an amount in excess of the maximum amount payable under the Plan provisions, you (or your dependent) must make a refund of the excess amount to the Plan or help the Plan obtain the refund from another person or organization.

If you or any other person or organization that was paid does not promptly refund the full amount, the plan may reduce the amount of any future benefits that are payable. The reductions will equal the excess amount paid. In the case of recovery from a source other than the plan, the refund equals the amount of recovery up to the amount that would have been paid under the plan. The plan may have other rights in addition to the right to reduce future benefits (see *Acts of Third Parties*).

Acts of Third Parties

When you or your covered dependent ("you") are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical and prescription drug) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party within a reasonable time, but no more than 60 calendar days after you knew or should have known of the actions or inactions of the third party that caused you injury or illness, and you must follow special plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery (also referred to as "reimbursement").

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury. You must pay the Plan back first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree:

- to notify the Plan and obtain its consent before settling claims with any third party responsible for your illness or injury;
- to notify any third party responsible for your illness or injury of the Plan's right to reimbursement for any claims related to your illness or injury;

- to hold any reimbursement or recovery received by you (or your dependent, legal representative, or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan with respect to such illness or injury and to reimburse the Plan promptly for the benefits paid, even if you are not fully compensated or made whole for your loss;
- that the Plan has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- that the Plan may appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- that the Plan has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or dependent is made whole) and that the Plan's claim has first priority over all other claims and rights;
- to reimburse the Plan in full up to the total amount of all benefits paid by the Plan in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance, or otherwise, must be turned over to the Plan as reimbursement up to the full amount of the benefits paid;
- that the Plan's claim is not subject to reduction for attorneys' fees, costs, or damages under the "common fund" doctrine or otherwise;
- that, in the event that you elect not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the Plan's request, any right or cause of action to the Plan;
- not to take or omit to take any action to prejudice the Plan's ability to recover the benefits paid;
- to cooperate in doing what is necessary to assist the Plan in recovering the benefits paid or in pursuing any recovery or reimbursement;
- to forward any recovery to the Plan within ten days of disbursement by the third party or to notify the Plan as to why you are unable to do so; and
- to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Plan's attorneys' fees, costs, or damages.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive; or

- any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Notify the Plan within 10 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

If the subrogation provisions in these Acts of Third Party provisions conflict with subrogation provisions in an insurance contract that governs the benefits at issue, the subrogation provisions in the insurance contract will control. If the right of recovery provisions in these Acts of Third Party provisions conflict with right of recovery provisions in an insurance contract that govern the benefits at issue, the right of recovery provisions in the insurance contract will control.

Notwithstanding anything to the contrary, no provision in any governing document or contract will be interpreted to limit the Plan's right to seek subrogation or reimbursement from you, your covered dependent, or the dependent, legal representative, or agent of you or your covered dependent.

Continuation of Coverage — COBRA

This section contains important information about the right to a temporary extension of coverage under the Comcast NBCUniversal-sponsored group health plan. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that Comcast NBCUniversal provide your covered dependents who are qualified beneficiaries under COBRA with the opportunity to continue coverage under the plan for a temporary period at group plan premium rates in certain instances where your coverage under the plan would otherwise end.

This SPD provides your initial COBRA notice rights with respect to the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan. COBRA continuation rights with respect to RRA benefits are described in the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account SPD*.

Your covered dependent will have to pay the entire premium plus a 2% administrative fee for continuation coverage. Regularly scheduled payment is due postmarked by the first day of each month to which the payments apply. There is a grace period of 30 days for the payment of the regularly scheduled premium. Payments must be postmarked on or before the end of the 30-day grace period.

Information regarding the Plan's COBRA Administrator can be found in *Administrative Information*.

COBRA Extensions due to COVID-19 Pandemic

Note that some of the COBRA deadlines may be extended due to the COVID-19 national emergency. Please contact the COBRA Administrator if you have questions about the deadlines associated COBRA during the COVID-19 emergency period.

Who Is Covered

If you are the spouse or eligible domestic partner/civil union partner of a retiree and are covered under the Independence Standard or Minimum PPO Plans and/or the CVS/Caremark Prescription Drug Plan on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose coverage under the Plan(s) due to divorce or the termination of your domestic partnership/civil union partnership.

