Health and Welfare Benefit Plan

Summary Plan Description

Effective Jan. 1, 2022

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Overview

Your Frontdoor Benefits Program

As a Frontdoor associate, you enjoy a broad range of valuable benefits that are designed to serve you as thoughtfully and effectively as you serve your customers. Frontdoor is committed to the well-being of our associates and their families in all forms: physical, financial, community, career and social. The company's philosophy is to provide a comprehensive benefits program that meets the needs of our diverse associate population.

The Frontdoor benefits program:

- Provides financial protection for you and your family against expenses associated with health care, disability and death
- Offers benefit options so you can choose a personalized program that meets your unique needs
- Makes benefits easy to use and understand
- Enhances and supports your career with the company along with your personal growth

This guide has been prepared for associates of participating companies listed below:

- American Home Shield
- Streem, Inc

Plan Highlights

This section gives you a brief overview of the benefits you enjoy as a Frontdoor associate. Subsequent sections describe each benefit in greater detail.

Medical and Prescription Drug Plan

Covers preventive care charges and day-to-day health care expenses, such as office visits and prescriptions.

Dental Plan

Covers a portion of charges for most of the dental care you and your family are likely to need. You can choose from two dental options.

Vision Plan

Provides coverage for eye exams, contact lenses (including disposable contacts), and eyeglass lenses and frames.

Flexible Spending and Health Savings Accounts

If you are enrolled in a medical PPO option or waive medical coverage, the Health Care Flexible Spending Account lets you set aside before-tax money for eligible health care expenses that are not covered by other insurance. The Dependent Day Care Flexible Spending Account lets you set aside before-tax money for eligible dependent day care expenses. If you are enrolled in either the Enhanced or Basic CDHP medical option, the Health Savings Account lets you set aside before-tax money for eligible health care expenses that are not covered by other insurance.

Life Insurance

Frontdoor provides basic life insurance. For additional life insurance, you can choose from several levels of supplemental life insurance coverage according to your personal needs. You can also choose coverage for your dependents.

Accidental Death and Dismemberment Insurance

Pays a benefit in the event of death or dismemberment from a covered accidental injury. You can choose coverage for yourself and your dependents.

Business Travel Accident (BTA) Insurance

Frontdoor provides company-paid business travel accident insurance, which protects you while you're traveling on approved company business.

Short-Term Disability (STD) and Long-Term Disability (LTD) Plans

STD is a company provided plan which replaces a percentage of your pay for a short-term, non-work-related disability. LTD replaces a percentage of your pay during an extended disability.

Frontdoor LifeManagement Program

This program provides free, confidential, short-term counseling for a variety of issues.

Legal Services Plan

The legal services plan provides coverage for the most common legal services, such as family law, real estate matters, and immigration services.

If You Have Questions About Your Benefits

Although this guide will answer most of your questions about your benefits, you may still have questions from time to time. The table below provides contact information for each of your benefit programs.

Contact	Website	Phone Number	Group ID
Benefits Enrollment and General Information	www.myworkday.com/frontdoor www.myfrontdoorbenefits.com (password: 2health)	866-851-1211	Not applicable
Medical BlueCross BlueShield of Tennessee • PPO option • Basic and Enhanced Plan (CDHP) options	www.bcbst.com	800-565-9140	130446
Prescription Drugs Express Scripts (ESI)	www.express-scripts.com/frontdoor	855-283-7451	AHSRX4U
Dental Delta Dental • Base DPPO and Buy-up DPPO options	www.deltadentaltn.com	800-223-3104	7253
Vision EyeMed Vision Care	www.eyemedvisioncare.com	866-723-0514	1016827
Associate Life, Dependent Life, and AD&D Insurance Prudential • General information • Claims information	prudential.com/mybenefits	800-524-0542	71160
Prudential			

Contact	Website	Phone Number	Group ID
Short-Term Disability Prudential • General information • Claims and payments	prudential.com/mybenefits	877-367-7781	-71160
Long-Term Disability Prudential • General Information • Claims and payments	prudential.com/mybenefits	877-367-7781	71160
Business Travel Accident Insurance Zurich	Not available	866-263-0261	Not applicable
Flexible Spending Accounts and Health Savings Account Alight Smart-Choice Account(s)	www.smartchoiceaccounts.com	833-769-4782	Not applicable
Frontdoor LifeManagement Program Magellan Health Services	member.magellanhealthcare.com	800-523-5668	Not applicable
Legal Services Plan MetLife Legal Plans	members.legalplans.com	800-821-6400	Not applicable

About This Guide

The sections that follow will help you understand how your benefit plans work. To make the best use of your benefits, we encourage you to take time to review and become familiar with this guide and to use it as a reference in the future.

The description of benefit options and plans provided in this guide, as well as in other communication materials, are in some instances intended to be summaries of the major provisions of the actual Frontdoor plan documents and contracts with insurers covering certain benefits. In summarizing these documents, we have tried to describe them in a way that is easy to understand. However, in the event of any discrepancy between this summary plan description (SPD) and the actual Frontdoor plan documents or contracts with insurers, the actual plan documents and contracts with insurers will control over the SPD. In other instances, this SPD is intended to be used as both the actual Frontdoor plan document and the SPD. In any case, Frontdoor reserves the right to amend or terminate all its benefit plans, in whole or in part, at any time and for any reason.

Participation

Associate Eligibility

You are eligible to participate in the Frontdoor benefit programs if you are a full-time associate who is regularly scheduled to work, on average, at least 30 hours a week for the company in the United States. U.S. expatriates are also eligible for the plan if employed by a business unit that includes this coverage in their contract.

You're eligible to participate in the business travel accident (BTA) insurance plan if you are an active full-time associate who is regularly scheduled to work at least 29 hours a week.

Special Eligibility Rules for Part-Time Associates

If you are a part-time associate who works an average of 30 hours or more per week, you may be eligible to participate in the Frontdoor medical plan in accordance with the federal Affordable Care Act (ACA).

Newly hired part-time associates will be measured during their first year of employment. An initial measurement period of eleven (11) months from the first of the month following the hire date will determine the average weekly hours worked. If you work an average of 30 or more hours per week during the initial measurement period, an offer of medical coverage will be made for an initial stability period of one (1) year. The offer of medical coverage will be made at the end of the administrative period that runs from the end of the initial measurement period through the end of the second calendar month on or after the end of the initial measurement period (not to exceed 90 days).

For subsequent years, hours will be tracked during a standard measurement period from October 15 of the current year through October 14 of the following year. If you work an average of 30 hours or more per week, as required to qualify under ACA regulations, an offering of medical coverage for the following plan year of January 1 through December 31 will be made.

Who Is Not Eligible

You are not eligible for the benefits described in this guide if you are:

- A part-time associate who works fewer than 30 hours a week (29 hours for the BTA insurance plan)
- A temporary or seasonal associate
- An independent contractor who is not designated as a regular associate through the company payroll (this includes leased associates, associates of an outsourcing company, or a leasing organization)

Dependent Eligibility

You can enroll your eligible dependents for medical, dental, and vision coverage; and dependent life and dependent AD&D insurance. Your eligible dependents are your legal spouse, your domestic partner and dependent children. The term “domestic partnership” is defined as a committed relationship between two adults, of the opposite sex or same sex, in which the partners:

1. Have lived together for at least six months.
2. Are not married to anyone else nor have another Domestic Partner.
3. Are at least 18 years of age and mentally competent to consent to contract.
4. Reside together in the same residence and intend to do so indefinitely.
5. Have an exclusive mutual commitment similar to that of marriage.
6. Are each other’s sole domestic partner and intend to remain so indefinitely
7. Are jointly responsible for each other's common welfare and share financial obligations.
8. Are not related in a way that would prohibit legal marriage in the U.S. jurisdiction in which the partnership was formed.
9. Can provide **any** of the types of documentation indicated below:
    - Designation of Domestic Partner as beneficiary for life insurance and retirement contract
    - Designation of Domestic Partner as primary beneficiary in associate's or insured's will.
    - Durable property and health care powers of attorney.
    - Joint ownership of motor vehicle.
    - Joint checking account or joint credit account.
    - Joint mortgage or lease.
10. Certify that they understand that willful falsification of the documentation required to establish that an individual is in a domestic partnership may lead to disciplinary action and the recovery of the cost of benefits received related to such falsification.

The term “domestic partnership” shall also include a domestic partnership registered under state law.

A legal spouse is defined as a person of the same or opposite sex who is your husband or wife through a legally recognized marriage. This includes common-law spouses in states that recognize common-law marriage.

The definition of an eligible child includes:

- Your biological children
- Your stepchildren
- Your legally adopted children or children who have been placed with you for adoption
- Children for whom you have legal custody
- Your domestic partner’s children if your domestic partner is also enrolled

Be Sure to Enroll New Dependents!
If you want to cover a new dependent, you must enroll the new dependent within 30 days after birth, marriage, adoption or otherwise acquiring the dependent.

Under the health care plans, you cannot enroll a foster child or a grandchild unless you have legal custody of the child.

For medical, dental and vision, you may cover eligible dependent children who are under the maximum age of 26. Coverage ends on the last day of the month in which the child reaches the maximum age.

For dependent life and AD&D insurance, your child must be at least 14 days old before coverage can begin. You can enroll your unmarried dependent children who are between ages 19 and 26 (ages 19 and 25 for BTA insurance) Dependent children who are full-time, active military personnel are not eligible for dependent life or AD&D insurance coverage.

Coverage Continuation for Disabled Children

For mentally or physically disabled children, coverage may be continued past the maximum age limit if your child is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law. For life insurance, proof of the disability must be sent to Prudential within 31 days after the date your child attains the age limit and at intervals as requested for dependent life insurance. For health coverage, a Certification of Dependency form must be completed by the child's physician and submitted to Blue Cross Blue Shield of Tennessee within 31 days after the date your child attains the age limit and at intervals as requested.

Coverage will end when the first of the following occurs:

- The child is no longer disabled
- You fail to provide proof that that disability continues
- You fail to have any required exam
- Coverage terminates for any reason other than reaching the maximum age limit

Dependent Verification

You will be required to verify your dependents' eligibility for coverage upon their initial enrollment in the medical, dental and/or vision plans. This means that you must submit documentation to verify that covered dependents are eligible under the Frontdoor plan rules. After your dependent's coverage becomes effective, you will be mailed a notice that will indicate the type of documentation required for each dependent as well as your deadline for providing the documentation.. If you do not submit the required documentation, coverage for unverified dependents will be cancelled and they will not be eligible for COBRA continuation coverage. If your dependent coverage is cancelled, you have the right to file an appeal for reinstatement.

For more information about verification of dependent eligibility, call the Frontdoor People Support Center at **866-851-1211.**

If Two Family Members Work for Frontdoor

If you and your spouse/domestic partner both work for Frontdoor, only one of you can cover your dependents. You can choose one of the following options:

- One spouse/domestic partner can carry all family members under his or her coverage (one spouse/domestic partner elects family coverage and the other spouse elects no coverage)
- Each spouse/domestic partner can be covered as an associate, but dependent children can be covered as dependents by only one spouse/ domestic partner (one spouse/domestic partner should elect family coverage and the other spouse/ should elect associate-only coverage)

If your dependent child works for Frontdoor and is eligible for coverage as an associate, you cannot cover that child as a dependent.

Enrolling for Coverage

To receive coverage under the medical, dental, vision, legal services, flexible spending accounts, and health savings account benefit plans, an annual enrollment will be offered. For optional life insurance, AD&D, and long-term disability plans, your elections stay in effect until you change them. Other plans are provided automatically by Frontdoor.

Optional Benefits	Optional Benefits — Annual Election Required	Automatic Benefits
Medical		Basic Life Insurance
Dental		Short-Term Disability (STD)
Vision	Healthcare Flexible Spending Account	Business Travel Accident (BTA)
Supplemental Life Insurance	Dependent Day Care Flexible Spending Account	Frontdoor Life Management Program (EAP)
Spouse Life Insurance	Health Savings Account	
Accidental Death & Dismemberment (AD&D)		
Child Life Insurance		
Long-Term Disability (LTD)*		
Legal Services		

**As an eligible new hire, you will be automatically enrolled in the 50% LTD option. You may choose to increase or opt-out of LTD coverage during your LTD enrollment period, a subsequent open enrollment period or while processing a mid-year qualified status change (if the qualifying event would allow a change to your disability coverage under IRS regulations).*

New Hire Enrollment

As an eligible new associate, you are provided with an opportunity to enroll yourself and your eligible dependents in the benefit plans.

Once you are ready to make your coverage elections, log on to **www.myworkday.com/frontdoor** and access the *Benefits Enrollment* activity in your Inbox or call the Frontdoor People Support Center at **866-851-1211**. Your elections must be completed within 30 days of your hire date.

If you enroll when first eligible, you'll be able to elect any of the options that are available.

If you do not enroll when first eligible, you will have no coverage until the next calendar year, unless you qualify for special enrollment under the Health Insurance Portability and Accountability Act or have a qualified status change. In addition, if you want to enroll at a later date, there may be limits on the options you can choose, and you may need to provide evidence of insurability before you can be covered.

Open Enrollment

During the open enrollment period held each year in the fall, you decide whether you want to participate in some or all the benefits programs during the next calendar year. In some cases, you also choose the level of coverage you want. These coverage choices go into effect on the next January 1 and remain in effect for one year through December 31, unless you have a qualified status change that would allow you to make a mid-year coverage change.

If You Do Not Enroll During Open Enrollment

If you do not enroll in flexible spending accounts or health savings account, you will not participate in these plans during the next year even if you have coverage in the current year.

If you do not actively enroll in optional life insurance or long-term disability, you will automatically continue in the prior year's plan for the next year as long as Frontdoor is offering the same plans and you are not informed otherwise.

Your Elections Are Effective for a Full Year

You cannot change your elections until the next open enrollment period unless you have a qualified status change. See pages 15 and 16 for additional information about qualified status changes.

Coverage Categories for Medical

When you enroll for medical coverage, you must choose which dependents you will be covering in the medical plan and your premiums will be based on type and number of dependents you choose to enroll. You may enroll:

- Yourself
- Your spouse or domestic partner
- Your children

Coverage Categories for Dental and Vision

When you enroll for dental and vision coverage, you also choose a coverage category:

- You only
- You plus your spouse or domestic partner
- You plus spouse or domestic partner plus 1 child
- You plus spouse or domestic partner plus 2 or more children
- You plus 1 child
- You plus 2 or more children

You can choose different coverage categories for each benefit option. For example, you can choose "you only" for medical coverage and "you plus spouse or domestic partner" for vision coverage.

Evidence of Insurability Required for Supplemental Life Insurance

Under the supplemental life insurance program, you must provide evidence of insurability (EOI) before you can be approved for coverage if you did not enroll when first eligible or if your coverage ever exceeds $1 million*.

Providing evidence of insurability means submitting a statement of health and may mean taking a physical exam and/or submitting a doctor's statement of your health. When this is required, your coverage starts on the first day of the month after the claims administrator approves your application for coverage (or an increase in coverage).

**You will be required to submit EOI for each year in which your coverage exceeds $1 million.*

For example: *Your 2020 annual earnings were $350,000 and you elected supplemental life insurance in the amount of 3 times your annual earnings, resulting in a coverage amount of $1,050,000 and therefore requiring you to provide EOI. Your 2020 EOI was approved on January 1, 2020. For 2021, your annual earnings are $365,000 and you elected supplemental life insurance in the amount of 3 times your annual earnings, resulting in a coverage amount of $1,095,000. As a result, you are required to provide EOI for the additional $45,000 in coverage based on the increase in your annual earnings.*

Evidence of Insurability Required for Dependent Life Insurance

Under the dependent life insurance program, you must provide evidence of insurability (EOI) for your spouse before your spouse can be approved for coverage if the elected coverage amount is either $75,000 or $100,000.

This means submitting a statement of health and may mean taking a physical exam and/or submitting a doctor's statement of your spouse's health. When this is required, your spouse's coverage starts on the first day of the month after the claims administrator approves the application for coverage (or an increase in coverage).

If EOI is not completed as required or is denied, your spouse will automatically be covered at the $50,000 level – the highest amount that does not require EOI.

It's a Crime!
It's a crime to knowingly make false statements or provide misleading information with intent to defraud or deceive Frontdoor or a claims administrator, including misstatements of age, health status, or dependent status.

If you make statements that are incomplete or untrue when you enroll for coverage or if you file a claim that contains false, incomplete, or misleading information, a plan may reduce or deny your claim or, in the case of fraud or intentional misrepresentation, cancel your coverage from the original effective date. A plan may also prosecute these cases under the law.

When Coverage Begins

Eligibility Effective Date

For most of the plans, you must complete a waiting period before you become eligible for coverage, as shown in the chart below.

Plan	Eligibility Effective Date
Medical and Prescription Drug, Dental, Vision, Flexible Spending Accounts, Health Savings Account, Life Insurance, AD&D, Legal Services	1st of the month following date of hire
Long-Term Disability (LTD), Short-Term Disability (STD)	On the date following completion of 6 months of employment
Business Travel Accident (BTA)	On your date of hire
Frontdoor Life Management Program	On your date of hire

If You Are Not at Work When Coverage Is Due to Start

If you are not actively at work because of an injury, sickness, temporary layoff, or leave of absence on the date the following coverage or increase in coverage is due to start, coverage will be delayed until the day you return to full-time active employment:

- STD and LTD coverage
- Basic, supplemental, or dependent life insurance
- Accidental death & dismemberment (AD&D) insurance

Your medical, dental, vision, legal services, flexible spending account, and health savings account coverage is not delayed.

If your dependent is disabled on the date dependent life or AD&D insurance is due to start, coverage for that dependent will begin on the date the dependent is no longer disabled. For purposes of this summary plan description, “disabled” means that you or your dependent is in a hospital, cannot perform daily living activities because of an illness or injury, is cognitively impaired or has a life-threatening condition.

LTD Coverage for Pre-Existing Conditions

If you are disabled due to a pre-existing condition during the first 12 months you are covered by the LTD plan, benefits are not paid for that disability. For the LTD plan, a pre-existing condition is a disease or an injury for which, during the three-month period before your effective date of coverage or your coverage increase effective date, you received medical treatment, consultation, care, services, diagnostic measures, or you took prescribed medicines that were prescribed or recommended by a health care provider.

Special Rules for an Increase in LTD Coverage

If your disability is caused by a pre-existing condition, your monthly benefit will be based on the amount of the monthly benefit that has been in effect for at least 12 months under this plan or any other prior coverage. You will not be eligible for any benefit increase if the disability starts within the first 12 months after you increase in coverage goes into effect.

Paying for Coverage

Frontdoor pays the full cost of some benefit programs. You and Frontdoor share the cost of some, and you are responsible for the full cost of others.

Frontdoor Benefit Programs

During your initial enrollment period and open enrollment period, you will receive information about the associate premium for each option. The price you pay for a benefit depends on the coverage level you select. You can choose to decline coverage for any of the voluntary benefit options for which you are eligible.

Before-Tax and After-Tax Contributions

You pay for several benefit programs on a before-tax basis. This means your contributions are deducted from your pay before federal, state, and Social Security taxes are withheld. You never pay any taxes on these contributions. For some benefit coverage, you pay your contributions on an after-tax basis. This means your contributions are deducted from your pay after taxes are withheld.