If you are a covered dependent child of a retiree covered by the plan on the day before the qualifying event, you also are a qualified beneficiary and have the right to continuation coverage if group health coverage under such plan is lost for any of the following reasons:

- The death of the retiree (if the dependent child cannot be covered under a spouse covered by the plan);
- The retiree's divorce or termination of domestic partnership/civil union partnership; or
- The dependent ceases to be a "dependent child" under the plan.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Comcast and NBCUniversal, and that bankruptcy results in the loss of coverage of any retired employee covered under the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, domestic partner, civil union partner, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan.

Special Rules for Domestic Partners and Civil Union Partners: Although eligible domestic partners or civil union partners and their eligible dependent children are generally not considered qualified beneficiaries for purposes of legal entitlement to COBRA continuation coverage, Comcast NBCUniversal does make COBRA-like coverage available to domestic partners or civil union partners and their eligible dependent children who meet the requirements for eligibility under the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan. Accordingly, eligible dependents for purposes of receiving COBRA coverage as described in this section also include domestic partners or civil union partners and their dependent child(ren). If your domestic partner or civil union partner and his or her eligible dependent children are covered under the Plan(s) and you terminate your domestic partnership or civil union partnership, you must notify Comcast NBCUniversal within 60 days of the event. Your domestic partner or civil union partner and his or her eligible dependent children will thereafter be eligible to continue to receive COBRA continuation coverage under the Independence Standard and Minimum PPO and CVS/Caremark Prescription Drug Plan, as described in this section.

Your Duties

Under the law, the retiree or a representative acting on your behalf (such as a family member) has the responsibility to inform Mercer Marketplace 365+ Retiree if applicable of a divorce, termination of domestic partnership/civil union partnership, or a child losing dependent status under the Independence Standard and Minimum PPO Plans and CVS/Caremark Prescription Drug Plan. This notice must be provided in writing within 60 days from the date of the divorce or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event). For the termination of a domestic partnership or civil union partnership, this notice must be provided in writing within 60

days from the date of the termination of domestic partnership or civil union partnership. You or a representative acting on your behalf (such as a family member) is responsible for providing the required notice.

The notice must include the following information:

- The name of the retiree who is or was covered under the Plan(s);
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan(s) due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- The signature, name and contact information of the individual sending the notice.

You must provide this notice to the COBRA Administrator at the address listed in the *Administrative Information* section of this SPD.

When the COBRA Administrator is notified that one of these events has happened, the COBRA Administrator will, in turn, notify you that you have the right to elect continuation coverage. If the above procedures are not followed or if you or your family member fail to notify the COBRA administrator within the 60-day notice period, then continuation rights are forfeited. Additionally, if any benefits are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce or termination of domestic partnership/civil union partnership or a child losing dependent status, then the retiree and/or family members will be required to reimburse the employer-sponsored group health plans for any benefits mistakenly paid.

Electing COBRA

To inquire about COBRA coverage, contact:

BenefitConnect | COBRA
PO Box 981915
El Paso, TX 79998

1-877-292-6272 [(858) 314-5108 International callers only]

If you or your covered dependent(s) have questions regarding the election forms or process, you should contact the Plan's COBRA Administrator. Information regarding the Plan's COBRA Administrator can be found in *Administrative Information*.

Under the law, a qualified beneficiary must elect continuation coverage within 60 days from the date that qualified beneficiary would lose coverage because of one of the events described earlier, or, if later, 60 days after Comcast NBCUniversal provides notice of the right to elect continuation coverage. A qualified beneficiary who does not elect continuation coverage within the time period described above will lose the right to elect continuation coverage. A qualified beneficiary's election must be postmarked within the 60-day election period. If the qualified beneficiary does not submit a completed election form within the 60-day election period, they will lose the right to COBRA.

If the qualified beneficiary elects continuation coverage, Comcast NBCUniversal is required to give coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated family

members. This means that if the coverage for similarly situated family members is modified, the qualified beneficiary's coverage will be modified. "Similarly situated" refers to a current dependent who has not had a qualifying event.

Notice of Unavailability of Continuation Coverage: The Department of Labor requires that the Plan Administrator provide a notification to a qualified beneficiary if continuation of coverage is not available once the Plan Administrator receives notice of an initial qualifying event resulting from divorce, loss of dependent status, or termination of domestic partnership or civil union partnership. This notice must be provided no later than 14 days after the Plan Administrator receives notice from the qualified beneficiary.

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months.

Early Termination of COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the 36-month period for any of the following reasons:

- Comcast NBCUniversal no longer provides group health coverage to any of its retirees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of the individual

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated.

Please note: if you are receiving subsidized COBRA, the end of your subsidized COBRA coverage is not a special enrollment period that would allow you to enroll in Medicare. You will not be able to enroll in Medicare when subsidized COBRA coverage ends unless you are first eligible for Medicare at that time, e.g., you are just turning 65. Otherwise, you will have to wait for the Medicare Annual Enrollment period, between January 1 and March 31, and your coverage will not begin until July 1.

Cost of Coverage

Qualified beneficiaries will be required to pay the full cost of coverage. In addition, there is a 2% administrative fee, making the payment a total of 102% of the cost of coverage.

The cost of group health coverage periodically changes. If qualified beneficiary elects COBRA coverage, they will be notified by the COBRA Administrator of any cost changes.

COBRA coverage is not effective and claims for coverage will not be processed until COBRA is elected and the required payments are made. The qualified beneficiary's first premium is due within 45 days after you elect COBRA coverage. The first payment must cover the cost of COBRA coverage from the time the coverage under the Plan would have otherwise terminated up through the end of the month before the month in which first payments are made. Qualified

beneficiaries are responsible for making sure that the amount of the first payment is correct. Qualified beneficiaries may contact the COBRA Administrator to confirm the correct amount of the first payment.

If a qualified beneficiary does not make the first payment for COBRA coverage within the 45 days after the date of the timely election, the qualified beneficiaries will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period).

All COBRA premiums must be paid by check or money order. The first payment and all monthly payments for COBRA coverage must be mailed to the COBRA Administrator. Each payment is considered to have been made on the date that it is postmarked. If a qualified beneficiary pays part but not all the premium, and the amount paid is not significantly less than the full amount due, your dependent(s) will have 30 days from the end of the initial 30-day grace period to pay the outstanding amount due. If a qualified beneficiary fails to make a monthly payment before the end of the grace period for that month, all rights to COBRA coverage under the Plan will be lost. The qualified beneficiary will not be considered to have made any payment by mailing a check if the check is returned due to insufficient funds or otherwise.

If the qualified beneficiary does not make timely payments, the COBRA coverage will be terminated as of the last day of the full coverage month for which a timely payment was made.

Conversion Coverage and Special Continuation Rights for California Workers

Some health plans offer conversion to individual coverage. Contact the health plan directly for information on converting to an individual policy. Many health plans will permit you to continue membership or equivalent coverage on an individual policy. Conversion rights may also be available to your spouse and/or dependents when their coverage may not otherwise qualify for health insurance under normal circumstances. Therefore, the cost of coverage is usually high and the conversion plans, prescribed by the state insurance regulations, will not offer the same comprehensive coverage as the plan. For that reason, you should also contact other insurance companies so you can be sure you are getting the best coverage for your money.

For more information about conversion rights, contact Independence directly.

Claims Review and Appeals Processes

In general, any participant or beneficiary or his/her duly authorized representative (the "claimant") may file a written claim for benefits using the proper form and procedure.

A benefit plan has a specific amount of time, by law, to evaluate and process claims for benefits covered by ERISA. The length of time the benefit plan has to evaluate and process a claim begins on the date the claim is first filed, even if the claim is considered incomplete.

If you have any questions regarding how to file or appeal the initial claim, contact the appropriate Claims Administrator.

Following an adverse benefit determination on review, and after exhausting the applicable plan appeal process described below, you are entitled to bring a civil action in a federal or state court of competent jurisdiction in accordance with Section 502(a) of the Employee Retirement Income Security Act of 1974.

Claim and Appeal Extensions due to COVID-19 Pandemic

Note that these deadlines may be extended due to the COVID-19 national emergency. Please contact the Claims Administrator if you have questions about the deadlines associated with filing claims and appeals during the COVID-19 emergency period.