Plans	Paying for Coverage
Medical, Dental, Vision*	You pay for coverage with before-tax dollars. **Note:** The cost of prescription drug coverage is included in your medical premium. Domestic Partner's and their children are subject to imputed income.
Health Care and Dependent Day Care Flexible Spending Accounts (FSAs)*	You can contribute before-tax dollars to one or both flexible spending accounts. Participation in the Health Care Flexible Spending Account is restricted to associates who enroll in one of the PPO medical options or who waive medical coverage.
Health Savings Account*	You can contribute before-tax dollars if enrolled in either the Enhanced or Basic (CDHP) medical options.
Basic Life Insurance	Frontdoor pays the full cost for coverage. Amounts over $50,000 are subject to imputed income
Supplemental Life Insurance	You pay for coverage with after-tax dollars.
Dependent Life Insurance	You pay for coverage with after-tax dollars.
AD&D Insurance	You pay for coverage with pre-tax dollars.
Business Travel Accident (BTA) Insurance	Frontdoor pays the full cost for coverage.
Long-Term Disability (LTD)	You pay for coverage with after-tax dollars.
Short-Term Disability (STD)	Frontdoor pays the full cost for coverage.
Frontdoor Life Management Program	Frontdoor pays the full cost for coverage.
Legal Services Plan	You pay for coverage with after-tax dollars.

**Medical, dental, and vision coverage, the health care flexible spending account, dependent care flexible spending account, and the health savings account are provided through the Frontdoor Company Cafeteria Plan (the "Cafeteria Plan"). No other benefits described in this SPD are provided through the Cafeteria Plan. With respect to your flexible spending accounts and the health savings account, eligible expenses are incurred when the services to which the expenses relate are performed, regardless of the time of payment.*

Retro Deductions and Arrears

If you make a retroactive election or change to your coverage – such as adding a spouse as the result of a recent marriage – you are responsible for any premium payments due as a result of the retroactive change. Retro premiums are deducted on the first possible paycheck after the retroactive election has been made. If the retro premium balance cannot be taken in full due because it is greater than your per-pay-period earnings, your retro premium balance due may be converted to an arrears balance. Arrears are deducted at a rate of 50% of your standard benefit premium rate. This additional 50% is added to your standard benefit deduction until the arrears balance has been paid in full.

If you are in an active employment status but do not receive enough gross wages to cover the full cost of your benefit premiums, premium amounts not paid will accumulate as an arrears balance. Arrears are deducted at a rate of 50% of your standard benefit premium rate. This additional 50% is added to your standard benefit deduction until the arrears balance has been paid in full.

Both retro deductions and arrears deductions are taken with the same tax structure as current benefits (e.g., before- and after-tax).

How Plan Costs Are Determined

Plan costs generally are based on the benefits provided by the plans, how frequently, and to what degree the benefits are used. The demographics of our associate group, such as the number and age of covered associates, are also factors that contribute to determining plan costs. For associate life insurance, they also are based on tobacco use. Frontdoor balances cost and quality concerns in making decisions about health plan costs.

Insured and Self-Insured Plans

Medical and STD benefits are self-insured. This means that medical and STD claim costs are paid by Frontdoor rather than through an insurance contract. Although BlueCross BlueShield of Tennessee, Express Scripts and Prudential provide administrative services (such as claims reimbursement, utilization review, case management, and similar support services), all plan benefit costs for claims and administration are paid from Frontdoor’s general assets.

Life, AD&D, and business travel accident insurance; LTD and vision coverage; the dental options; and the legal services plan are provided through contracts with insurance companies. For these insured benefits, a premium is paid directly to the insurance company to provide the coverage.

Naming a Beneficiary

You must log on to **www.myworkday.com/frontdoor** or call the Frontdoor People Support Center at **866-851-1211** to name a beneficiary for your life and AD&D insurance. Your beneficiary is the person who will receive benefits if you die. If you wish, you can name more than one beneficiary. If you name two or more beneficiaries, you must indicate the respective percentages for how benefits should be divided. You may designate both primary and contingent beneficiaries. Your beneficiary designation will apply to your life and AD&D insurance, unless you specifically name different beneficiaries for each coverage.

For dependent life insurance benefits, you are automatically the named beneficiary.

Your beneficiary designations take effect on the day you complete your beneficiary designation either online or by phone.

If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate or your surviving family members (spouse, child or children, mother or father, or sisters or brothers) according to the provisions established within each specific plan.

If a beneficiary is a minor or otherwise legally incapable of accepting payment, the insurance company may make a payment to the guardian of your beneficiary's estate, the custodian of the beneficiary's estate under the Uniforms Transfer to Minors Act, or an adult caretaker/legal guardian.

If Your Beneficiary Dies Before You

If one of your beneficiaries dies before you, that beneficiary's share will become payable in equal shares to any other living beneficiaries. If you have named a contingent beneficiary, your contingent beneficiary will only be paid if all primary beneficiaries die before you.

Changing Your Beneficiary

You can change your beneficiary designation at any time. Because family situations change, you may want to review your beneficiary designation from time to time.

You also have the right to permanently assign your coverage to another person. We suggest that you talk to a qualified financial advisor before making such an assignment and call the insurance company for information about the process for an assignment.

Changing Your Coverage

Changing Your Benefit Program Elections

Once you make your benefit program elections, they are effective for the calendar year. Because of plan provisions and tax advantages, the IRS restricts the coverage changes you can make after your initial or open enrollment. However, under certain circumstances, you can enroll for coverage or change your elections during the year. These circumstances include the following:

- You qualify for a special enrollment under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as described below
- You have a qualified status change (QSC) that affects you, your spouse/domestic partner, or your dependent
- The plan receives a court order, such as a qualified medical child support order (QMCSO)
- You, your spouse, or your dependent qualifies for Medicare or Medicaid

Special Enrollment Rights

If you declined enrollment in the medical, dental, or vision plan for yourself or your dependents (including your spouse) because you have other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

If you declined enrollment in the medical, dental, or vision plan for yourself or your dependents because you had coverage under Medicaid or the Children's Health Insurance Program (CHIPRA), you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIPRA coverage ends.

If you declined enrollment in the medical, dental or vision plan for yourself or your dependents, you may be able to enroll yourself and your dependents in this plan if you or your dependents become eligible for Medicaid or CHIPRA assistance with respect to coverage under this plan. However, you must request enrollment within 60 days after the Medicaid or CHIPRA assistance eligibility determination date.

You will be provided a separate notice explaining benefits under CHIPRA in your specific state. You can request special enrollment or obtain more information by calling **866-851-1211**.

Qualified Status Changes

You can change your elections during the year if you have a qualified status change (see the chart below) and meet these three requirements:

- The qualified status change causes you, your spouse/domestic partner or your dependent to lose or gain eligibility under Frontdoor's plans or under a spouse's or dependent's plan
- Your election change is consistent with the gain or loss of eligibility. For example, if you are divorced, dropping coverage for your spouse would be considered a change that's consistent with your qualified status change, but dropping other family members would not be considered consistent with the qualified status change.
- You make your new benefit elections within 30 days following the qualified status change by logging on to **www.myworkday.com/frontdoor** or calling **866-851-1211.**

If you experience a qualified status change and you meet all the requirements above, you can make a change to your medical, dental, vision, and LTD coverage; flexible spending accounts; and supplemental life insurance, dependent life insurance, AD&D insurance, and legal services plan. Changes in life insurance and LTD coverage may require evidence of insurability.

Your new coverage choices are effective on the date of the qualifying event. Sample qualified status changes include the following:

Qualified Status Changes
You marry, divorce, legally separate, or have your marriage annulled
You have a baby, adopt, have a child placed with you for adoption or legal guardianship, place a child for adoption, or cease to be a guardian for a dependent
Your spouse or dependent dies
You, your spouse/domestic partner, or your dependent starts or ends employment
You, your spouse's/domestic partner's, or your dependent's employment status is affected by a strike or lockout
You, your spouse's/domestic partner's, or your dependent's employment status changes (a switch from temporary to regular employment and vice versa)
You, your spouse's/domestic partner's, or your dependent's work location or home address changes
Your dependent becomes eligible or ineligible for coverage
You, your spouse/domestic partner, or your dependent gains or loses Medicare or Medicaid coverage

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a judgment, decree, or court order that creates or recognizes the right of a child to receive benefits under a group health plan. A qualified medical child support order may affect your coverage under the medical, dental, or vision plans. Once the Frontdoor People Support Center determines that an order meets the requirements for a QMCSO, coverage will be provided as required by law. The plan administrator may automatically enroll you for coverage in order to provide coverage for the affected child(ren) as required by the QMCSO. Please call **866-851-1211** if you become aware of an order like this affecting you. You are entitled to receive from the plan administrator, without charge, a copy of the procedures used to determine whether an order meets the requirements of a QMCSO.

Situations Affecting Your Participation and Coverage

When You Leave the Company or Are No Longer Eligible

Your coverage under the plans ends at midnight on the day you leave the company due to layoff or other employment termination, retirement, or death; or you no longer meet the eligibility requirements for coverage—for example, if you start working fewer than 30 hours a week on a regular basis (29 hours for the business travel accident insurance (BTA) plan) or you transfer to a class of associates that is not eligible for coverage. When your coverage ends, your dependents' coverage also will end unless you remain in your stability period then you and your dependents medical coverage will end at the end of the year.

If you die, medical and prescription drug, dental, and vision coverage will automatically be continued for an additional 60 days for your covered dependent(s). After this 60-day continuation period, your dependent(s) may continue coverage for the remainder of the COBRA period by paying the monthly COBRA premium.

Continuation of Coverage
When your or your dependent's health care coverage ends, you can usually continue coverage under COBRA for up to 18 or 36 months, at your expense.

You may also be able to continue life insurance and legal services coverage under portability and conversion provisions.

When Your Dependent No Longer Meets the Eligibility Requirements

Coverage for a dependent will end when the dependent no longer meets the eligibility requirements—for example, your spouse's coverage ends upon divorce or annulment, or your child's coverage ends at the end of the month when the child reaches the limiting age for coverage. Dependent coverage also ends on the date your coverage ends.

If You Are on Leave of Absence

If you go on an employer approved leave of absence, your coverage continues up to the maximum allowable time based on the provision under the respective leave policy. You must pay the premiums to continue coverage. Failure to pay the monthly premiums as required will result in coverage being cancelled retroactively to the date premiums were last paid in full. Special coverage reinstatement rules apply if your leave of absence is protected by the Family and Medical Leave Act of 1993 (FMLA).

If You Stop Making Required Contributions

If you stop making the required contributions for coverage, coverage will end as of the last day for which you made contributions.

If a Plan Ends

If a plan ends, coverage will end as of the date of plan termination.

Reinstatement of Benefits Following a Rehire

If you leave the company and are rehired within 90 days, your coverage is reinstated on the first of the following month after your rehire date. If you are rehired after 90 days, you are considered a new associate. This means you need to meet the eligibility waiting periods before coverage starts, and any service earned during the earlier periods of employment will not count toward calculating your benefits.

Portability and Conversion

When you leave Frontdoor, you can continue basic, supplemental, and dependent life insurance through portability, or you can convert your basic, supplemental, and dependent life, insurance to individual policies. The plan's continuation provision gives you two advantages:

- You may be able to continue coverage without the evidence of insurability that would be required if you were applying for an individual policy. Portable insurance is a continuation of group insurance with group rates.
- Prudential's conversion provision allows you to convert coverage to an individual whole life premium plan. The premiums for a conversion policy may be higher than the premiums for portable coverage.

Life Insurance Portability

You can continue associate life insurance and dependent life insurance through the plan's portability provisions if your employment ends or you are no longer eligible for coverage. Dependent life insurance may only be continued if you elect to continue your associate life insurance.

To continue coverage, you (or your spouse) must contact Prudential at 877-889-2070 within 31 days after your employment ends or you are no longer eligible. You must then complete the application process and pay the first premium during the period required by Prudential. You cannot apply for coverage after 31 days.

When your employment ends, you will be mailed information about the portability policy and the amounts of coverage you can continue. In general, you can continue up to the amount of life and dependent life insurance you have when you leave the company. Please call 877-889-2070 if you have questions about portability.

The minimum amount of portable coverage available is $5,000 for you and $1,000 for your spouse and dependent children. The maximum amount of portable coverage available is $500,000 for you, $100,000 for your spouse, and $5,000 for your dependent children.

Life Insurance Conversion

When coverage ends, you and/or your dependents can convert coverage to an individual life insurance policy without evidence of insurability. You or your dependent must apply for a conversion policy and pay the first premium within 31 days after your employment terminates or you or your dependents are no longer eligible. The maximum amount that can be converted by each person is $10,000.

If you previously received an accelerated benefit payment, the amount of life insurance that you are eligible to convert to an individual policy will be limited to the reduced amount of life insurance after the payment is made.

To continue coverage, you (or your spouse) must contact Prudential at 877-889-2070 within 31 days after your employment ends or you are no longer eligible. You must then complete the application process and pay the first premium during the period required by Prudential. You cannot apply for coverage after 31 days.

Please call 877-889-2070 if you have questions about conversion.

Legal Services Portability

When you leave Frontdoor, you can continue your legal services coverage through direct enrollment with MetLife Legal Plans. You must enroll within 30 days of the date your employment ends. For additional information, call the MetLife Legal Plans Client Service Center at **800-821-6400**.

COBRA Continuation Coverage

This section contains important information about your right to temporarily continue health care coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

What Is “COBRA Continuation Coverage”?

COBRA coverage is a temporary continuation of health care coverage when it otherwise would end because of a life event, known as a “qualifying event” (explained in detail below).

Frontdoor’s health care coverage includes medical and prescription drug, dental, and vision coverage and the health care flexible spending account.

After a qualifying event, COBRA continuation coverage must be offered to each “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the health care plans is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for it.

COBRA Qualifying Events and Qualified Beneficiaries

Associates

You become a COBRA-qualified beneficiary if you lose your coverage under the health care plans because of either of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason (other than your gross misconduct)

Spouse of the Associate

Your spouse becomes a COBRA-qualified beneficiary if he or she loses coverage under the health care plans because of any of the following qualifying events:

- You die*
- Your hours of employment are reduced
- Your employment ends for any reason (other than your gross misconduct)
- Your marriage ends through divorce or annulment
- You become entitled to Medicare benefits (under Medicare Part A or B)

Dependent Children

Your dependent children become COBRA-qualified beneficiaries if they lose coverage under the health care plans because of any of the following qualifying events:

- You die*
- Your hours of employment are reduced
- Your employment ends for any reason (other than your gross misconduct)
- Your marriage ends through divorce or annulment
- You become entitled to Medicare benefits (under Medicare Part A or B)
- Your child loses eligibility for coverage as a "dependent child" under the health care plans (for example, he or she attains the maximum age)

Qualified beneficiaries also include any children born to you or placed with you for adoption during the COBRA continuation period.

**If you die, medical, dental, vision, and prescription drug coverage will automatically be continued for an additional 60 days for your covered dependents. After this 60-day continuation period, your dependents may continue their coverage for the remainder of the COBRA period by paying the monthly COBRA premium.*

Notification of Qualifying Events

The health care plans offer COBRA continuation coverage to qualified beneficiaries *only* after being notified that a qualifying event has occurred.

This section of your guide meets the SPD's COBRA notice requirement. However, you and your qualified beneficiaries will receive another notice if you have a qualifying event.

The Company will notify the COBRA administrator within 30 days of the qualifying event in these cases:

- Your employment ends or your hours are reduced
- You become entitled to Medicare
- You die

You, your qualified beneficiary, or a representative must notify COBRA administrator at 866-634-9784 in these cases:

- Your marriage ends through divorce or annulment
- Your child loses eligibility to coverage under the health care plans (for example: he or she reaches the limiting age)

Be Sure to Keep Your Address and Your Dependents' Addresses on File in Workday

It is critical that you (or anyone who may become a qualified beneficiary) maintain your current address in Workday to ensure that you receive COBRA election information following a qualifying event, and all related information and billing notices while you are on COBRA.

This notification must occur within 60 days from the latest of the following:

- The qualifying event
- The date you or your qualified beneficiary loses (or would lose) coverage as a result of the qualifying event
- The date you or your qualified beneficiary is informed, through the SPD or a general COBRA notice, about the responsibility to submit a completed COBRA election form to the Frontdoor People Support Center as notification

If You or Your Qualified Beneficiary Is Disabled

If you or your qualified beneficiary becomes disabled at any time within the first 60 days of COBRA coverage, you may be entitled to a COBRA disability extension (see disability extension section on page 24). With respect to a disability determination, **you or your qualified beneficiary must notify the Frontdoor People Support Center of the disability determination, in writing, within 60 days after the latest of the following**:

- The date of the Social Security Administration disability determination
- The date the qualifying event occurs
- The date you or your qualified beneficiary loses (or would lose) coverage due to the qualifying event
- The date you or your qualified beneficiary is informed, through the SPD or a general COBRA notice, of the responsibility to provide the disability

Note: You or your qualified beneficiary must provide notification of the disability determination, in writing, to the Frontdoor People Support Center before the end of the initial 18 months of COBRA coverage. If you or your qualified beneficiary is subsequently determined by the Social Security Administration to no longer be disabled, you or your qualified beneficiary must provide notification, in writing, to the Frontdoor People Support Center within 30 days of the date of the final determination.

How COBRA Coverage Is Offered

When Workday is notified of a qualifying event, COBRA continuation coverage is offered to each qualified beneficiary.

The Frontdoor People Support Center will mail a COBRA continuation notice and a COBRA election notice within 14 days after receiving notice of the qualifying event. This information is sent to the last known address that was provided to the Frontdoor People Support Center. If your qualified beneficiary lives at another address, a separate information packet will be sent if that address is provided.

To notify the Frontdoor People Support Center of your new address, call **866-851-1211**. Customer service representatives are available Monday through Friday between 8 a.m. and 5 p.m., Central time.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered associates can elect COBRA continuation coverage on behalf of their spouse, and parents can elect COBRA continuation coverage on behalf of their children.

Your COBRA Elections

Once you receive your COBRA enrollment package, you have 60 days to elect coverage. The 60-day election period starts on the latest of these dates:

- The date coverage is lost
- The date you receive the COBRA continuation notice
- The date of the qualifying event

You or your dependent's coverage starts on the date of the qualifying event, unless you or your dependent waives COBRA coverage and then revokes the waiver within the 60-day election period. (In this case, your elected coverage begins on the date you revoke your waiver). When you or your dependent elects COBRA continuation coverage, you or your dependent can keep the same level of coverage you had as an active associate.

You or your dependent can change coverage (if enrolled within the initial 60-day enrollment window):

- During the open enrollment period, or
- If you or your dependent has a qualified status change or another change in circumstances recognized by the Internal Revenue Service (IRS) and the company

You can enroll any newly eligible spouse or dependent child under the health care plan's rules.

What COBRA Coverage Costs

COBRA participants pay monthly premiums for coverage.