Eligibility and Enrollment Claims and Appeals

Any claim for eligibility and enrollment for a benefit under the Plan must be received by the Plan Administrator, or its delegate, in writing within 90 days after the date on which you believe your eligibility or enrollment should have occurred. The Plan Administrator, or its delegate, will notify you of any adverse determination on your claim for eligibility and enrollment for a benefit under the Plan within a reasonable time after it is received, generally within 90 days after the claim is received by the Plan, unless special circumstances require an extension of time for processing. If there is an extension, you will be notified of the extension and the reason for the extension within the initial 90-day period. The extension shall not exceed 180 days after your claim is filed.

If your eligibility and enrollment claim is denied, you may appeal your claim to the Plan Administrator, or its delegate, which will make all determinations regarding your eligibility and enrollment claim on appeal, in writing within 60 days after you receive notice of the denial. The requested review will take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. If you don't appeal on time, you lose your right to later object to the decision.

The Plan Administrator, or its delegate, will review your claim and issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period, but no later than 60 days after receipt of your written request for review, unless the Plan Administrator, or its delegate, determines that special circumstances require an extension. You will be notified in writing of any such extension within 60 days following the request for review. The extension shall not exceed 180 days after your claim is filed. A copy of the review determination will be provided to you and will be final and binding upon you and all other persons or entities involved.

Medical and Prescription Drug Claims

The health care programs listed above recognize four categories of health benefit claims:

Urgent Care Claims — Claims for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician with knowledge of the patient's condition, would subject the patient to severe pain that cannot be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-service Claims — Claims must be decided before a patient will be afforded access to health care (e.g., preauthorization requests).

Post-service Claims — Claims involving the payment or reimbursement of costs for medical care that has already been provided.

Concurrent Care Claims — Claims where the plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments.

Adverse Benefit Determination — If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, the Plan will not rescind coverage under a medical or prescription drug option for a participant or covered dependent unless the participant or covered dependent performs an act, practice, or omission that constitutes fraud (as defined by the plan) or intentionally misrepresents a material fact with respect to the medical or prescription drug coverage.

Initial Benefit Determination

Urgent Care Claims

The Claims Administrator will notify you of the Plan's determination, whether adverse or not, as soon as possible, taking into account requirements but, not later than 72 hours after receipt of the claim unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. Notification of the improper filing may be

made orally, unless the claimant requests written notification. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of the Plan's benefit determination as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded you to provide the specified additional information.

Pre-Service Claims

The Plan Administrator will notify you of the Claims Administrator's determination, whether adverse or not, within a reasonable period of time, but not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and notifies you, within the initial period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information.

If the claim is improperly filed, the Claims Administrator will notify you as soon as possible, but not later than five (5) days after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless you request written notification. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claims

For non-urgent post-service health claims, the plan has up to 30 days following receipt of the claim to evaluate and respond to claims for benefits covered by ERISA. This period may be extended by 15 days provided the Claims Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the plan and notifies you, within the initial period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims

Concurrent care claims may fall under any of the other three categories, depending on when the request is made. If you request an extension of ongoing treatment in an urgent care situation, the claims administrator will notify you within 24 hours of your request, provided your request is made at least 24 hours before the end of the approved treatment. Non-urgent claims will be treated as either pre-service or post-service claims.

If you reside in a county where 10 percent or more of the population is literate in a non-English language, your Comcast/NBCUniversal medical option must provide foreign language assistance for benefit questions, claims, appeals, and external review. If you have questions about foreign language assistance, please see the statements on your Comcast/NBCUniversal medical option explanation of benefits (EOB) or contact your medical carrier using the phone number on the back of your medical identification card.

Appealing a Claim Determination

The following section generally describes the health plan's appeals process.