Premiums are based on the full cost per covered person, set at the beginning of the year, plus a 2% fee for administrative costs. If you or a dependent is eligible for the disability extension, the cost for that person is the full cost plus a 50% additional fee. Dependents making separate elections are charged the same rate as for single coverage.

Payment is due at election, but there is a 45-day grace period from the date you submit your elections to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s), retroactive to the date benefits terminated under the plan.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period. For example, the June payment is due June 1, but will be accepted if postmarked by June 30.

The Full Cost of Coverage

The "full cost of coverage" means an amount that is not subsidized by Frontdoor. As a result, your COBRA coverage is more expensive than your coverage as an active associate.

How Long COBRA Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is due to any of the following:

- Your death
- Your marriage ends through divorce or annulment
- Your dependent child's loss of eligibility as a dependent child
- You become entitled to Medicare benefits (under Medicare Part A or B)

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of your hours of employment. This 18-month period of COBRA continuation coverage can be extended in two ways, as explained below.

Disability Extension of 18-Month Period of Continuation Coverage

If a qualified beneficiary covered under the health care plan(s) is determined by the Social Security Administration to be disabled and you notify the Frontdoor People Support Center in a timely fashion, you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage (for a total maximum of 29 months) if all three of the following conditions are met:

- Your COBRA-qualifying event was a termination of employment or a reduction in hours
- The disability began at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage
- A copy of the Notice of Award from the Social Security Administration is provided to the Frontdoor People Support Center within 60 days of the date of the Notice of Award and before the end of the initial 18 months of COBRA coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify, you or your dependent must notify the Frontdoor People Support Center of the second qualifying event within 60 days after the later of the qualifying event or the loss of coverage.

This extension may be available to your spouse and any dependent children receiving continuation coverage if you divorce or legally separate, or if your child is no longer eligible as a dependent child under the health care plan(s), but only if the event would have caused your spouse or child to lose coverage under the plan(s) had the first qualifying event not occurred.

Situations When COBRA Coverage May End Earlier

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or your covered dependent does not make timely premium payments or contributions as required
- Frontdoor stops providing health care benefits to its associates
- You or any of your covered dependents become covered under another health care plan not offered by the company

Continuation coverage also can be terminated for any reason the health care plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud).

Special Rules for the Health Care Flexible Spending Account

Under certain circumstances, a qualified beneficiary can elect to continue benefits under the health care flexible spending account (FSA) by electing COBRA continuation coverage. In this case, however, COBRA continuation coverage will terminate at the end of the plan year (December 31) in which the qualified beneficiary experiences a qualifying event. If the cost of coverage for the rest of the plan year does not exceed the amount the qualified beneficiary could recover in benefits for the rest of the plan year (that is, the account is "under spent"), the qualified beneficiary can elect COBRA continuation coverage for health care reimbursement.

For example, let's say you elect to contribute $1,200 to the FSA for the current plan year at a rate of $100 a month. You have a qualifying event on June 30th and have already submitted $400 in reimbursable expenses. The amount of potential reimbursement remaining through the end of the plan year is $800 ($1,200 − $400 = $800), and the cost of coverage for the six months remaining in the plan year is $612 ($100 a month × 6 months = $600 × 102% = $612). Since the cost of COBRA coverage does not exceed the amount of potential reimbursement, you have the right to elect COBRA continuation coverage, but only for the period from the date of the qualifying event through the end of the plan year in which the qualifying event occurs.

If, on the other hand, you had submitted $900 in reimbursable expenses as of the date of the qualifying event, COBRA continuation coverage would not be offered because the cost of COBRA continuation coverage—$612—exceeds $300 ($1,200 − $900 = $300), the amount for which you could still be reimbursed for the plan year.

COBRA continuation coverage under the health care FSA will be the coverage in effect at the time of the qualifying event (the elected annual contribution to the health care FSA minus expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the health care flexible spending account will be covered for this COBRA continuation coverage.

If You Have Questions

Questions concerning your group health care plan and your COBRA continuation coverage rights should be addressed to the Frontdoor People Support Center. For more information about your rights under the Associate Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other laws affecting group health care plans, contact the nearest regional or district office of the U.S. Department of Labor's Associate Benefits Security Administration (EBSA) in your area, or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

If a Plan Changes or Ends

Plan Amendments

The company has the right to amend the plans. Plan amendments could include increasing, reducing, or terminating benefits for all associates or for any group of associates or changing carriers, network administrators, or benefits; increasing premiums, deductibles, or other payments; or any other changes. When benefit changes are made, you will be notified.

Plan Termination

Frontdoor intends to continue the plans indefinitely. However, the company reserves the absolute right, in its sole discretion, to end, suspend, withdraw, or amend the plans in whole or in part at any time. If the plans should end in whole, in part, or for any associate group, benefits will be paid up to the date of plan termination. No benefits will be paid after the date of plan termination, and no charges incurred after the date of plan termination will be covered.

Medical

Your Medical Plan

The main purpose of the medical plan is to protect your finances against the high costs of treating a serious medical condition as well as provide preventive care services that can help you stay healthy. In addition, the plan covers treatment for minor illnesses and injuries.

This section of the guide describes how the medical plan works.

Medical Plan Options and Coverage Categories

When you enroll for coverage each year, you choose a medical plan option and a coverage category that best fit your situation. The medical plan options that are available to you are:

- Basic (CDHP)
- Enhanced (CDHP)
- PPO

When you enroll in a medical plan option, you must choose which dependents you will be covering in the medical plan. You may enroll:

- Yourself
- Your spouse/domestic partner
- Your children
- You plus spouse/domestic partner and child(ren)

If you enroll in a medical plan option, you automatically have coverage under the prescription drug, mental health and substance abuse programs.

Making Your Choices

When you make your medical plan choice, you'll need to decide whether you want coverage under one of the CDHP options or the PPO. All plan options contract with a broad network of doctors, hospitals, and other facilities to offer discounted rates to Frontdoor participants.

You have the freedom to choose any provider for your medical care. When you choose in-network providers, the plan pays a higher portion of costs, and you pay a lower amount. When you choose providers outside the network, the plan usually pays a lower portion of costs, and you pay a higher amount. Out-of-network providers may also balance bill for costs of services greater than what is allowed by the medical carrier. The amounts you and the plan pay depend on the option you choose and whether you receive care from in-network or out-of-network providers.

You can get a list of network providers on the Workday website, on BlueCross BlueShield of Tennessee's website at **www.bcbst.com**, or by calling **800-565-9140** toll free. It's important to check a provider's participation in the network, because participation can change from time to time. This includes laboratories and radiology facilities.

How the Medical Options Work

When you choose one of the medical options, your medical expenses are covered as described below:

- Some charges, such as preventive care services, are covered at 100% with no deductible requirement, if received from an in-network provider.
- For most expenses, you must meet a deductible each calendar year before the plan starts to pay benefits. Once you meet the deductible, you and the plan each pay a percentage of eligible charges, in the form of copayments (PPO option only) and coinsurance. Different deductibles and coinsurance percentages apply depending on which medical option you choose, and whether you use in-network or out-of-network providers.
- If your portion of charges reaches the out-of-pocket maximum for your medical during the calendar year, the plan pays 100% of eligible charges for the rest of the calendar year.

All medical options provide prescription drug coverage through Express Scripts. See the section titled *Prescription Drug Coverage* starting on page 54 for more information.

About Eligible Charges

The plan pays benefits for services and supplies that are specifically covered by the plan and listed in the section *Covered Charges Under the Medical Options*. To be covered, a medical service must be an “eligible charge” and must be medically necessary.

Medically Necessary

“Medically necessary” means that a specific health care service is required for the treatment or management of a medical symptom or condition. The service must be the most efficient and economical service that can be provided safely. All determinations of covered health services for inpatient care or other health care services and supplies are made by the reasonable medical judgment of BlueCross BlueShield of Tennessee.

Examples of Services That Are Not Medically Necessary

Examples of hospitalization and other health care services and supplies that are not medically necessary include:

- Hospitalization when the medical services provided do not require an acute hospital inpatient (overnight) setting, but can be provided in another setting—for example, a physician’s office, the outpatient department of a hospital, or some other setting—without adversely affecting the patient’s condition
- Hospital admissions primarily for observation or evaluation that can be provided safely and adequately in some other setting
- Hospital admissions primarily for diagnostic testing that can be provided safely and adequately in some other setting
- Continued inpatient hospital care when the patient’s medical condition no longer requires hospitalization
- Admission to a hospital, skilled nursing facility, nursing home, or other facility for the primary purpose of providing custodial care, convalescent care, rest cures, or domiciliary care to the patient
- Admission to a hospital or skilled nursing facility for the convenience of the patient, physician, or family or because care in the home is unavailable or unsuitable
- The use of skilled or private duty nurses to assist in daily living activities, provide routine supportive care, or provide services for the convenience of the patient or family

Eligible Charges

When you use in-network providers, the eligible charge for a specific medical service or supply is the amount that has been negotiated between the provider and the claims administrator.

When you use non-network providers, the eligible charge is as follows:

- Negotiated rates agreed to by the non-network provider and either the claims administrator or one of its vendors, affiliates, or subcontractors.
- One of the following:
  - Out-of-network reimbursement percentage of the billed charge; or
  - A fee schedule that the claims administrator develops

These provisions do not apply if you receive covered health services from an out-of-network provider in an emergency. In that case, eligible charges are the amounts billed by the provider, unless the claims administrator negotiates lower rates.

About the Deductibles

The deductible is the amount of covered medical expenses you pay each year before the plan starts to pay benefits. Each option has different individual and family deductible requirements for in-network and out-of-network services:

- For individual coverage, you must meet the individual medical deductible each year before the plan starts to pay in-network or out-of-network medical benefits
- The family deductible provides protection against high-deductible expenses for larger families. Once combined deductible expenses from all covered family members reach the family medical deductible, no further deductibles will be required from your family for the rest of the year. A family member cannot contribute more than the individual amount toward the family deductible.

In-Network and Out-of-Network Charges

Charges for in-network and out-of-network services count toward the in-network and out-of-network deductibles, out-of-pocket maximums, and maximum coverage amounts.

For the PPO option, there are separate deductible requirements for prescription drug coverage (explained on page 55).

All eligible medical charges count toward the medical deductible, with these exceptions:

- Any charges that are not covered by the plan or that exceed the plan's eligible charge limits
- Copayments for doctors' visits (PPO option only)
- Prescription drug deductibles copayments or coinsurance (except for the Basic and Enhanced (CDHP) medical options)
- The $500 penalty for failure to notify BlueCross BlueShield of Tennessee of an out-of-network inpatient admission or other treatment when required and within the time limits described on page 49

The options have an additional feature, called the "common accident provision," which can help you save on deductible expenses. If two or more members of your family are injured in the same accident, only one deductible is required for all family members for expenses related to the accident.

About Copayments and Coinsurance

You share in the cost of medical services through copayments and coinsurance.

In the PPO medical option, you pay a copayment (or flat-dollar amount) before the plan pays benefits for certain doctors' visits and urgent care facilities. The plan's copayment is based on the medical option you choose. See *Covered Charges Under the Medical Options* on page 32 for copayment amounts. There are no copayments in the Basic or Enhanced (CDHP) plans.

Coinsurance is the percentage of charges that you and the plan each pay for covered services and supplies. The percentage is based on the medical option you choose and on whether you use in-network or out-of-network providers.

Benefits Based on Eligible Charges

The plan's percentage is applied, based on the amounts that have been negotiated with medical providers. It works like this:

- When you receive care from an in-network provider, the provider bills the plan at its regular rate. Then the plan reduces the bill to the negotiated eligible charge. (The provider has agreed to accept the negotiated eligible charge as payment.) The plan pays its percentage and you pay the remaining coinsurance based on the negotiated eligible charge, except as provided by the outpatient dialysis provision. See your separately issued Outpatient Dialysis Program Document.
- When you receive care from out-of-network providers, the provider bills the plan at its regular rate. The plan calculates what the negotiated eligible charge would have been and then pays its percentage, based on that amount. The providers are not responsible for reducing their costs, so you are responsible for paying the full remaining amount except as provided by the outpatient dialysis provision. See your separately issued Outpatient Dialysis Program Document.

Here's an example: Say you have health care charges of $1,000. Under the PPO, the negotiated eligible charge is $700. Assuming that you've met any deductible requirements and that the plan pays 80% in-network and 60% out-of-network, payments would be:

	In-Network	**Out-of-Network**
Full charge	$1,000	$1,000
Negotiated eligible charge	$700	$900
Plan pays percentage of network-negotiated eligible charge	80% of $700 = $560	60% of $900 = $540
You pay remainder	$700 − $560 = $140	$1,000 − $540 = $460

In this example, you pay $140 if you receive services from in-network providers, or you pay $460 if you receive services from out-of-network providers. Please note that this is a very simple example to show how the concept works. The actual negotiated eligible charges may vary depending on the type of expense; the physician's billing practices, and the geographic area. The percentage the plan pays also may vary depending on the type of expense and plan enrolled.

About the Annual Out-of-Pocket Maximums

The plan places a maximum on the amount of money you have to pay out-of-pocket each year for your share of covered medical expenses. This is called the out-of-pocket maximum. The out-of-pocket maximum protects you from high medical expenses. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the rest of the calendar year.

Each medical option has different individual and family out-of-pocket maximums for in-network and out-of-network expenses. If you use both in-network and out-of-network providers, you may have to pay more in coinsurance before you're eligible for 100% coverage for the rest of the year. (This is another good reason to try to use in-network providers whenever possible.)

In general, any deductibles, copayments and coinsurance you pay apply to the out-of-pocket maximum. The following charges do not count toward the out-of-pocket maximum:

- Charges that are not covered by the plan
- Charges that exceed the eligible charge limits
- Prescription drug deductibles or coinsurance (except for the Basic or Enhanced (CDHP) medical options)
- The $500 penalty for not notifying BlueCross BlueShield of Tennessee of an out-of-network hospital admission or other treatment that requires notification

No Lifetime Maximum

The medical options do not have a lifetime maximum. If you or a covered family member has a serious illness or injury, there is no maximum on the benefits you can receive. However, there are day and visit limits for specific benefits.

About Using Non-Participating and Out-of-Network Providers

Generally, you receive the highest benefits when you use in-network providers. But in certain situations, you may be eligible for benefits at negotiated rates when you use other providers:

- Some providers may have contracts with BlueCross BlueShield of Tennessee even though they are not considered to be in-network providers under our plan. These providers are called "non-participating providers." If you use non-participating providers, your coinsurance generally is higher than if you use in-network providers.

If you need services or supplies that are not available from an in-network provider, you may be able to receive those services or supplies from an out-of-network provider and still receive benefits at in-network coverage. To do so, you must notify BlueCross BlueShield of Tennessee before receiving services as described on page 49.

Covered Charges Under the Medical Options

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$3,000 individual/ $6,000 family	$9,000 individual/ $18,000 family	$2,800 individual/ $5,600 family	$9,000 individual/ $18,000 family	$1,500 individual/ $3,000 family	$4,500 individual/ $9,000 family
Annual Out-of-Pocket Maximum (includes deductible, copayments, and coinsurance)	$5,000 individual/ $10,000 family	$10,000 individual/ $20,000 family	$3,500 individual/ $7,000 family	$10,000 individual/ $20,000 family	$3,500 individual/ $7,000 family (include prescription)	$10,500 individual/ $21,000 family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Physician's Services (sickness or injury) *						
Family and general practitioners, internists, OB-GYNs, pediatricians	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after $25 copayment	50% after deductible
Specialists	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after $40 copayment	50% after deductible
Urgent care facility	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after $40 copayment	50% after deductible
Telemedicine visit	70% after deductible**	50% after deductible	80% after deductible**	50% after deductible	100% covered after $25 copay	50% after deductible
Provider-administered specialty drugs	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after office visit copayment	50% after deductible
Diagnostic laboratory and x-ray services (excluding Advanced Radiological Imaging)	100% after deductible	50% after deductible	100% after deductible	50% after deductible	100% no deductible	50% after deductible

* *For the PPO option, the doctor's office visit copayment applies to the office visit and all other services provided in the office on the same day, except for surgery; emergency care; physical, occupational, and speech therapies; or muscle manipulation (coverage for these services is described later in this chart).*

***For the Basic and Enhanced (CDHP) options, you will pay the full cost of the medical telemedicine visit or the full cost of the behavioral health telemedicine visit at the time of service. If your deductible has been met, you will be reimbursed the difference between the cost and your coinsurance.*

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive Care						
Routine physical exam for adults and children	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Immunizations (includes immunizations for travel)	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Routine and diagnostic colorectal cancer screening prescribed by a physician and according to screening guidelines (includes prescribed sigmoidoscopy/ colonoscopy)	100% no deductible, routine screening 100% after deductible, diagnostic screening	50% after deductible, routine and diagnostic screening	100% no deductible, routine screening 100% after deductible, diagnostic screening	50% after deductible, routine and diagnostic screening	100% no deductible	50% after deductible
Routine prostate-specific antigen test and digital rectal exam for men	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Routine cervical or Pap test	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Routine mammogram, including 3-D mammograms	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and occur no more than every three years.	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Counseling for sexually transmitted infections for all sexually active men and women	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Counseling and screening for human immune deficiency virus (HIV) for all sexually active men and women	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Genetic testing and counseling for BRACA1 and BRACA 2 genes for those at high risk	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital Care						
Inpatient hospital room and board up to the semiprivate room rate, general nursing care, medications, injections, diagnostic services and special care units. Prior authorization from BCBST is required. **Note:** Inpatient private-duty nursing is not covered.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Intensive care unit	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Physician services	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Services and supplies provided by the hospital during confinement, such as medicines, lab tests, use of operating rooms and surgical dressings	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Preadmission testing	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Penalty for failure to receive prior authorization from BCBST	Not Applicable	$500	Not Applicable	$500	Not Applicable	$500
Surgery						
Surgery performed by a physician	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Anesthesia administered for a covered surgical procedure	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Surgical assistance	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Surgery, continued						
Consultations while you are hospitalized and when requested by your attending physician for diagnosis or treatment of your condition.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Organ transplants (except kidney transplants), as described on page 47. Prior authorization from BCBST is required for transplant services or supplies.	100% after deductible if received at an in-transplant-network facility 70% after deductible at any other in-network facility	Not covered	100% after deductible if received at an in-transplant-network facility 70% after deductible at any other in-network facility	Not covered	100% after deductible if received at an in-transplant-network facility 80% after deductible at any other in-network facility	Not covered
Kidney transplants, as described on page 47. Prior authorization from BCBST is required for transplant services or supplies.	70% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Cardiac and pulmonary rehabilitation therapy from a BCBST-approved program within the six-month period following eligible inpatient services	70% after deductible, up to 36 combined visits per calendar year	Not covered	100% after office visit copayment, up to 36 combined visits per calendar year	Not covered	100% after office visit copayment, up to 36 combined visits per calendar year	Not covered
Emergency Care						
Emergency medical or accident care	70% after deductible	70% after deductible	80% after deductible	80% after deductible	$350 copayment then 80% after deductible (Copay waived if admitted)	$350 copayment then 80% after deductible (Copay waived if admitted)
Emergency care resulting from criminal sexual assault or abuse	100% after deductible	100% after deductible	100% no deductible	100% no deductible	100% no deductible	100% no deductible
Ambulance transportation (includes air ambulance when medically necessary) *	70% after deductible	70% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible

**Benefits are not provided for use of an ambulance because it is more convenient than other transportation or for transportation from your home to a skilled nursing facility or convalescent facility.*

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Care, continued						
Advanced Radiological Imaging (includes MRIs, CT/CAT scans, PET scans, nuclear medicine services, MRAs and MRSs)	70% after deductible	70% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Outpatient Care						
Services or supplies provided for outpatient surgery at a hospital or ambulatory surgical facility, including related diagnostic services provided on the day of the surgery and preadmission testing	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Physician services	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Second surgical opinions, including consultation with a physician and related diagnostic services	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after office visit copayment	50% after deductible
Outpatient hospital charges for laboratory, x-ray, Pap smear, pathology, and diagnostic procedures related to surgery or medical care, except MRIs, CT and PET scans	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% no deductible	50% after deductible
Advanced Radiological Imaging (includes MRIs, CT/CAT scans, PET scans, nuclear medicine services, and other similar technologies) Advanced Radiological Imaging services require prior authorization from BCBST.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Allergy injections	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after office visit copayment (you pay full cost if it is less than the copayment)	50% after deductible

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Care continued						
Allergy testing	70% after deductible	50% after deductible	100% after office visit copayment	50% after deductible	100% after office visit copayment	50% after deductible
Radiation therapy, chemotherapy, and shock therapy	70% after deductible	50% after deductible	100% after office visit copayment 80% after deductible if hospital-based facility or home health care	50% after deductible	100% after office visit copayment 80% after deductible if hospital-based facility or home health care	50% after deductible
Renal Dialysis: Outpatient (in a dialysis facility or your home. **See your separately issued Outpatient Dialysis Program Document.**						
Renal dialysis treatments in a hospital.	70% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Muscle manipulations and other chiropractic services	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible,
Treatment of routine foot disorders examples include flat feet, corns, bunions, calluses, toenails, fallen arches, and weak feet or chronic foot strain	70% after deductible, up to 30 visits per calendar year	50% after deductible, up to 30 visits per calendar year	80% after deductible, up to 30 visits per calendar year	50% after deductible, up to 30 visits per calendar year	80% after deductible, up to 30 visits per calendar year	50% after deductible, up to 30 visits per calendar year
Physical, occupational, and speech therapy provided by a registered physical, occupational, or speech therapist under the supervision of a doctor and under the doctor's written plan, which specifies the diagnosis; therapeutic goals; and the type, amount, frequency, and duration of therapy*	70% after deductible, up to 60 combined visits per calendar year	50% after deductible, up to 60 combined visits per calendar year	100% after office visit copayment, up to 60 combined visits per calendar year 80% after deductible if hospital-based facility	50% after deductible, up to 60 combined visits per calendar year	100% after office visit copayment, up to 60 combined visits per calendar year 80% after deductible if hospital-based facility	50% after deductible, up to 60 combined visits per calendar year

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Care, continued						
Speech and occupational therapy for development delays (including autism spectrum disorder for children age 12 and under, dyslexia, and rehabilitation) *	70% after deductible, up to 60 combined visits per calendar year	50% after deductible, up to 60 combined visits per calendar year	80% after deductible, up to 60 combined visits per calendar year	50% after deductible, up to 60 combined visits per calendar year	100% after office visit copayment, up to 60 combined visits per calendar year 80% after deductible if hospital-based facility	50% after deductible, up to 60 combined visits per calendar year
Care in Other Settings						
Hospice care, as described on page 46, when life expectancy is one year or less.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Home health care as described on page 45. Prior authorization from BCBST is required for home health care, as described on page 45 before services begin. Custodial care is not covered.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Skilled nursing facility expenses, including room and board, general nursing services and ancillary services. Prior authorization from BCBST is required.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Private-duty nursing, when you need services that can only be provided by a licensed health care professional. Private-duty nursing includes teaching and monitoring complex care skills. It is not intended for long-term care.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Family Planning/Maternity Care						
Office visits (prenatal and postnatal)	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after $40 copayment	50% after deductible
Screening for gestational diabetes for women between 24 and 28 weeks of gestation and at the first prenatal visit for women identified to be at high risk for diabetes.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% no deductible	50% after deductible
In-hospital delivery services*	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Routine newborn nursery services	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Newborn initial exam	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Newborn hearing screening provided by a doctor other than the doctor who delivered the child or administered anesthesia	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Newborn treatment of an illness or injury (you must have dependent coverage or enroll your dependent within 30 days after the child's birth to receive these benefits)	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Breastfeeding support, supplies and counseling including comprehensive lactation support and counseling by a trained provider during the pregnancy and/or in the postpartum period. Includes costs for renting breastfeeding equipment, one lactation consultant visit, and one manual breast pump. Applies in conjunction with each birth.	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible

**The plan does not limit childbirth-related hospital stays to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section. In addition, the plan does not require a provider to receive authorization for any length of stay that is less than the above period.*

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Family Planning/Maternity Care, continued						
Midwife services (must be licensed and certified)	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Infertility treatment (diagnosis and treatment of underlying cause only)	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Sexual dysfunction treatment. Vacuums, pumps, implants and other devices are subject to durable medical equipment (DME) coverage limits and exclusions, as described on page 42.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Abortion. Coverage only applies when the pregnancy is the result of rape or incest, the mother's life is endangered, the fetus is not viable, or the fetus has been diagnosed with a lethal or otherwise significant abnormality	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	5% after deductible
Elective abortion	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Other Services						
Blood and blood components. However, the plan does not cover blood derivatives that are not classified as drugs.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Oxygen and its administration	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Other Services, continued						
Outpatient treatment of diabetes, including self-management training, education, and medical nutrition therapy. Services may be provided by a physician or a registered or licensed health care professional with expertise in diabetes management. *	70% after deductible	50% after deductible	80% after deductible	50% after deductible	Treatment by a physician: 100% after $40 copayment Treatment by another health care professional: 80% after deductible	50% after deductible
Nutritional counseling	70% after deductible	50% after deductible, up to three visits per condition per lifetime	80% after deductible	50% after deductible, up to three visits per condition per lifetime	100% after office visit copayment	50% after deductible, up to three visits per condition per lifetime
Behavioral health telephonic counseling	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Screening and counseling for interpersonal and domestic violence through a BCBST assigned counselor	100% no deductible	50% after deductible	100% no deductible	50% after deductible	100% no deductible	50% after deductible
Internal medical equipment, such as internal cardiac valves, internal pacemakers, bone screws, bolts, nails, plates, and other internal and permanent devices -	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Sleep studies (includes home sleep studies)	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Standard leg, back, arm, and neck braces	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Medical and surgical dressings, supplies, casts and splints	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Wigs, for hair loss resulting from injury, chemotherapy or radiation	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible

**Diabetes coverage includes regular foot care exams by a physician or podiatrist (do not count towards 30 visits per calendar year limit for routine foot care services).*

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Other Services, continued						
Rental of durable medical equipment (DME) or items that in the absence of illness or injury are of no medical or other value to you, can withstand repeated use in an ambulatory or home setting, require the prescription of a practitioner for purchase and are approved by the FDA for the illness or injury for which it is prescribed and are not solely for convenience. Prior authorization from BCBST is required if the cost to rent or purchase DME is over $500.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Prosthetic appliances, devices, and surgical implants needed to replace, or to replace the function of, a human organ or tissue. Benefits also may include adjustments, repair, and replacements when required because of wear or change in a patient's condition.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Dental Care						
Dental services provided by a doctor or dentist when needed to treat an accidental injury	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after specialist visit copayment	50% after deductible
Surgery to remove tumors and cysts, and to correct accidental injury to the jaws, cheeks, lips, tongue, roof and floor of mouth	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Removal of bony impacted wisdom teeth (Note: tissue impacted are normally covered under dental plan)	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Dental Care, continued						
Removal of growths on the jaws or hard palate; drainage of infections; surgical opening of sinuses, salivary glands or ducts; treatment of facial bone fractures	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Diagnosis and treatment of temporomandibular joint (TMJ) disorder, including surgical treatment for dislocation of the temporomandibular joints. =pre-authorization is required. **Note:** The plan does not cover appliances for treatment of TMJ or related disorders.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Eye and Vision Care						
Optometric services for treatment of an illness, medical condition, or injury to the eye, provided that treatment would have been covered if provided by a physician	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Routine vision exams, eyeglass lenses and frames, contact lenses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Single set of eyeglass lenses and frames or contact lenses following cataract surgery	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Cataract lenses	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Keratoconus contact lenses	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health						
Outpatient when rendered by a physician, psychologist, clinical social worker, or clinical professional counselor working within the scope of their license	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after $40 copayment	50% after deductible
Inpatient. Prior authorization is required.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Substance Abuse						
Outpatient	70% after deductible	50% after deductible	80% after deductible	50% after deductible	100% after $40 copayment	50% after deductible
Inpatient. Prior authorization is required.	70% after deductible	50% after deductible	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Prescription Drugs (Express Scripts)						
See pages 55 through 66 for details about the prescription drug program.						

Special Features Under the Medical Options

Reconstructive Procedures, Including Surgery After Mastectomy: Prior Authorization Required

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures that are associated with an injury, sickness, or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance. Benefits are paid at the same rates as any other illness or injury.

If you or your dependent receives plan benefits for a mastectomy, coverage will include reconstructive surgery after the mastectomy, as follows:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

Home Health Care – Prior Authorization is Required

Home health care is care you receive at home, usually following a hospitalization. The medical plan covers home health care expenses if all of the following requirements are met:

- Charges are made by a hospital's home health care department or a home health care agency
- Services are ordered by a physician
- Services are provided or supervised by a registered nurse
- Care is provided according to a home health care treatment plan
- The care is provided to a covered patient in his or her home when skilled nursing services are medically necessary

Home health care charges include the following services and supplies:

- Part-time or intermittent care by a registered professional nurse
- Physical, occupational and speech therapy (subject to the limitations)
- Medically appropriate supplies
- Laboratory services provided by a hospital
- Medical social services
- Dietary guidance

Home health care items such as non-treatment services are not covered. This includes routine transportation, homemaker or housekeeping services, behavioral counseling, supportive environmental equipment, maintenance care or custodial care, social casework, meal delivery, personal hygiene, convenience items, domiciliary care, respite care, and rest cures. In addition, services that were not authorized are not covered.

Hospice Care: Prior Authorization Required

Hospice care is intended for patients whose life expectancy is one year or less as certified by your attending physician. It is directed at providing comfort and relief (not treatment or a cure) for a terminal illness. Care may be provided in a patient's home or in a hospital, skilled nursing facility, or hospice facility.

Hospice care must be provided through a licensed hospice care agency. Hospice care services and supplies include the following:

- Room and board when confined in a hospital, skilled nursing facility, or hospice facility, including services and supplies furnished by the facility for pain control and other acute and chronic symptom management
- Coordinated home care
- Medical supplies and dressings
- Medications
- Nursing services (skilled and unskilled)
- Occupational therapy
- Pain management therapy
- Physician visits
- Social and spiritual services
- Respite care services

The plan does not cover the following charges under your hospice care benefits, although they may be covered under other parts of the plan:

- Durable medical equipment
- Home-delivered meals
- Homemaker services
- Traditional medical services provided for the direct care of the terminal illness
- Transportation or ambulance service
- Convenience or comfort items not related to the illness
- Supportive environmental equipment
- Private-duty nursing
- Funeral or financial counseling

Organ Transplants - Prior Authorization is Required

You have access to three levels of benefits for organ transplants, in-transplant-network, in-network and out-of-network. In order to receive coverage under the plan for an organ transplant, you must receive services at a BCBST in-transplant-network facility or a BCBST in-network facility. The transplants listed below must be done at a hospital that is in the BlueCross BlueShield of Tennessee network:

- Heart
- Heart/lung
- Intestinal
- Kidney (in-transplant-network does not apply)
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Lung
- Pancreas
- Bone marrow (either from you or a compatible donor) and peripheral stem cell transplants, with or without high-dose chemotherapy

Benefits may be available for other organ transplant procedures that are not experimental or investigational and that are medically necessary and medically appropriate.

Coverage for Transplant Recipients and Donors

The plan pays benefits for both transplant recipients and donors as follows:

- If both the donor and recipient have medical coverage, each person's plan covers charges for its participant
- If you are the recipient and the donor does not have coverage from another source, this plan pays benefits for both you and the donor

If you are the donor and the recipient does not have coverage from another source, this plan pays benefits for your expenses; however, this plan does not pay benefits for the recipient's expenses.

Covered Charges

The plan covers the following expenses:

- Inpatient and outpatient covered services related to the transplant surgery, including outpatient immunosuppressive drugs prescribed in connection with the transplant
- Evaluation, preparation, and delivery of the donor organ
- Removal of the organ from the donor
- Transportation of the donor organ to the location of the transplant surgery (benefits are limited to transportation within the United States or Canada)

Special Rules for Transplants

You or your physician must notify the BCBST Transplant Case Management prior to receiving any transplant service, including pre-transplant evaluation. Failure to notify BCBST or coordinate all transplant-related services with BCBST will result in the reduction or exclusion of payment for those services. You must participate in Transplant Case Management and receive prior authorization from BCSBT for your transplant to be covered.

Once you have notified Transplant Case Management and received prior authorization for the transplant, you may choose to have the transplant performed outside the BCBST in-transplant network; however, this will result in a reduction in benefits.

Travel Expenses for Covered Transplants

If you or your covered dependent are the recipient of a transplant and you live more than 50 miles from the facility where you receive the transplant, the plan also covers travel expenses for the patient and one companion (two companions if the patient is your dependent child). Travel expenses include meals and lodging. Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the BCBST in-transplant-network.

The plan covers travel expenses for your evaluation prior to the transplant as well as travel expenses to and from the facility where the transplant is performed. Travel expenses are limited to a maximum of $10,000 per covered transplant and are covered only if the transplant is performed at a BCBST in-transplant-network or in-network facility.

Transportation and lodging expenses are not covered for any other persons, and they are not covered for any other transplants except those noted above that are performed at BCBST in-transplant-network or in-network facilities.

Travel Expenses for Cancer and Congenital Heart Disease Treatment

If you or your covered dependent are the recipient of treatment for cancer or congenital heart disease and you live more than 50 miles from the facility where you receive the treatment, the plan also covers travel expenses for the patient and one companion (two companions if the patient is your dependent child). Travel expenses include meals and lodging. Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the BCBST network.

Travel expenses are limited to a maximum of $10,000 per course of treatment and are covered only if the treatment is performed at a BCBST in-network facility.

Transportation and lodging expenses are not covered for any other persons, and they are not covered for any other treatments except those noted above that are performed at BCBST in-network facilities.

Dialysis Treatment- Outpatient: Please see your separately issued Outpatient Dialysis Program Document.

Managing Medical Costs

Before you or a covered dependent receives certain types treatment (inpatient hospital or skilled nursing facility admission, home health care, or private duty nursing) you must receive prior authorization from BlueCross BlueShield of Tennessee. In some situations, a $500 penalty will be charged if prior authorization is not obtained.

How to Obtain Prior Authorization

To receive prior authorization from BlueCross BlueShield of Tennessee, call **800-565-9140**. You can make the call yourself, or you can have your doctor, the hospital, or another person make the call on your behalf. However, you are ultimately responsible for notification for out-of-network services. If you do not notify BlueCross BlueShield of Tennessee of a hospital stay or other treatment when required, your benefits may be reduced or denied, as shown below.

When you or your representative call, you'll need to give BlueCross BlueShield of Tennessee the name of your doctor, the name of the hospital or facility, the date the admission or treatment is scheduled to start, and the preliminary diagnosis or reason for admission or treatment.

Situations and Timing Requirements for Notification

Here are the situations when you must receive prior authorization from BlueCross BlueShield of Tennessee:

- Inpatient hospital services for treatment of an illness or injury (including transplants)
- Out-of-network inpatient hospital services for maternity and in network stays beyond 48 hours for a vaginal delivery, 96 hours for a cesarean section
- Outpatient surgery or facility services (some services require prior authorization; contact BCBST to determine if prior authorization is required)
- Inpatient hospital services or admission to a partial hospitalization treatment program
- Inpatient treatment of a mental health disorder or substance abuse
- Skilled nursing or rehab facility stays
- Home health care services, including home infusion therapy
- Hospice care
- Advanced Radiological Imaging (includes MRIs, CT/CAT scans, PET scans, nuclear medicine services, and other similar technologies)
- Inpatient or outpatient electro-convulsive therapy (ECT)
- Rental and/or purchase of durable medical equipment over $500

Healthy Maternity℠ Program

If you or your covered dependent is expecting, the Healthy Maternity℠ program will connect you with personalized support from maternity nurses and online pregnancy resources.

Participants in the program receive:

- Personalized one-on-one support from a dedicated maternity nurse
- Helpful prenatal information and online pregnancy resources at **bcbst.com/healthy maternity**
- Postpartum support for up to 8 weeks after delivery
- Newborn education and details about immunizations
- Guidance from high-risk maternity nurses, if needed

To enroll in the program, call **800-818-8581** and choose the *Case Management* and then *Healthy Maternity* prompts.

About Medically Necessary Services Decisions

Decisions regarding medically necessary services are determined according to standards set by BlueCross BlueShield of Tennessee (the claims administrator).

The plan's definition could be different from your physician's opinion. Notification lets you know whether the plan will pay benefits for certain charges before you proceed with treatment. You and your doctor must then decide how to proceed with your course of treatment.

Notification Decisions and Length of Stay/Service Review

After you or your representative calls for prior authorization, BlueCross BlueShield of Tennessee will let you, your doctor, or the hospital know if the admission or treatment is determined to be a covered health service.

If the admission or treatment is covered, a letter stating the covered length of stay or the covered number of services will be sent to your doctor or hospital. If an admission or treatment needs to be extended beyond the number of days originally covered, the additional days must be approved before your hospital stay or treatment period that was originally covered ends. If an admission, treatment, or extension of services is not covered, you may appeal the decision as indicated under *Claim Review and Appeal Process* on page 169 of the Claims section.

Note: Notification is not a guarantee of benefits. Actual availability of benefits is also subject to eligibility and the other terms, conditions, limitations, and exclusions of the medical plan, some services require predetermination for the approval of the actual benefit under the plan. Predetermination is required when it is necessary to review medical records and a patient's history to determine whether a service is covered. Please call the BCBST customer service team before receiving non-emergency services. If the service requires predetermination approval, the customer service representative will notify you or your provider of the materials needed for a predetermination review.

How Notification Affects Your Benefits

Situation	Effect on Your Benefits
If you call within the required time frame and the plan determines that treatment is covered	Plan pays benefits at regular rates
If you call within the required time frame and the plan determines that treatment is not covered	No benefits are paid for services that are not considered to be covered
If you do not call within the required time frame and the plan determines that treatment is covered	Plan pays benefits at regular rates after you pay a $500 penalty if using out-of-network providers/facilities
If you do not call within the required time frame and the plan determines that treatment is not covered	No benefits are paid for services that are not considered to be covered

Medical Case Management

If you have a serious illness or injury that is likely to require complex, long-term health care, the plan may offer the services of a medical case manager. The case manager's role is to give you information about treatment alternatives and plan benefits, to help you to get quality care, and to help you manage your benefit dollars most effectively.