Coverage for you, your spouse/domestic partner/civil union partner and your or your spouse/domestic partner's/civil union partner's dependent children will continue, pending the outcome of an internal appeal. This means that a plan can't terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

An "adverse benefit determination" is a denial, reduction or termination of a benefit, or failure to provide or pay (in whole or in part) for a benefit. This can also include a denial to participate in the plan. For health coverage, an adverse benefit determination also means a claim denial on the grounds that the treatment is experimental or investigational or not medically necessary, this also includes concurrent care determinations. An adverse benefit determination includes any rescission of coverage under the plan, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time. In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reason for the adverse determination,
- The specific provisions of the plan on which the determination is based,
- A description of any additional information needed to reconsider the claim and the reason this information is needed,
- A description of the plan's review procedures and the time limits applicable to such procedures,
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review (after the internal review process),
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request,
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, either an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request,
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than three (3) days after the oral notice,
- The notice will include information sufficient to identify the claim involved. This includes:
  - the date of service,
  - the health care provider,
  - the claim amount (if applicable), and
  - the denial code and corresponding meaning;
- A statement describing availability, upon request, of diagnosis code and its corresponding meaning and treatment code and its corresponding meaning;
- The notice will also include a description of the plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes;
- Description of available internal appeals and external review processes, including information about how to initiate an appeal;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to records, and other information relevant to the claim for benefits; and
- A description of your right to obtain additional information upon request, about any voluntary appeals procedures under the Plan.

Internal Appeal

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) may appeal and request a claim review within 180 days after receiving the denial notice. The request must be made in writing and should be filed with the Claims Administrator.

The Plan will provide continued coverage pending the outcome of an internal appeal. Further, the Plan will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

The Claims Administrator/Insurer is typically the named fiduciary for review. If it is not the named fiduciary, the Claims Administrator/Insurer will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator or other appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

In addition, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the experts' reputation for outcomes in contested cases, rather than based on the professionals' qualifications.

You will be able to review your file and present evidence and testimony as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable U.S. Department of Labor regulations. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the plan) in connection with

the claim. This evidence will be provided at no cost to you, and will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the plan's determination on review within the following timeframes:

- For urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours after receipt of the request for review,
- For pre-service claims, within a reasonable period of time given the medical situation, but no later than 15 days after receipt of the request for review, and
- For post-service claims, within a reasonable period of time, but not later than 30 days after receipt of the request for review.

In certain cases, the plan may obtain a limited extension of time if notice of the extension is provided to the claimant before the end of the initial decision-making period.

In the case of denial of your appeal,, you will receive notice containing the following:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the plan on which the determination is based;
- A statement that 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 claim for benefits;
- A description of your right to bring a civil action under section 502(a) of ERISA following a final adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- For adverse determinations, the notice will include information sufficient to identify the claim involved. This includes:
  - the date of service,
  - the health care provider,

  - the claim amount (if applicable), and
  - the denial code and corresponding meaning;.
- Statement describing availability, upon request, of diagnosis code and its corresponding meaning and treatment code and its corresponding meaning;
- The notice will also include a description of the plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman and/or the Employee Benefits Security Administration (EBSA) to assist enrollees with the internal claims and appeals and external review processes;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal; and
- A description of your right to obtain additional information upon request about any voluntary appeals procedures under the plan.

If the Claims Administrator fails to strictly adhere to all of the internal review procedures described here, you will be deemed to have exhausted the plan's internal review process and may initiate an external review (as described below) or pursue other legal remedies, including a lawsuit against the plan fiduciaries. Despite the strict adherence rule, the internal claims and appeals procedures are not deemed exhausted on account of violations that are de minimis.

Second Level of Appeals

If you have exhausted the first level of appeals and if the appeal of your benefit claim is denied, you or your representative may make a second appeal of your denial in writing to Claims Administrator. If you are appealing an adverse benefit determination, you will be required to complete two levels of appeals before you can initiate an external review process (if applicable) or pursue civil action under section 502(a) of ERISA.

You or your representative may make a second appeal of your denial within 60 days of the receipt of the written notice of denial or 60 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Your decision to submit a benefit dispute to this second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending. The Plan will also provide information about the applicable rules, your right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process. There is no administrative fee imposed by the Plan to initiate a second level of appeal.