Payment of Claims and Assignment of Benefits

All payments by the claims administrator for the benefit of any covered person may be made directly to any provider furnishing covered services for which such payment is due, and the claims administrator is authorized by such covered person to make such payments directly to such providers. However, the claims administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the plan directly to the covered person or provider furnishing covered services. All benefits payable to the covered person that remain unpaid at the time of the death of the covered person will be paid to the estate of the covered person.

Once covered services are rendered by a provider, the covered person has no right to request the claims administrator not to pay the claim submitted by such provider and no such request by a covered person or his/her agent will be given effect. Furthermore, the claims administrator will have no liability to the covered person or any other person because of its rejection of such request.

Neither the plan nor a covered person's claims for payment of benefits under the plan are assignable in whole or in part to any person or entity at any time. Coverage under the plan is expressly non-assignable or nontransferable and will be forfeited if a covered person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the plan.

The plan expressly prohibits, and the plan will not accept under any circumstances, any assignment or any attempt to assign any benefit claims or any other types of claims, regardless of the nature of such claims, to any person or entity, including, but not limited to, an out-of-network provider or an out-of-network hospital or facility. This prohibition on assignments applies to all benefit plans and any claims for benefits or monies alleged to be due under this plan or the benefit plans, any claim for a determination as to future rights to benefits under this plan or the benefit plans, any claim for access to documents or information under ERISA or any other applicable law, any claim for a breach or alleged breach of fiduciary duty under ERISA, and any and all other claims regardless of the nature of such claims. In the event the plan, the plan administrator, the claims administrator, or any other party makes a direct payment to a person or entity or otherwise communicates with such person or entity, such payment or communication shall in no way be construed or interpreted as a waiver of the plan's prohibition on assignments.

Coverage under the plan will be forfeited if a covered person attempts to assign or transfer coverage, fraudulently obtains or attempts to obtain coverage, or aids or attempts to aid any other person in fraudulently obtaining coverage under the plan.

Charges Not Covered Under the Medical Options

Although the plan covers most health care expenses, it does not cover all medical charges. The following charges are not covered by the medical options:

- Services or supplies that are not covered health services
- Services or supplies that are not specifically mentioned as covered charges under the medical options
- Medical treatment received outside the United States (except in cases of a medical emergency)
- Hearing aids; appliances, devices, or implants that are for cosmetic purposes
- Durable medical equipment to replace items that were lost, damaged, stolen or prescribed as a result of new technology
- Replacement of contacts after the initial pair is provided after cataract surgery
- Custom-made shoes (except as required by law for diabetic patients as part of a leg brace)
- Any experimental/investigational or unproven services, supplies, or diagnostic testing and all related charges (the cost of routine patient care associated with investigational cancer treatment is covered if those services and supplies would otherwise be covered if they were not provided in connection with an approved clinical trial program)
- Remedial education services, such as evaluation or treatment of learning disabilities, developmental and learning disabilities, behavioral training, and cognitive rehabilitation
- Services or supplies that do not meet accepted medical, vision or dental practice standards
- Charges that you would not be required to pay if you did not have this or similar coverage
- Premarital exams, surveys, case finding, research studies, screening, or similar procedures or studies
- Services or supplies for a sickness or injury that is occupational or sustained at work or in the course of your employment, whether or not you can make a claim under workers' compensation
- Services or supplies for which benefits are provided under any local, state, or federal governmental program, except for Medicaid or similar programs
- Any outpatient prescription drugs, except specialty drugs requiring provider administration and immunosuppressive drugs prescribed in connection with an organ transplant (See Prescription Drug plan for coverage)
- Specialized braces, splints, equipment, appliances or ambulatory apparatus, or battery implants
- Nicotine replacement therapy and aids to smoking cessation including but not limited to patches and gum (See Prescription Drug plan for coverage)
- Abdominoplasty, panniculectomy, removal of skin tags or removal of redundant skin
- Genetic testing and counseling except as otherwise noted
- Injury or illness occurring after your coverage date that results from war or any act of war
- Charges for missed appointments or completion of insurance forms

- Hospital services and supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions that do not result from a mental illness
- Custodial care, domiciliary or private-duty nursing, or long-term care
- Services not received in a Medicare-certified nursing skilled nursing facility
- Services for cognitive rehabilitation
- Services provided by a family member or person who ordinarily lives in your home
- Maintenance care
- Massage, aquatic, and homeopathic therapies (including acupuncture)
- Sleep therapy
- Biofeedback therapy and hypnotherapy
- Family, or bereavement counseling (unless a behavioral health diagnosis, such as depression, is provided)
- Respite care, except as specifically allowed under the hospice benefits
- Physician home visits
- Any nonsurgical treatment of temporomandibular joint (TMJ) disorder, including all adjacent or related muscles. (the plan does not cover dental restorations, orthodontics, physical therapy, oral appliances, oral splints, oral orthotics, or any other devices or prosthetics for TMJ treatment other than diagnosis and surgery)
- Any dental care or treatment, except as specifically mentioned. (See Dental Plan for coverage)
- Cosmetic surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors, or diseases
- Vision expenses for diagnosis or treatment of refractive errors, eyeglasses, contact lenses, cataract lenses, exams for prescribing or fitting eyeglasses or contacts, or keratotomy or laser surgery (See Vision Plan for coverage)
- Hearing aids or exams for prescribing or fitting hearing aids
- Elective abortions
- Sterilization reversal
- Services provided mainly because of a lack of a willing or available professional
- Services and supplies to the extent benefits are duplicated for dependents covered separately under this plan

Prescription Drug Coverage

Your prescription drug coverage offers you choices of how and where to get your prescriptions filled. You have access to a network of retail pharmacies offered through Express Scripts (ESI). For long-term or maintenance medications, you also have access to a home delivery service. Both programs are designed to help you pay for your prescription drug expenses, and help the company better manage rising prescription drug costs. In addition, if you need specialty drugs for complex chronic conditions, you receive enhanced services through Accredo, Express Scripts' Specialty Pharmacy Program. For more information, and examples of specialty drugs, please see page 65.

The chart below gives a brief description of how the retail pharmacy network and Smart-90 home delivery service or preferred pharmacy network operate.

Feature	Retail Pharmacy Network – up to a 30-day supply	Smart-90 - Home Delivery Service or Preferred Retail Pharmacy Network –up to a 90-day supply
Access	You have access to a network of participating pharmacies that have agreed to discounted prices. You must use participating pharmacies to receive benefits from the plan.	For long-term or maintenance medications, you have access to a convenient home delivery service or preferred pharmacy network that offers discounted prices. You complete a home delivery form and turn it in with your prescription and payment. The plan mails your medication to you. You can order refills online or over the phone. In addition, you can also choose to fill your long-term or maintenance medications at any preferred pharmacy. Please note that Walgreen's and CVS Caremark are not preferred retail pharmacies for long-term or maintenance medications.
Your Cost – Brand Name Drugs	There is no deductible and no coinsurance in the PPO option, only a flat copayment of $30. For the CDHP options, all medications are subject to the combined medical and prescription drug deductible before coinsurance is applied	For the PPO option, you do not pay a deductible or coinsurance. You pay your flat $60 copay for each prescription. For the CDHP options, all medications are subject to the combined medical and prescription drug deductible before coinsurance is applied except for the preventative prescription (deductible waived) for 90-day mail or 90-day retail.
Your Cost – Non-Brand Name Drugs	There is no deductible and no coinsurance in the PPO option, only a flat copayment of $60. For the CDHP options, all medications are subject to the combined medical and prescription drug deductible before coinsurance is applied	For the PPO option, you do not pay a deductible or coinsurance. You pay your flat $120 copay for each prescription. For the CDHP options, all medications are subject to the combined medical and prescription drug deductible before coinsurance is applied except for the preventative prescription (deductible waived) for 90-day mail or 90-day retail.
Your Cost – Generic Drugs	There is no deductible and no coinsurance in the PPO option, only a flat copayment of $10. For generic drugs in the CDHP options, those are subject to the combined medical and prescription drug deductible, as well as coinsurance	For the PPO option, there is no deductible or coinsurance for generic drugs, only a flat copayment of $20. For the CDHP options, generic drugs are subject to the combined medical and prescription drug deductible, as well as coinsurance.

Finding a Provider	You select a participating pharmacy from a directory. For a complete list, log on to the Express Scripts' website at **www.express-scripts.com** or call Express-Scripts toll free at **855-283-7451**.	You can get home delivery forms by calling Express Scripts toll free at **855-283-7451** or logging on to Express Scripts' website at **www.express-scripts.com**.

How the Prescription Drug Program Works

The program covers your prescription drug expenses as described below:

- Each year, you pay an annual deductible before retail pharmacy benefits are paid.
  - If you are enrolled in the Basic or Enhanced (CDHP) medical options, your prescription drug deductible is integrated with the medical deductible. The integrated deductible will apply to all medical services and prescriptions, including for generic medications, until the deductible has been fully satisfied.
  - If you are enrolled in the PPO, there is no deductible, only flat co-payments.
- Once you have satisfied your applicable prescription drug deductible, the plan pays a percentage of charges for prescriptions (called “coinsurance”). The amount the plan pays depends on your medical option, on the type of medication, and on whether you fill your prescriptions through a participating retail pharmacy or through the home delivery program. Your coinsurance is the remaining percentage of charges. In the PPO option, there is no coinsurance only flat co-payments.
- The plan has an annual out-of-pocket maximum that limits the total amount you pay each calendar year.
  - If you are enrolled in the Basic or Enhanced (CDHP) medical option, your prescription drug out-of-pocket maximum is integrated with the medical out-of-pocket maximum. The integrated out-of-pocket maximum will apply to all medical services and prescriptions, including generic medications, until the out-of-pocket maximum has been fully satisfied.
  - If you are enrolled in one of the PPO option, the prescription drug out-of-pocket is integrated with the medical out-of-pocket. The prescription drug out-of-pocket applies to all medications.
- If you need specialty medications, you receive enhanced services through Accredo—the Express Scripts Specialty Pharmacy Program.
- Types of drugs available from your prescription drug plan fall into different categories and the plan covers different amounts based on those categories. Contraceptives are covered under the prescription drug coverage options in accordance with the Affordable Care Act’s Preventive Services provision. Coverage for smoking cessation is covered under the prescription drug coverage option in accordance with the U. S. Preventive Services Task Force (USPSTF) recommendations.
- A prescription is required to process any of the products listed through the prescription drug plan.
- The prescription plan covers the first two courtesy fills for a 30-day supply of maintenance medications through an in-network retail pharmacy. After the first two courtesy fills at 30 days each, you are required to move your maintenance prescription to a 90-day supply and can fill the prescription through mail order or a preferred retail pharmacy (CVS and Walgreens are not preferred retail pharmacies). If you fill the 90-day prescription at an in-network, non-preferred pharmacy after the courtesy fills, you will pay the full cost of the medication. For the Basic and Enhanced CDHP medical plans, all prescription expenses are subject to the medical deductible with the exception of preventive prescriptions.

About Generic Drugs
A generic drug includes the same ingredients as its brand-name equivalent. Generic drugs are less expensive than brand-name drugs, so the plan automatically fills your prescription with the generic drug unless your doctor specifically requests the brand name (this is called “dispense as written”). If you choose the brand name instead of a generic, you pay an additional cost.

About Preferred Brand Name Drugs
Preferred brand-name drugs are selected for their safety, effectiveness, and cost. You pay less for a preferred brand-name drug than for a non-preferred brand-name drug.

Covered Charges Under the Prescription Drug Plan

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Plan Feature**	**In-Network**	**Out-of-Network**
Annual Deductible	Included in Medical	Not covered	Included in medical	Not covered	None	Not covered
Annual Maximum Benefit (Retail and home delivery combined)	No Maximum	Not covered	No Maximum	Not covered	No Maximum	Not covered
Annual Out-of-Pocket Maximum* (Retail and home delivery combined)	Included in medical	Not covered	Included in medical	Not covered	Included in medical	Not covered
Generic	Covered at 70% after deductible	Not covered	Covered at 80% after deductible	Not covered	$10 copayment retail/ $20 copayment home delivery/smart-90 supply	Not covered
Coinsurance: Retail						
Preferred Brand Name	Covered at 70% after deductible	Not covered	Covered at -80% after deductible	Not covered	$30 copayment	Not covered
Non-Preferred Brand Name	Covered at 70% after deductible	Not covered	Covered at 80% after deductible	Not covered	$60 copayment	Not covered
Coinsurance: 90 Day Home Delivery or at Select/Preferred Pharmacies						
Preferred Brand Name	Covered at 70% after deductible	Not covered	Covered at 80% after deductible	Not covered	$60 copayment	Not covered
Non-Preferred Brand Name	Covered at 70% after deductible	Not covered	Covered at 80% after deductible	Not covered	$120 copayment	Not covered
Preventive Rx (Deductible Waived) –90 Day Home Delivery or at Select/Preferred Pharmacies						
Generic	$0	Not covered	$0	Not covered	Same as above	Not covered
Preferred Brand Name	$0	Not covered	$0	Not covered	Same as above	Not covered
Non-Preferred Brand Name	$0	Not covered	$0	Not covered	Same as above	Not covered

	Basic (CDHP)		Enhanced (CDHP)		PPO	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Women's Contraceptive Coverage						
Diaphragm	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered
Hormonal Contraceptives (Generic, Single Source Brands, and Multi-Source Brands with DAW1)	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered
Emergency Contraceptives (Generic, Single Source Brands, and Multi-Source Brands with DAW1)	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered
Implant Contraceptives	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered
Spermicide	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered
Female Condoms*	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered
Smoking Cessation						
Smoking Cessation Medications (all FDA-approved products, up to 180-day supply in any 365-day period)	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered
Nicotine Replacement Therapy Nasal Spray or Inhaler (up to 180-day supply in any 365-day period)	100% (no deductible)	Not covered	100% (no deductible)	Not covered	100% (no deductible)	Not covered

**Only condoms with a National Drug Code (NDC) will process electronically through the prescription drug plan at the point of sale. Costs for condoms without an NDC must be paid for out-of-pocket at the point of sale and a manual claim must be submitted to Express Scripts for reimbursement.*

About the Deductible

The deductible is a fixed-dollar amount that you must pay out of your pocket each calendar year for brand drugs prescriptions received at retail pharmacies before Express Scripts pays benefits.

In the PPO medical plan, there is no deductible, only flat co-payments.

For the Basic and Enhanced (CDHP) medical options, because the prescription drug deductible is integrated with the medical deductible, the applicable deductible must be fully met before the plan will begin to pay benefits for prescription drugs, even for generic drugs and home delivery prescriptions.

About Coinsurance

Coinsurance is the percentage of eligible expenses for brand drugs that you and the plan are responsible for paying. The Basic and Enhanced CDHP plans pay different coinsurance percentages depending on the medical option you choose; on whether you purchase generic, preferred brand-name, or non-preferred brand-name drugs; and on whether you purchase drugs at a participating retail pharmacy or through the home delivery program.

Participating Pharmacies

A participating pharmacy is any pharmacy that has a written agreement with Express Scripts to provide services to you at the time you receive them. Express Scripts selects participating pharmacies based on geographic location and cost-effectiveness of care. You can locate a participating pharmacy by logging onto the Express Scripts website at **www.express-scripts.com** or by calling Express Scripts at **855-283-7451.**

You can also check with your pharmacist before you fill your prescription to make sure the pharmacy is still participating. There is no coverage for prescriptions purchased at non-participating pharmacies.

Preferred and Non-Preferred Pharmacy Network

The network of pharmacies is divided into two groups; Preferred and Non-Preferred. You have the choice which you will use to fill your prescriptions but using a non-preferred pharmacy will cost more.

Preferred pharmacies are retail pharmacies that have agreed to offer the lowest-cost prescription drug services to plan members. When filling prescriptions, you are encouraged to use a preferred pharmacy. Check the Express Scripts website at **www.express-scripts.com** or call **855-283-7451** to check for names of preferred pharmacies as the list does change.

Non-preferred retail pharmacies offer covered drugs to plan members at higher out-of-pocket cost than what the member would pay at a preferred network pharmacy.

Prescription Supplies

The plan pays benefits for up to a 30-day supply of medication through the retail pharmacy network. The plan pays benefits for up to a 90-day supply of most medications through the home delivery service. Quantity limits are based on FDA-approved prescription drug dosing guidelines. If your medication has a quantity limit, you make one copayment for each purchase of the maximum allowed quantity limit per prescription. If you require a prescription that exceeds the quantity limit, your doctor must call ESI at **800-417-8164** to request authorization for an exception to the quantity limit.

Your ID Card

If you elect coverage for yourself, you receive one ID card. If you elect family coverage, you receive two ID cards in your name. Please present your ID card when you visit a participating pharmacy. Your Social Security number is your ID number, but it is not shown on your ID card. If you need additional or replacement ID cards, you can call Express Scripts or order on-line. You can download a temporary ID card for immediate use or use the mobile application to provide a copy of your ID card to be used at the pharmacy. Cards will only be supplied when you first enroll.

How to Use Participating Retail Pharmacies

When you or a covered family member needs a prescription filled, simply take it to a participating retail pharmacy. To fill a prescription through the retail pharmacy network:

- Go to a participating pharmacy
- Make sure that your pharmacist has complete and correct information about you and your covered dependents
- Present your prescription and your ID card to the pharmacist
- Pay any applicable deductible, coinsurance, and copayment
- Receive your prescription

As long as you go to a participating pharmacy and pay your deductible, coinsurance, and copayment, you do not have to file a claim.

How to Use the Smart-90 Home Delivery Service or Preferred Retail Pharmacy

If you enroll in coverage during the year and you or your covered dependents use long-term or maintenance medications, you are required to order these prescriptions through the home delivery service or use a preferred retail pharmacy (Walgreen's and CVS Caremark are not preferred retail pharmacy for maintenance medications). You can receive up to a 90-day supply of most covered medications with each order.

Follow these steps to order a prescription for the home delivery service.

Have your doctor write a new original prescription that you can submit to the home delivery program or you can have your doctor ePrescribe or fax your prescription. For a one-year supply, your doctor should write the prescription for a three-month supply, renewable four times. If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (take this to your local participating pharmacy)
- A second one for the extended supply (send this in with your home delivery order form)

Complete the home delivery order form that you receive in your welcome packet. You can also go online or call Express Scripts to get home delivery order forms. A new order form and envelope are then sent to you with each delivery.

Contact Express Scripts to get your cost for the prescription. Make your coinsurance check payable to Express Scripts or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.

Mail the order form and your method of payment to:

Express Scripts
P.O. Box 66567
St. Louis, MO 63166-6567

You will receive your prescription approximately 14 days from the date Express Scripts receives your order. Be sure to refill your prescriptions on time before you run out. You can request your refills online or by calling Express Scripts.

Extended Payment Program

To help make home delivery prescriptions easier to afford, you can enroll in the Express Scripts Extended Payment Program (EPP). The EPP allows you to spread your home delivery prescription payments over three equal credit or debit card installments so that you do not have to incur the full cost of the 90-day supply at once. Your medication will ship after you make the first payment.

For example: You order a 90-day supply of a medication for which your cost share is $-60. Your initial payment of $20 is charged to your credit or debit card at the time the order is placed, and your 90-day supply of medication is shipped to your address on file. Your second $20 payment will be charged to your credit or debit card 30 days after the first payment. Your final payment of $20 will be charged to your credit or debit card 30 days after the second payment.

To enroll in the EPP, visit the Express Scripts website at **www.express-scripts.com** or call Express Scripts at **855-283-7451**. When you enroll in the EPP, it will apply to every home delivery prescription for you and your covered dependents.

If you wish to opt out of the EPP, you may do so at any time. Any outstanding balance for your current medications will be your responsibility.

Covered Prescription Drugs and Medical Devices

The plan pays benefits for the following prescription drugs and medical devices:

- A prescription legend drug for which a written prescription is required
- Injectable insulin dispensed only upon the written prescription of a physician
- For compound drugs to be covered under the Plan, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g. if the cost of any ingredient has increased more than 5% every other week or more than 10% annually), the cost will not be considered reasonable. Any denial of coverage a compound drug may be appealed in the same manner as any other drug claim denial under the Plan. Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician
- Contraceptives (oral, ring, and transdermal patch, and injectables)
- Prenatal vitamins, upon written prescription
- Injectable drugs or medicine, for which a prescription is required
- Insulin needles and syringes
- Migraine medications (quantity limitations may apply)
- Nail fungal treatment (quantity limitations may apply)
- Weight management drugs used to suppress appetite and control fat absorption (prior authorization required)
- Glucose test strips

If you would like to verify any medications, call Express Scripts at **855-283-7451** or log on to **www.express-scripts.com/frontdoor**. The plan pays benefits only for eligible expenses at a participating pharmacy that you (or your covered dependent) receive on or after your (or your dependent's) coverage effective date.

Prescription Drugs and Medical Devices Not Covered

Although the plan covers most types of prescription drugs and medical devices, it does not cover all. The following charges are not covered by the prescription drug plan:

- Non-legend drugs, other than those specified above in the section titled *Covered Prescription Drugs and Medical Devices*
- Any charges that are unlawful where you live when expenses are incurred
- Charges that would not have been made if you were not covered by these benefits
- Experimental drugs or drugs labeled “Caution: Limited by federal law to investigational use.”
- Drugs that are not considered essential for the necessary care and treatment of an injury or illness.
- Prescriptions filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician’s order
- Indications not approved by the Food and Drug Administration
- Therapeutic devices or appliances, support garments, and other non-medicinal substances
- Drugs used for cosmetic purposes
- Administration of any drug, or medication that is taken or administered, in whole or in part, at the place where it is dispensed
- Prescriptions that you are entitled to receive without charge from workers’ compensation or similar law, or any public program other than Medicaid
- Nutritional or dietary supplements
- Prescription vitamins other than prenatal vitamins
- Herbal supplements, vitamins, or over-the-counter medications
- Infertility drugs
- Allergy serums
- Some vaccines/toxoids
- Hair growth drugs
- Prescription drugs with equivalent products also available over the counter (these products are identical in active chemical ingredient, dosage form, strength and route of administration)
- Prescriptions purchased at a non-participating pharmacy

Additional Express Scripts Information

Express Scripts offers several programs to ensure that you obtain the best medications and understand their use and effects. These include Prior Authorization, Step Management, RX logic, and Specialty Drug.

Prior Authorization

In order to ensure that your medication is the optimal one for your condition, some medications require prior authorization before the prescription can be filled. If a drug you take requires prior authorization, your doctor will need to contact Express Scripts to see if the prescription meets your plan’s criteria for coverage. If you are prescribed a drug that requires prior authorization, your doctor should call the Express Scripts Prior Authorization Department at **800-417-8164**.

You can go to **www.express-scripts.com** and search to see if a particular medication requires prior authorization. The medication will indicate if prior authorization is needed.

Step Management

How Step Management Works

Step Management is designed for people who regularly take prescription drugs to treat ongoing medical conditions such as arthritis, asthma or high blood pressure. In Step Management, prescription medications are grouped into two categories:

Step 1 medications are mostly generic and some preferred brand drugs that have been rigorously tested and approved by the FDA. Generics should be prescribed first because they can provide the same health benefits as higher-cost medications.

Step 2 medications are preferred, and non-preferred brand-name drugs are recommended only if a Step 1 medication doesn't work for you. Step 2 medications almost always cost you and your plan sponsor more than Step 1 medications.

How do I make sure my doctor prescribes a Step 1 medication?

Ask if a generic or preferred brand (Step 1) medication may be right for you. Your doctor can check the list of preferred brand/formulary drugs with ESI. You can also go to **www.express-scripts.com** to see preferred alternatives.

If you are prescribed a Step 2 medication before trying Step 1, the claim will be denied, and your doctor must write a new prescription for you to change from a Step 2 medication to a Step 1 medication. The pharmacy will not automatically change your prescription. If a Step 1 medication is not a good choice for you, then your doctor can request prior authorization to determine if a Step 2 medication will be covered by your plan.

To see if a particular medication is included in Step Management, search for the drug on the ESI website and if Step Management is needed, that will be indicated by the medication.

Accredo—Express Scripts' Specialty Pharmacy Services

Specialty medications are helping people with complex chronic or genetic conditions lead longer, healthier lives. People who receive specialty medications, such as oral or injectable specialty drugs, usually need enhanced services because monitoring the administration of these medications can be complex. Accredo—the Express Scripts Specialty Pharmacy Program—provides these drugs through their Accredo pharmacy, delivered to you or your doctor, along with enhanced services to help you take the medication properly. All specialty drugs must be purchased through Accredo and billed to the pharmacy plan.

These services include:

- Personal attention from a pharmacist-led Care Team at Accredo that provides condition-specific education, medication administration instruction, and advice to help you manage your therapy; this might include review of dosing and medical schedules, help with injection-related issues, and discussion of side effects
- Access to pharmacists and other health experts 24 hours a day, 7 days a week for emergency consultations
- Assistance in securing coverage for new drugs and therapies
- Delivery of medications in temperature-controlled packaging and with any other supplies needed for administration (such as needles, syringes, disposable containers, and alcohol swabs)
- Claims assistance

The Accredo pharmacy will ship your prescription to the location of your choice including your doctor's office and provide follow-up care calls to remind you when it's time to refill your prescription, check on your therapy progress, and answer any of your questions. To receive coverage of your specialty medication through the Accredo Specialty Pharmacy Program, call Accredo at **866-848-9870**, Monday through Friday from 7 a.m. to 9 p.m., Central time, and Saturday from 8 a.m. to 12 p.m., Central time.

Examples of Specialty Medications

- Hemophilia factor and blood products
- Growth hormone
- Medications to treat MS, hepatitis C, rheumatoid and osteoarthritis, osteoporosis, HIV and psoriasis
- Oral and injectable oncology products
- Respiratory products
- Hematopoietics

SaveonSP Program

If you are enrolled in the PPO medical plan, our Prescription Drug Plan partners with Express Scripts program, SaveOnSP, to help you save money on certain specialty medications. If your medication is on the SaveOnSP drug list and are eligible for the program.

- **If your specialty medication is noted on the SaveOnSP drug List, you must participate in the SaveOnSP program to receive your medications free of charge ($0) and you must speak with SaveOnSP prior to the first fill under the program.**
- Your prescriptions will be filled through your approved specialty pharmacy.
- Contact SaveOnSP at 1-800-683-1074, to enroll and to avoid delays in obtaining your prescription(s). This is very important. You must speak to SaveOnSP prior to the first fill under the program.
- If you do not participate in the SaveOnSP program, you will be responsible for 30% coinsurance listed on the SaveOnSP Drug list**. Please note that the 30% co-insurance for these medications will not count towards your deductible or out-of-pocket maximums.**

SaveOnSP targets drugs in more than 20 specialty categories, including:

- Oncology
- Inflammatory conditions
- Multiple sclerosis
- Blood cell deficiency
- Hepatitis C
- Hereditary angioedema
- Pulmonary arterial hypertension
- Cystic Fibrosis
- Hemophilia
- Asthma & Allergy

Please note that the medications and associated copays included in this program are subject to plan clinical rules and subject to change. The medications included in the SaveOnSP program are classified as Non-Essential Health Benefits under the Affordable Care Act.

Your Dental Plan

Getting regular dental care is an important part of taking care of our health. Since dental care can be costly, Frontdoor offers a dental plan to help offset some of your expenses. The plan encourages regular checkups and preventive treatment.

This section of your guide describes how the dental plan works. For more information, go to the www.myfrontdoorbenefits.com (password: 2health) or call the Frontdoor People Support Center at 866-851-1211.

Dental Plan Choices

When you enroll for coverage each year, you choose a dental plan option and a coverage category that best fits your situation.

You can choose between the Base and Buy-up DPPO options, and you can choose coverage for:

- You only
- You plus your spouse or domestic partner
- You plus spouse or domestic partner plus 1 child
- You plus spouse or domestic partner plus 2 or more children
- You plus 1 child
- You plus 2 or more children

Making Your Choices

Under the dental options, you can choose any dentist you want for your dental care. However, when you use providers who are part of Delta Dental's network you pay a lower deductible and the providers charge discounted rates. These discounts can result in significant savings for you.

You can get a list of participating providers on Delta Dental's website at **www.deltadentaltn.com** or by calling **800-223-3104**. It's important to confirm a provider's participation in the network, because participation can change from time to time.

How the Dental Options Work

For most dental expenses, the DPPO options work like this:

- Each year, you must meet a deductible before the plan begins to pay benefits for basic and major expenses. You do not have to meet a deductible for preventive expenses or if available, orthodontia expenses covered under the plan.
- When you receive dental care, the plan pays a percentage of covered expenses and you pay the rest. This is called coinsurance. The percentage the plan pays is based on the type of expense.
- There is an annual maximum on the amount of benefits you and each covered dependent can receive.
- If you choose the DPPO option with orthodontia, there is a separate lifetime maximum for orthodontia.

Types of Expenses

For plan purposes, dental expenses are generally divided into the following four categories. The plan pays different benefits for each category of expenses.

- Preventive expenses (Type A)
- Basic expenses (Type B)
- Major expenses (Type C)
- Orthodontia expenses (Type D)—included only if you elect the Buy-Up DPPO option

Delta Dental's Participating Dentist Program

Your dental options offer a network of dentists and dental care providers who contract with Delta Dental to offer discounted rates to plan participants. These dentists and dental care providers are called participating providers.

When you need dental care, you can choose any dentist you want. The plan pays the same percentage of the covered expense. However, choosing a participating provider can save you money several ways:

- You pay a lower deductible
- Participating providers have agreed to discounted rates
- Non-participating providers may charge amounts in excess of reasonable and customary, which you will be responsible for paying

The Deductible

The deductible is the amount of covered basic and major expenses you pay each year before the plan starts to pay benefits. Each covered person must meet the deductible each year before the plan starts paying benefits for that person. All eligible dental expenses count toward the deductible, with these exceptions:

- Diagnostic and preventive care expenses
- X-rays, cephalometric film, and photos
- Sealants
- Emergency palliative treatment
- Full mouth debridement
- Orthodontia expenses
- Expenses that are not covered by the plan
- Expenses that exceed reasonable and customary amounts or other plan limits

Coinsurance

You share in the cost of dental expenses through coinsurance. After the plan pays the appropriate percentage of charges, you are responsible for the remaining amount. That is your coinsurance. There are no copayments under the dental options.

Benefit Maximums

There is a maximum amount of benefits you and each covered dependent can receive each year. All preventive, basic, and major expenses count toward the annual maximum. There is a separate, per-person lifetime maximum for orthodontia expenses. Orthodontia expenses do not count toward the annual maximum.

Predetermination of Benefits

Your dentist may obtain a predetermination of benefits (pretreatment estimate) before treatment begins.

Predetermination works like this: Your dentist decides what treatment is needed and describes it on the claim form along with an estimate of treatment charges. Your dentist should include x-rays and other supporting records with the form and send them to Delta Dental.

Delta Dental will review the claim to make sure the charges are reasonable and customary, and the proposed services are within the plan's guidelines. Delta Dental will tell you and your dentist an estimate of what benefits the plan will pay. A predetermination is not a guarantee of payment. Actual benefits will be based upon procedures completed and will be subject to continued eligibility as well as plan limitations and maximum.

If you do not ask your dentist to file for a predetermination of benefits, Delta Dental will decide what the plan will pay. Delta Dental's decision will be final and binding.

You do not need to request predetermination of benefits for treatments, but it is recommended for those services expected to cost more than $250.

How Benefits Are Determined

The plan pays the same percentage of benefits whether or not you use a participating provider. However, the participating provider will always charge the discounted rate, while a non-participating provider may charge a higher amount. When you receive care from a participating provider, the plan pays its percentage of charges based on the negotiated rate for that type of dental expense. You pay the remaining amount (your coinsurance).

When you receive care from a non-participating provider, the provider bills the plan at its regular rate. The plan calculates the reasonable and customary (R&C) charge and pays its percentage of charges based on the R&C charge. You are responsible for paying the remaining amount. Since non-participating providers have not agreed to accept the rate as payment and may charge more than the R&C amount, you could pay significantly more than you would if you used a participating provider.

Here's an example: Assume you've met the deductible and that the plan pays 85% of charges for the type of expense you incur. Payments would be:

	Participating Provider	Non-Participating Provider
Full charge	$1,000	$1,000
Basis for plan benefits	$700—PDP rate	$800—R&C charge
Plan pays	85% of $700 = $595	85% of $800 = $680
You pay	$700 − $595 = **$105**	$1,000 − $680 = **$320**

In this example, you pay $320 if you use a non-participating provider, but only $105 if you use a participating provider. Please note that this is a simple example to show how the concept works. The actual PDP rates may vary depending on the network, the dentist's billing practices, and the geographic area.

Reasonable and Customary Charges (R&C)

The amount the plan pays for services performed by non-participating providers is based on reasonable and customary charges. Reasonable and customary charges are the usual charges made for similar dental services or supplies in the area where services are provided. You are responsible for paying charges above those that the claims administrator considers reasonable and customary.

Generally Accepted Dental Standards

Many dental problems can be treated in more than one way. The plan covers the least expensive procedure that meets generally accepted dental standards. For example, if a removable denture will serve as well as fixed bridgework, plan benefits will be based on the less-costly removable denture.

To avoid unexpected expenses or uncovered care, always ask your dentist if there are less-costly, alternative treatments.

Dental Necessity

The plan will pay only for treatment that Delta Dental deems necessary according to generally accepted dental standards.

Expenses Covered Under the Dental Options

The following chart shows the plan's deductible and benefit maximums. It also shows what types of expenses are covered and how much the plan will pay.

Plan Feature	Base DPPO (PPO Network)	Buy-Up DPPO (PPO and Premier Networks)
Annual Deductible for Basic and Major Expenses Combined	$100/individual, participating provider $100/individual, non-participating provider	$50/individual, participating provider $100/individual, Premier and non-participating provider
Annual Maximum Benefit for Preventive, Basic, and Major Expenses	$1,000/individual	$1,500/individual
Preventive Care Expenses (Type A) • Oral exams once every six months • Prophylaxis (teeth cleaning) once every six months • Bitewing x-rays twice every year • Full-mouth x-rays once every 60 months • Caries susceptibility tests and bacteriologic studies for determination of bacteriologic agents • Fluoride treatment for a dependent child under age 19 once every year • Space maintainers for a dependent child under age 19 • Emergency palliative treatment • Sealants applied to non-restored, non-decayed, first and second permanent molars for a dependent child up to the age of 19 once every 60 months	100%, no deductible, up to annual maximum	100%, no deductible, up to annual maximum
Basic Care Expenses (Type B) • Consultations twice every year • Amalgam or resin fillings • Simple extractions • Root canal treatment not more than once every 24 months for the same tooth • Treatment of periodontal disease and other diseases of the gums and mouth tissues, unless specifically mentioned in this section • Periodontal scaling and root planning - not more than once every 24 months per quadrant • Periodontal maintenance where periodontal treatment (such as root planing, gingivectomy, or gingivoplasty) has been previously performed up to four treatments every year for periodontal maintenance treatments and oral prophylaxes • Periodontal surgery once every 36 months per quadrant	85% after deductible, up to annual maximum for fillings, simple extractions, scaling and root planing, perio maintenance, rebasing and relining, repair of crowns, inlays, denture and bridgework 50% after deductible, up to annual maximum for root canals, treatment of periodontal disease, oral surgery	85% after deductible, up to annual maximum

Plan Feature	Base DPPO (PPO Network)	Buy-Up DPPO (PPO and Premier Networks)
Basic Care Expenses (Type B), continued • Complex oral surgery • Administration of general anesthetics when dentally necessary • Injections of antibiotic drugs • Rebasing and relining of existing removable dentures not more than once every 36 months • Root removal of exposed roots • Prefabricated stainless-steel crown or prefabricated resin crown not more than once for any one tooth within five years of a prior restoration Repair or recementing of crowns, inlays and onlays, dentures, and bridgework	85% after deductible, up to annual maximum for fillings, simple extractions, scaling and root planing, perio maintenance, rebasing and relining, repair of crowns-inlays-dentures-bridgework 50% after deductible, up to annual maximum for root canals, treatment of periodontal disease, oral surgery	85% after deductible, up to annual maximum
Major Care Expenses (Type C) • Services needed to replace one or more natural teeth lost as a result of a covered first-time installation of fixed bridgework or a partial or full removable denture • Replacing an existing, unusable, removable denture or fixed bridgework not earlier than seven years after the existing denture or bridgework was installed • Replacing an existing, immediate temporary full denture with a new, permanent full denture when the existing denture cannot be made permanent not later than 12 months after the existing denture was installed • Adding teeth to an existing, partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed Inlays, gold foil, onlays, and crown restorations other than prefabricated stainless-steel crowns or prefabricated resin crowns not more than once for any one tooth within five years of a prior restoration	50% after deductible, up to annual maximum	50% after deductible, up to annual maximum
Implants (frequency limitation of one in 7 years)	50% after deductible, up to annual maximum	50% after deductible, up to annual maximum
Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards. (Limited to 1 appliance every 24 months)	Not Covered	50% after deductible, up to annual maximum
Orthodontia Expenses (Type D) (adults and children)	Not Covered	50%, up to lifetime maximum
Lifetime Orthodontia Maximum (adults and children)	N/A	$1,500

The fact that a dentist, even a participating provider, recommends a dental treatment does not mean that the plan will pay benefits. The claims administrator will decide if the recommended treatment is dentally necessary and eligible for payment. Delta Dental will also decide how much the plan will pay.

Orthodontia Benefits

The orthodontist will submit a treatment plan before treatment begins. The orthodontic treatment plan generally consists of:

- The initial placement of an appliance and a number of follow-up visits specified by the dentist
- Other services, such as transseptal fibrotomy and extractions of certain teeth

Orthodontia expenses do not count toward the annual benefit maximum for other dental benefits. There is a separate, per-person lifetime orthodontia maximum.