The Claims Administrator will make a determination on your second level claims according to the same timeframes as the first level of appeals as described above in the Internal Appeals section. In the case of an adverse benefit

determination on the second level appeal, you will receive a notification containing the same information as the benefit determination notice under the first level of appeals as described above in the Internal Appeals section.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

External Review Process

If your appeal under the internal review process outlined above is denied, you may request an external review of your claim within four months after being notified of a denied claim. External review is not automatic; you must request it. The external review is conducted by an independent review organization (IRO) and its decision is binding on you and the Plan, except to the extent other remedies are available under federal law. The procedures for filing an appeal under the external review process are outlined below.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health Plan (for example, worker classification and similar issues). External review only applies if the adverse benefit determination is based on:

- Clinical reasons;
- Claims involving medical judgment, as determined by the external reviewer,
- Claims resulting in a rescission of coverage; or
- The exclusions for experimental or investigational services or unproven services.

Within five days of receiving your request, the Claims Administrator will conduct a "preliminary review" to ensure the request can be sent for external review (for example, to ensure the denied claim or appeal doesn't relate to Plan eligibility and that the request is complete). The Claims Administrator will notify you in writing once the preliminary review is complete. If the request is complete but not eligible for external appeal, such notification must include the reasons for its ineligibility. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and you will have the later of the remaining time within the four-month filing period or 48 hours following the receipt of the notification to perfect your appeal request.

The IRO assigned to conduct your external review will notify you of its acceptance of the assignment and you will have 10 business days to submit any additional written information for the IRO to consider. (Within one business day of receiving your additional information, the IRO must share the new material with the Claims Administrator. After considering the new information, the Claims Administrator may reconsider and reverse its claim or appeal denial, stopping the external review procedure.) To ensure independence, the Claims Administrator or other applicable party will randomly assign the appeal request to one of at least three IROs with whom the medical carrier or other applicable party has contracted for such external appeals.

The IRO must conduct its external review "de novo", without giving any weight to the Plan's earlier conclusions or decisions. IROs may consider information beyond the denied claim's records, such as the claimant's medical history, appropriate practice guidelines and Plan terms. The IRO must complete its external review and send notice of its decision to you and the Plan within 45 days for standard (non-urgent) external reviews or within 72 hours for urgent external reviews.

Decisions resulting from an external review are binding on the plan or insurer and the claimant, subject to judicial review. If the IRO reverses the Plan's earlier decision to deny a claim or appeal, the Plan will immediately provide coverage or payment for the claim, even if the Plan chooses to challenge that decision in court.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within one year of the date of the final adverse benefit determination or final review decision on your claim under the Plan. A claim is incurred when the service giving rise to payment is performed by the provider.

ADMINISTRATIVE INFORMATION

Plan Information	
Plan Name	Comcast Comprehensive Retiree Health and Welfare Benefit Plan
Plan Number	506
Plan Year	January 1 through December 31
Plan Type	Group Medical and Prescription Drug Plan
Source of Contributions	The cost is paid for out of the general assets of Comcast Corporation, except for any amount paid by COBRA beneficiaries.
Employer Identification Number	Comcast: 27-0000798 NBCUniversal: 27-3526824
Plan Administrator	**Comcast Corporation** **Benefits Fiduciary Committee** 1701 John F Kennedy Blvd. Philadelphia, PA 19103 215-286-1700
Plan Sponsor	**Comcast Corporation** 1701 John F Kennedy Blvd. Philadelphia, PA 19103
Claims Administrator	**Independence Standard and Minimum PPO Plans** P.O. Box 8900016 Camp Hill, PA 17089 1-800-ASK-BLUE (1-800-275-2583) www.ibx.com/comcast **CVS/Caremark Prescription Drug Plan** CVS/Caremark 9501 East Shea Boulevard Scottsdale, AZ 85260-6719 1-800-652-5798
COBRA Administrator	BenefitConnect | COBRA PO Box 981902 El Paso, TX 799981-877-292-6272 [(858) 314-5108 International callers only]
Agent for Service of Legal Process	**Plan Administrator**

OTHER IMPORTANT PROVISIONS

For information on other important provisions related to the Plan, please review the *Comcast NBCUniversal Post-Retirement Health Care & Retiree Reimbursement Account Program* SPD. This information includes (but not limited to):

- HIPAA
- Your Rights Under ERISA
- Plan Fiduciaries
- Plan Administrator
- Plan Amendment, Continuation and Termination
- Limitations on Rights
- Non-Assignment of Benefits