How Orthodontia Payments Work

When your dentist places the initial appliance, the plan will pay up to 33% of the total covered expense, determined from the submitted treatment plan, times the percentage payable for orthodontia expenses.

After your dentist places the initial appliance, the plan will pay any remaining benefit over the course of the orthodontic treatment (including follow-up visits). The amount payable will be the *lower* of:

- The amount of the covered expense times the percentage payable for orthodontia expenses, and
- The remaining amount of the maximum lifetime benefit for orthodontia expenses (for all Dental Expense Periods)

This amount will be divided by the number of months in the scheduled course of treatment.

Here is an example of how orthodontia payments work:

Total Fee	$3,000.00
	× 33%
	$ 990.00
	× 50%
Initial Payment	$ 495.00

Remaining Benefit	$1,005.00 ($1,500 lifetime maximum less the $495.00 initial payment)
	÷ 12 months
Amount Paid Every Month*	**$ 83.75**

**In this example, the plan would pay up to this amount every month until the lifetime maximum is reached. Please note that this is only an example to demonstrate how the payment plan might work. Actual fees and amounts payable will vary.*

Benefits for Orthodontic Care Begun Prior to Coverage Under This Plan

If the initial placement of the appliance was made before the person became covered under this plan, this plan will pay no benefits for the initial placement.

If follow-up visits began before the person became covered under this plan:

- The number of months of scheduled treatment for which benefits are payable will be reduced by the number of months of treatment provided before the person became covered under this plan, and
- The total amount of benefits payable will be reduced proportionately

Expenses Not Covered Under the Dental Options

The dental options do not cover certain expenses. You and your dentist should consult the following list when you are planning a course of treatment. The dental plans do not cover:

- Treatment of injury or illness covered by any workers' compensation laws or employers' liability laws
- Services received without cost from any federal, state, or local agency (exclusion will not apply if prohibited by federal law)
- Services for congenital or developmental malformations, including cleft palate and upper and lower jaw malformations
- Treatment to restore tooth structure lost from wear
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion, or treatment to stabilize the teeth (For example, equilibration, periodontal splinting and double abutments on bridges)
- Oral hygiene and dietary instructions
- Treatment for desensitizing teeth
- Prescribed drugs or other medication
- Experimental procedures
- Conscious sedation
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility
- Diagnosis or treatment for any disturbance of the temporomandibular joints or myofacial pain dysfunction
- Services by a dentist beyond the scope of his/her license
- Dental services incurred at no charge
- Dental services where charges for such care exceed the charge that would have been made and actually collected if no coverage existed
- General anesthesia or I.V. sedation not administered by a properly licensed dentist or in conjunction with covered surgical procedures or when necessary due to concurrent medical conditions

Your Vision Plan

You can elect vision coverage for yourself and your covered dependents. The vision plan covers expenses for routine eye exams, eyeglasses, and contact lenses, and it provides discounts on laser eye surgery.

How the Vision Plan Works

If you elect vision coverage, the plan covers costs of eye exams, contacts, or eyeglass lenses and frames. There are also discounts on special features, such as tints and UV coatings on scratch-resistant lenses.

When you need eye care services, you choose whether or not to use an in-network provider that has contracted with EyeMed Vision Care. You can get a list of participating providers on EyeMed's website at **www.eyemedvisioncare.com**, or by calling **866-723-0514** toll free between 8 a.m. and 11 p.m., Eastern time, Monday through Saturday, and between 11 a.m. and 8 p.m., Eastern time, on Sunday. It's important to check a location's participation in the network, because participation can change from time to time.

If you use a network provider, you just need to identify yourself to the provider as an EyeMed member through your Frontdoor plan and/or present your member identification number. You pay the applicable copayments to the provider for services and materials, and the provider files a claim on your behalf.

If you use an out-of-network provider, you pay the full costs at the time you receive care, and you must submit your receipts to EyeMed Vision Care to receive the appropriate reimbursement.

In-Network Benefits

Coverage includes benefits for an eye exam once every 12 months and either frames or contact lenses once every 12 months. Benefits are valid once per benefit period and cannot be used with other discounts, coupons, or promotions.

Vision Care Services	In-Network	Out-of-Network Reimbursement
Exam	Covered at 100%	Up to $25
Frames[1]	$0 copay, $150 allowance annually; any amount over $130, 20% discount	Up to $30
Lenses[1]	Single vision: $10 copay Lined bifocal: $10 copay Lined trifocal: $10 copay Standard progressive: Up to $75	Single vision: Up to $20 Lined bifocal: Up to $30 Lined trifocal: Up to $40 Standard progressive: Up to $30
Elective Materials (add to standard lens prices)	Polycarbonate: $40 Solid or gradient tint: $15 Scratch-resistant coating: $0 copay Anti-reflective coating: $45 Ultraviolet coating: $15	Polycarbonate: Not available Solid or gradient tint: Not available Standard scratch-resistant coating: Up to $5 Anti-reflective coating: Not available Ultraviolet coating: Not available

Vision Care Services	In-Network	Out-of-Network Reimbursement
Contact Lens Fitting	Up to $40 for a standard contact lens fit and follow up	Not Available
Contact Lenses[1]	Conventional: $0 copay, $130 allowance annually; any amount over $130,15% discount Disposable: $0 copay, $130 allowance annually; any amount over $130, no discount	Conventional: Up to $70 Disposable: Up to $70

[1]A covered member is eligible for either a full pair of glasses or contact lenses every 12 months or the option to purchase contact lenses and frames under the plan, but will pay out of pocket for the lenses to fit the frames

Discounts

Once you have used your in-network benefits, pairs of eyeglasses and contact lenses are available through a participating provider at additional savings.

Note: Discounts cannot be used together with other discounts, coupons, promotions, or where the manufacturer prohibits a discount. The member is responsible for applicable taxes.

Contact Lens Replacement Program

The EyeMed Contacts program offers you and your covered dependents a convenient and economical alternative for purchasing contact lenses. With an inventory of more than one million lenses, EyeMed Contacts carries many brands, providing you with several options to fulfill your eye care needs.

Contact Lenses
After the initial purchase, replacement contact lenses may be obtained via the Internet at a substantial savings and mailed directly to the member. Details are available at **www.eyemedvisioncare.com**.

The contact lens benefit is not applicable to this service. [Note: what does this mean?] – The contact lens benefit is for the office only, not the online ordering of additional lenses.

Prior to processing any orders, please note that a valid contact lens prescription is required. If you do not have a copy of your prescription, EyeMed Contacts will obtain it from your provider free of charge. For pricing and ordering seven days a week, visit **www.eyemedvisioncare.com** or call **800-508-1399** and a representative will assist you.

Laser Vision Correction Program

A member may receive a 15% discount or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for which the member will be responsible and such fees are not subject to the 15% discount or the 5% discount on promotional pricing. The laser providers are not part of the EyeMed network. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call **877-5LASER6** (877-552-7376). You can use your health care flexible spending account (FSA) to pay for laser correction surgery, if you plan on having this procedure be sure to include that in your annual calculations for your health care flexible spending account (FSA) elections.

Other Vision-Related Accessories
The member will receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to the EyeMed provider's professional services or contact lenses.

Charges Not Covered Under the Vision Plan

The following charges are not covered by the vision plan:

- Orthoptic or vision training. Subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures (may be eligible under medical plan)
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan
- Services provided as a result of any workers' compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except the 20% discount)
- Two pairs of glasses in lieu of bifocals
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to, Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim, and Pro Design

Frontdoor LifeManagement Program

The Frontdoor LifeManagement Program gives you and your household members access to qualified professionals to assist you with life's many challenges, including child-rearing, financial, family, or other personal issues at no cost to you, such as those listed in the box below.

The Frontdoor LifeManagement Program is managed by Magellan, a third-party vendor, and is completely confidential. It consists of three service components: Employee Assistance Program (EAP) services, work/life service, and financial/legal consultation services. Resources are available on the Magellan Health Services website at member.magellanhealthcare.com or by calling **800-523-5668**.

You, your covered dependents and other permanent household members are eligible for this program if you are regularly scheduled to work at least 30 hours a week. Coverage begins on your date of hire.

The Frontdoor LifeManagement Program Can Help With:

- Time management
- Family and parenting concerns
- Child and elder care needs
- Legal and financial issues
- Work-related stress
- Personal and daily life concerns
- And more!

EAP Services

You can obtain confidential assessment and counseling services to help with issues or problems that could potentially affect your health, relationships, and job performance. This includes marital and family problems (marital tension, parental concerns, etc.), emotional concerns (anxiety, depression, stress, etc.), substance abuse (drug, alcohol, prescription drugs, etc.), and workplace issues.

You and each of your eligible dependents and permanent household members can participate in up to five in-person* counseling sessions per problem per 12-month period (as considered clinically appropriate by Magellan). If you and a dependent (such as your spouse) attend in-person counseling together, you are each still eligible for just three sessions—not six. In other words, the number of available sessions does not multiply by the number of persons participating.

EAP services are available only through Magellan's network of EAP counselors. The network includes psychologists; clinical social workers; marriage, family, and child counselors; and other behavioral care professionals. For information about the network, call Magellan at **800-523-5668** or go to member.magellanhealthcare.com and log on.

As clinically appropriate, the EAP counselor may refer you to treatment resources in your community—such as a psychologist, social worker, hospital, or treatment center—for longer-term or specialized care. In this case, charges are the responsibility of the individual receiving services, which may be covered under another plan, such as the medical plan. You are responsible for obtaining any necessary authorization from your medical plan. You must be referred by Magellan to access the EAP services.

**The in-person session limit includes counseling sessions in five different settings: by videoconference (telehealth), over the phone, or in person.*

Work/Life Services

You can speak with a trained work-life consultant over the phone about the challenges you face throughout all life stages. The consultant will help you find practical solutions to your prenatal, parenting, adoption, childcare, elder care, educational, special needs, relocation, retirement planning, daily living and convenience concerns. They will identify your options so you can make informed decisions on the care and services provided for you and your dependent family members. The consultant can also give you relevant educational materials and pre-screened referrals to resources, such as family and child care, before- and after-school care, day care centers, adoption assistance, senior housing living arrangements, retirement homes, skilled nursing facilities, hospice care, adult day care, and special needs care for newborns or developmentally challenged adults. The final decision about the work-life services and arrangements is always up to you.

Financial/Legal Consultation Services

You can obtain services to help you reach your financial goals, as well as legal consultation services on routine personal legal issues from estate planning to family law.

You may speak to a financial consultant on a wide range of topics, including planning for retirement and debt consolidation, to furnish you with information and assist you in formulating financial planning strategies. The financial consultation services consist of free telephone consultations with a financial advisor and access to financial planning tools.

Legal consultation services consist of a free initial face-to-face or telephone consultation per subject, per year, with a local lawyer. If additional services are needed, you may obtain them from the lawyer at a discounted rate.

Access to Frontdoor LifeManagement Program Services

To obtain services, call **800-523-5668**. Magellan representatives are available 24 hours a day, 365 days a year. The Frontdoor LifeManagement Program is a confidential program and Magellan is committed to protecting your privacy.

When you call the Frontdoor LifeManagement Program, you will talk to a consultant who will ask you to briefly describe the problem for which you are seeking assistance. Then the consultant will help you clarify your problem, identify your needs, and develop a plan of action. EAP consultants are licensed mental health professionals.

- If you want to meet with an EAP counselor, Magellan will give you information about EAP counselors in the area where you would like to be seen. You may call the EAP counselor to schedule an appointment. If you have any problems scheduling your initial appointment, you may call Magellan and request assistance. Please note that if you cannot keep a scheduled appointment with the EAP counselor—whether it is the first or a later appointment—you must notify the counselor's office at least 24 hours before the appointment time.
- If you want work/life or legal or financial consultation services, the EAP consultant will link you to the appropriate specialists for assistance.

About Frontdoor LifeManagement Program Costs

Frontdoor pays the full cost of covered services under the Frontdoor LifeManagement Program. You pay no costs for services provided by Magellan or EAP counselors, and you do not have to file any claims. In addition, there are no copayments, coinsurance, or deductibles. You are responsible for any costs associated with work/life services that you select from referred providers and for any financial or legal services provided beyond the initial free consultations.

You should not make any payment to a provider for EAP services and you should not make any agreement with an EAP counselor to pay the counselor for EAP services. Longer term counseling may be eligible under the medical plan. Those services are subject to relevant deductibles, coinsurance and copayments.

You are responsible for paying the cost for any services not covered by the EAP that you and the EAP counselor decide are necessary, for EAP services from a counselor who is not in the Magellan network, and for EAP services that you access directly, without first calling the Magellan toll-free number.

Services Not Covered by the Frontdoor LifeManagement Program

Services, supplies, and treatments not covered by the Frontdoor LifeManagement Program include, but are not limited to, the following:

- Counseling by someone other than an EAP counselor to whom Magellan referred you
- Charge for failure to keep a scheduled visit
- Charges for completing claim forms
- Services or supplies not needed for treatment or not approved by the attending EAP counselor
- Services or supplies required or paid for under any government law, including workers' compensation or other federal, state, or local law
- Services or supplies for which there is no charge
- Services rendered before coverage became effective
- Services rendered by a family member
- Treatments, procedures, or devices considered experimental or investigational in nature as determined by Magellan
- Treatment for any problem or condition that cannot be resolved in brief counseling (for example, a psychosis or any other condition that requires inpatient treatment or more than three sessions)
- Psychiatric services or other medical care
- Inpatient treatment
- Treatment for any physical illness
- Direct treatment for intellectual development disorder, learning disabilities, or autism
- More than three EAP sessions per problem per year, unless formally requested by your EAP provider and approved by Magellan
- Psychological, psychiatric, neurological, educational, or IQ testing
- Remedial education services, such as evaluation or treatment of learning disabilities, developmental and learning disorders, behavioral training, cognitive rehabilitation, or any other services required to be provided by a state educational system
- Medication, medication management, or treatment of any condition for which medication is required, unless you are seeing a doctor who prescribes medication for that condition and oversees your use of the medication
- Evaluations for fitness for duty or for excuses for leaves of absence or time off
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), and obtaining any kind of insurance coverage
- Court-mandated counseling, and evaluations required by a state or federal judicial officer or other governmental agency or to be used in legal actions of any kind (for example, child custody proceedings)
- Testimony in legal proceedings or preparation for legal proceedings
- EAP services when you sue, or threaten to sue, Frontdoor or any of its affiliated or subsidiary companies

- Acupuncture/accupressure
- Aversion therapy
- Biofeedback and hypnotherapy
- Sleep therapy
- Services by providers who are not part of Magellan's network of EAP counselors
- EAP sessions that were not accessed through Magellan for the particular episode of care.
- Legal consultation services in connection with employment- or business-related matters
- Legal consultation services in connection with disputes or proceedings involving Magellan, its subsidiaries or affiliates, Magellan's financial/legal consultation services vendor or any of its attorneys, or Frontdoor
- Legal services that are frivolous, harassing, or otherwise involve violation of ethical rule

Flexible Spending Accounts

Flexible spending accounts allow you to set money aside on a tax-free basis to pay health care and dependent care expenses. By paying expenses through your flexible spending accounts, you save money by lowering your federal income and Social Security taxes. You get the full buying power of every dollar you spend for these expenses because taxes are not deducted from the money you contribute to these accounts. Visit the Alight Smart-Choice Account(s)website at **www.smartchoiceaccounts.com** for more information.

Flexible Spending Account—a Great Financial Planning Tool
When you contribute to a flexible spending account, you reduce your federal income taxes and Social Security taxes. In addition, your reimbursements are not taxed. And, you set aside money through regular payroll deductions, so the money for health care and dependent care expenses is available when you need it.

How Flexible Spending Accounts Work

Here's how the flexible spending accounts, also called flexible spending accounts, work:

There are two types of accounts: the health care flexible spending account and the dependent day care flexible spending account.

Every year, you decide how much you want to contribute to each flexible spending account. You make your before-tax contributions through regular deductions from your paycheck.

When you make before-tax contributions, you authorize the company to reduce your pay by the amount of your contributions. Since your pay is lower, you pay lower federal income taxes, lower Social Security taxes, and, in most areas, lower state and local taxes.

When you have eligible expenses, you can arrange for your account to pay providers directly, or you can pay the expenses yourself and file a claim for reimbursement from your account. You can also pay health care expenses with a dedicated Alight Smart-Choice card. Regardless of which method you use, disbursements from your accounts are tax free.

In exchange for the significant tax advantages that your flexible spending accounts can provide, the IRS requires that you forfeit any money that remains in your account at the end of the plan year. Because of this "use it or lose it" rule, it's important that you estimate your eligible expenses carefully, so you do not contribute any more than you expect to use during the plan year.

Save Your Receipts
Be sure to save all bills, receipts, Explanations of Benefits (EOB), and other proofs of expense, even if you are using the Alight Smart-Choice card, so you can properly document your expenses.

Go to the Alight Smart-Choice Account(s) website

You can:

- View your account balance and activity
- Check the status of claims
- Request payments to providers
- Print forms for filing paper claims
- Order additional Smart-choice cards

Note: There is a claim extension period for the health care flexible spending account. You have until March 15 of the following year to incur expenses that can be reimbursed from your health care flexible spending account and until May 31 of the following year to submit your health care claims. During the claim extension period, the previous year's dollars are used first for Alight Smart-Choice card transactions, paper claims and pay my provider transactions. There is no claim extension period for the dependent day care flexible spending account. You have until December 31 of the current plan year to incur expenses that can be reimbursed from your dependent day care flexible spending account and until May 31 of the following year to submit your dependent day care flexible spending claims.

Eligible Health Care Expenses

You can only use your health care flexible spending account for medical, prescription drug, dental, vision, and hearing expenses that are not covered by the Frontdoor health care plans or by other plans in which you or your dependents participate. Eligible health care expenses include your medical and dental deductibles, coinsurance, and copayments; your share of other expenses covered by a health care plan; as well as certain additional medical, prescription drug, vision, and dental expenses that are not covered or fully reimbursed by any employer-provided plans. Premiums to purchase health care coverage are not an eligible expense.

In general, most expenses that qualify as itemized deductions on your federal income tax return are eligible for reimbursement through the health care flexible spending account. For an exhaustive list of eligible expenses, go to the Alight Smart-Choice website **www.smartchoiceaccounts.com** or call **833-769-4782** for help.

Making Contributions to Your Flexible Spending Accounts

Contribution Amount

When you enroll, you decide how much you want to contribute to your health care flexible spending account and your dependent day care flexible spending account. Contributions are automatically deducted from each paycheck in equal amounts throughout the calendar year.

There are minimum and maximum contributions for each account. Evan if you begin participating other than on January 1 of any year, the maximum amount you can set aside in each account will not be prorated or reduced.

Flexible Spending Account	Minimum Contribution	Maximum Contribution
Health Care	$120 each plan year	• $2,750 each plan year
Dependent Day Care	$120 each plan year	• $5,000 each plan year • Married taxpayers filing separate returns: $2,500 each plan year

Avoiding Forfeiting Flexible Spending Account Funds

The Internal Revenue Service (IRS) requires you to forfeit any unused balances in your health care flexible spending account and dependent day care flexible spending account at the end of each plan year. The plan year for the dependent day care flexible spending account is the calendar year. The plan year for the health care flexible spending account is the calendar year; however, claims may be incurred until March 15 of the following year. To avoid forfeitures, it’s important to carefully estimate the expenses you expect to have during the year.

Additional Considerations for Dependent Day Care Contributions

If your spouse also makes deposits into a dependent day care flexible spending account where he or she works, your combined dependent day care deposits cannot be more than $5,000 a year.

You cannot contribute more than your earned income. If you're married, you cannot contribute more than your own earned income or your spouse's earned income—whichever is less. For example, if you earn $25,000 per year and your spouse earns $4,000 per year, the maximum amount you can contribute is $4,000.

If your spouse does not work because he or she is disabled, or if your spouse is a full-time student for at least five months during the year, the plan allows you to contribute up to the following amounts, even if your spouse's income is less than these amounts:

- Up to $300 per month, if you pay for day care for one qualified dependent
- Up to $400 per month, if you pay for day care for two or more qualified dependents

Coordinating Contributions with Tax Credits and Deductions

When you use before-tax dollars from the flexible spending accounts to pay expenses, you cannot take a tax deduction or credit on your federal income tax return for the same expenses. Whether you would be better off using the flexible spending accounts or taking deductions and credits on your federal income tax return depends on your personal situation. You should talk with a tax advisor to determine which option is best for you. You may also want to visit **www.irs.gov** for specific information about the tax credit.

Following are some points to consider as you make your decisions. This information does not provide complete details and is not a substitute for obtaining advice from a tax professional or the IRS.

Health Care Expenses

Under current tax law, you can only deduct out-of-pocket health care expenses over a certain amount of your adjusted gross income on your federal income tax return. In addition, you must itemize all your deductions to be eligible for this deduction. Check with your tax professional for details.

In contrast, the health care flexible spending account gives you a tax break beginning with your first $1 of expense, but only up to the maximum contribution. You do not have to report the expenses or the reimbursements on your income tax returns. So, if your medical and dental expenses are less than the minimum allowable income tax deduction for medical expenses, you may be better off using the flexible spending account.

Planning Your Flexible Spending Account Contributions

As you plan your contributions to each account, keep in mind that:

- The funds in your health care and dependent day care flexible spending accounts must remain separate.
- You cannot shift money from one account to the other.
- Expenses you incur before your participation starts, or after the end of the plan year or claims-incurred deadline, are not eligible for reimbursement.
- The plan year for the dependent day care flexible spending account ends on December 31 of each year.
- The plan year for the health care flexible spending account ends on December 31 of each year; however, expenses may be incurred through March 15 of the following calendar year. For example, claims submitted for the 2021 plan year health care account can contain expenses incurred up to March 15, 2022.
- Your dependents do not need to be covered under the Frontdoor medical plan to be eligible for the reimbursement through the FSA plan.

Note: Keep copies of all your itemized receipts, invoices, and Explanations of Benefits (EOB) you claim on your health care and dependent daycare flexible spending accounts. You may be required by Alight Smart-Choice Account(s) to provide support for a claim, or you may be required to verify your expenses to the Internal Revenue Service (IRS)

Here are some suggestions on how to estimate your expenses. For more help, log onto the Alight Smart-Choice Account(s) website at **www.smartchoiceaccounts.com**.

Health Care Flexible Spending Account	Dependent Day Care Flexible Spending Account
• Be sure to consider eligible expenses that are not covered by your health care plans. • Estimate out-of-pocket expenses for doctor and hospital bills, prescription drugs, dentistry and orthodontia, and eye care, including deductibles, coinsurance and copayments. • Remember to include expenses for everyone who is an eligible dependent (see below).	• Day care expenses usually are predictable. Estimate the weekly charge for your eligible dependents and multiply it by the number of weeks that each dependent will receive care. • Be sure to exclude vacations, holidays, or other periods when you will not be using dependent care services. • Remember that the account cannot be used for childcare expenses after your child reaches age 13.

Eligible Dependents for Your Health Care Flexible Spending Account

You may request reimbursement for health care expenses incurred by you, your spouse and/or any of your dependents that you can claim on your tax return. You may also submit claims for eligible health care expenses incurred by your adult child through the end of the calendar year in which they turn age 26.

Eligible Health Care Expenses

You can only use your health care flexible spending account for medical, dental, vision, and hearing expenses that are not covered by Frontdoor's health care plans or by other plans in which you or your dependents participate. Eligible health care expenses include your medical and dental deductibles, coinsurance, and copayments; your share of other expenses covered by a health care plan; as well as certain additional medical, prescription drug, vision, and dental expenses that are not covered or fully reimbursed by any employer-provided plans. In general, most types of expenses that might qualify as itemized deductions on your federal income tax return are eligible for reimbursement through the health care flexible spending account. To learn more about eligible expenses, go to https://www.irs.gov/pub/irs-pdf/p502.pdf.

Eligible Dependent Day Care Expenses

You can use your dependent day care flexible spending account for childcare expenses for your children under age 13 or for elder care expenses for a disabled spouse or other dependent who is incapable of self-care. The purpose of the dependent day care flexible spending account is to reimburse you for day care that is needed to allow you and your spouse to work. You can also be reimbursed for dependent care while your spouse is attending school as a full-time student or if your spouse is incapable of self-care due to a mental or physical condition.

Generally, the type of expense that qualifies for inclusion under the Credit for Child and Dependent Day Care Expenses on your federal income tax return also qualifies for reimbursement from the dependent day care flexible spending account.

Eligible Dependents for Your Dependent Day Care Flexible Spending Account

For this account, a qualifying dependent is either of the following:

- A dependent child who is under age 13 years at the time the care is provided and for whom you can claim an exemption on your federal income tax return.
- A mentally or physically disabled child or adult, if he or she lives with you, depends on you for at least half of his or her financial support, and is incapable of caring for himself or herself.
- If you're divorced or legally separated and have custody of your children, but your former spouse claims them as dependents for income tax purposes, you can be reimbursed for their dependent care expenses if you have custody of them for more than six months during the year.
- A dependent does not need to meet the definition of qualified dependent under other company plans to qualify as a dependent under the dependent day care flexible spending account.

Information About Your Dependent's Care Provider
You'll need your day care provider's name and address as documentation when you file a paper claim for dependent care expenses. You'll also need your provider's tax ID number when you file your taxes each year. (**Note:** A tax ID number is not required for a tax-exempt-church dependent care provider.)

You can use your dependent day care flexible spending account to pay for eligible expenses incurred by you or any qualifying child or other relative. Here are definitions of "qualifying persons":

Qualifying Child

Each of the following must be true. The child:

- Is your birth, adopted, foster, half, step, and/or grandchild; or your brother and/or sister or any of their children under the age of 13
- A child cannot be claimed as a qualifying child by more than one person.

Qualifying Relative

Each of the following must be true. The person:

- Is physically or mentally incapable of self-care
- Lives with you for more than half of the plan year* while you provide more than half of his or her support
- Is your birth, adopted, foster, half, step, and/or grandchild; your brother and/or sister or any of their children (who is not a qualifying child for you or anyone else); or is your spouse; your birth, adopted, step, or grand father or mother; your aunt, uncle, or in-law (son, daughter, father, mother, brother, or sister); or another member of your household (provided the relationship is not in violation of local law)

**Disregard temporary absences due to illness, education, vacation, business, or military service.*

Eligible Dependent Day Care Expenses

Generally, any expense that qualifies for inclusion under the Credit for Child and Dependent Care Expenses on your federal income tax return also qualifies for reimbursement from the dependent day care flexible spending account. The list that follows shows many of the most common types of dependent care expenses and whether or not they are eligible. This is not an exhaustive list. In addition, the list may change if regulations or the IRS tax code changes. If you are not sure if an expense you incur is eligible, call **833-769-4782** or go to the Alight Smart-Choice Account(s) website at **www.smartchoiceaccounts.com**.

How to Use Your Flexible Spending Accounts

As you incur eligible expenses, you can pay your provider directly from your flexible spending account, submit paper claims or use your Alight Smart-Choice Account(s) card (health care expenses only).

Paying Your Provider Directly from Your Flexible Spending Account

You can go to the Alight Smart-Choice Account(s) website (**www.smartchoiceaccounts.com**) and authorize a payment to your provider directly from your health care or dependent day care flexible spending account. The amount is automatically deducted from your account and you receive email notification that the payment has been made. You should save all documentation from your provider so that there is a complete record of the expense.

Submitting Paper Claims

You can obtain a claim form from the Alight Smart-Choice Account(s) website (**www.smartchoiceaccounts.com**) or you can call **833-769-4782** and ask for one to be mailed to you.

Using the Health Care Alight Smart-Choice Account(s) Card

In general, you can use the Alight Smart-Choice Account(s) card for any eligible health care expenses, as long as the provider agrees to accept it.

Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to use it as either "credit" or as "debit." If you choose the credit option, you must provide your signature. If you choose debit, you must use your personal four-digit Personal Identification Number (PIN) that you set up when your Alight Smart-Choice Account(s) card was issued. If you forgot or need to change the PIN associated with your card, you can call **1-888-999-0194** to make an update.

At the beginning of the plan year, your account balance is set based on your election. From January 1 through December 31, you can use your - Alight Smart-Choice Account(s) card to pay for eligible expenses. From January 1 through March 15 of the following plan year, the claim extension period during which you can incur claims against the remaining balance, you may also use your Alight Smart-Choice Account(s) card to pay for eligible expenses. Claims incurred during this period will be applied to your prior year account balance if you have any funds still available. If you enroll for the next plan year and do not have any funds still remaining in your prior year account, all Alight Smart-Choice Account(s) card purchases will be applied to your health care flexible spending account balance for the next plan year.

Make the Best Use of Your Health Care Card:

- **Activate your card** before you use it. Follow the instructions that come with the card.
- **Choose the Credit option** when you use your card. The card will not work if you choose Debit.
- **Use your card only for current, eligible health care expenses.** Separate health care items from other items you're purchasing (such as food, cosmetics, and magazines). Pay for the health care items with your card and pay for the other items separately.
- **Save your itemized receipts.** The IRS requires that you be able to document the eligibility of your card purchases. Save receipts that show the date, the name of the item purchased, and the cost. An Explanation of Benefits (EOB) statement is also valid documentation.
- **Buy prescriptions at the pharmacy counter**. Give your card to the pharmacist along with your prescription drug ID card.
- **Be prepared to document your purchases.** If you do not provide the required documentation when requested, your card transaction will be considered an "overpayment" and your card may be suspended until the overpayment is repaid.

For example, for 2020 you elect to contribute $500 to the health care flexible spending account. As of December 31, 2020, you have $80 still available in your 2020 account. Let's also assume you elect to contribute $400 to the health care flexible spending account for 2021.

December 31, 2020: $80 remaining in your 2020 account

January 1, 2021: $80 remaining in your 2020 account and $400 available in your 2021 account

January 18, 2021: You use your Alight Smart-Choice Account(s) card to purchase a prescription costing $25. This purchase is deducted from your 2020 account balance, resulting in a remaining 2020 account balance of $55 and a 2021 account balance of $400.

Alight Smart-Choice Account(s) card expires three years from the original issue date, or when your coverage ends. You will receive a new card upon the expiration date if you are a current health care flexible spending account participant. If you lose your card or if it is stolen, you should contact Alight Smart-Choice Account(s) immediately.

Alight Smart-Choice Account Card Overpayments

If you buy products or services with your Alight Smart-Choice Account(s) card that are not eligible for reimbursement or require substantiation, you will be asked to provide documentation to verify the expense is eligible. If you do not submit the required documentation within 30 days from the date you are notified, the transaction will be identified as an overpayment.

If you have an overpayment of $100 or more on your account and you do not submit documentation to prove the expense is eligible, your Alight Smart-Choice Account(s) card may be suspended until the overpayment is resolved. You may continue to submit paper claims. These claims will be processed, and eligible amounts will be applied to the outstanding overpayment. Claims will not be paid until the overpayment has been fully recovered. If you submit the required documentation, the recovery process will be canceled.

How to Refund an Overpayment by Check and Electronically

You can pay an overpayment online via electronic check or by mailing a check to Alight Smart-Choice Account(s), P.O. Box 785040, Orlando, FL 32878-5040. The repayment will be reflected in your account two to three business days after it is received. You can enter an electronic check payment directly on the site. This functionality is only for online checks and cannot accept credit card numbers. When online, you can view your overpayment and immediately take action by providing payment amount, institution name, account type, routing number, and account number.

You can continue to submit paper claims. These claims will be processed, and eligible amounts will be applied to the outstanding overpayment. Claims will not be paid until the overpayment has been fully recovered. If you fail to refund an overpayment, Frontdoor may choose to withhold the overpayment amount from your wages or other compensation to the extent consistent with applicable law.

Protection from Court Order

To the extent permitted by law, any money in your flexible spending accounts cannot be attached or garnisheed to pay for your debts and liabilities.

Deadline for Submitting Claims

You must submit all health care and dependent day care claims by the May 31 that follows the end of the plan year.

Health Savings Account

If you enroll in either CDHP medical plan options, you have the option to contribute to a Health Savings Account (HSA). An HSA is an individually owned, tax-advantaged account that may be used to pay for qualified medical expenses or saved for retirement and long-term care expenses. Please see chart below for company funding. In order for you to receive the company funds (contribution), you must select "elect" in the Health Savings Account enrollment; however, you do not have to contribute to receive the company funds (contribution). The company funding is broken down by payroll period and distributed per payroll period throughout the entire plan year.

Save Your Receipts
Be sure to save all bills, receipts, Explanations of Benefits (EOB), and other proofs of expense, even if you are using the Alight Smart-Choice Account(s) card, so you can properly document your

2022 HSA Funding Amounts			
Coverage Level	**2022 HSA Funding Limits**	**Frontdoor Funding for 2022**	
		Basic CDHP	**Enhanced CDHP**
Individual Coverage	$3,650	$500	$750
Family Coverage	$7,300	$1,000	$1,250
Age 55 or Older	Contribute an additional $1,000 on top of these amounts	-	-

How Health Savings Accounts Work

Tax Advantages

An HSA is tax-advantaged in three ways:

- Contributions to the HSA are tax-deductible
- Earnings on your HSA account balance are not taxed
- Funds withdrawn to pay for qualified medical expenses are not subject to income tax or penalties

Eligibility

To be eligible for an HSA, you must:

- Be enrolled in either the Basic or Enhanced CDHP medical plan (if you enroll in the HSA, but had a balance in an FSA on December 31 of the prior year, you are not eligible to contribute to, or receive any Frontdoor contributions, until April 1 of the current year).
- Not be covered by any other health plan, such as a flexible spending account (FSA) or a spouse's health care plan

- Not be enrolled in Medicare or any other government-sponsored medical plan (such as TRICARE®)
- Not be claimed as a dependent on another person's tax return
- Expenses you incur before your participation starts, or after the end of the plan year or claims-incurred deadline, are not eligible for reimbursement.

Account Set-Up

Upon electing to contribute to the HSA, an account is automatically opened on your behalf through UMB Bank. Your account can be established as early as the effective date of your coverage in the CDHP medical options; however, if your medical coverage begins on any day other than the first of the month, you cannot establish your HSA until the first day of the month following your medical coverage effective date.

For example: If your coverage in the Basic (CDHP) medical option began on January 1, your HSA can be established effective January 1. If your coverage in the CDHP medical option began January 15, your HSA cannot be established until February 1.

You cannot be reimbursed for qualified medical expenses incurred before your HSA is established.

To view the terms and conditions of your account, visit **www.smartchoiceaccounts.com**.

Communications
Once your account is opened with UMB Bank, you will receive a welcome letter from UMB Bank that contains your account number and UMB Bank's contact information. You will also receive Alight Smart-Choice debit card to use for eligible expenses.

Ongoing, you will receive quarterly account statements detailing your account activity. At the end of each calendar year, you will receive a form 1099-SA. This form details all your account distributions and must be used for tax filing purposes. The following April you will also receive a form 5498-SA with the total annual contribution for the prior year.

Beneficiary Designation
Assigning a beneficiary to your HSA ensures that your assets are properly assigned in the event of your death. To access the beneficiary designation form, visit the Alight Smart-Choice Account(s) website at **www.smartchoiceaccounts.com**.

Making Contributions to Your HSA
Every year, you decide how much you want to contribute to your HSA, up to the maximum annual contribution limit as determined by the U.S. Treasury Department. For 2022, you may contribute up to $3,650 as an individual or up to $7,300 for your family. If are 55 or older during the year, you may also contribute up to an additional $1,000 to your HSA. The amount that you elect to contribute will be deducted from your paycheck on a before-tax basis and automatically deposited into your HSA. Any company funding into your HSA will count toward your overall annual HSA maximum contribution limit

Frontdoor may also choose to contribute to your HSA. Frontdoor deposits 50% at the beginning of the plan year, with the remainder of the funds deposited per pay period throughout the plan year. Company funding is included in your annual contribution limit. If you are hired on or after January 1, 2022, you will receive a prorated amount of the company funding your first year. You are not eligible for Frontdoor contributions if you are terminated or not enrolled in the HSA plan. You can receive the Frontdoor HSA contribution only if you are enrolled in the HSA even if you do not choose to contribute.

If you elect to make additional contributions outside of payroll, you may do so through the Alight Smart-Choice Account(s) website accessible at **www.smartchoiceaccounts.com**. From the Alight Smart-Choice Account(s) site you can download a deposit form to allow you to make a deposit to your HSA via personal check, or you can transfer funds electronically from your bank account to your HSA.

Your HSA does not have an available balance until a deposit – through payroll contributions or direct contribution – is received. Once funds are deposited, you may choose to withdraw, save, or invest the funds.

Prior Year Contributions
You may make HSA contributions for a prior year in which you had an established HSA no later than the deadline, without extensions, for filing a federal income tax return for that year. For calendar-year taxpayers, this deadline is typically April 15 following the year in which contributions were made.

Trustee-to-Trustee Transfers
If you currently have an HSA and wish to transfer the balance to your Frontdoor HSA, you must complete and submit a transfer form to facilitate the transaction. The process typically takes 10 to 14 days to complete from the time your prior administrator receives your trustee-to-trustee transfer form, depending on your prior administrator's processing requirements. There may be a fee charged by your prior administrator for processing the transaction. See the Alight Smart-Choice Account(s) website at **www.smartchoiceaccounts.com** for more information and to obtain the trustee-to-trustee transfer form.

Disbursements From Your HSA

Funds in your HSA may be withdrawn, without tax penalty, to pay for qualified medical expenses for you, your spouse, and your dependent(s), even if your spouse or dependent(s) are not covered by a CDHP medical option. Qualified medical expenses include out-of-pocket medical expenses subject to the plan deductible and coinsurance, as well as expenses for dental and vision services, health care supplies, and long-term care premiums. It is solely your responsibility to retain receipts and records of reimbursements for tax purposes.

Disbursement Options

There are two primary methods of withdrawing funds from your HSA – your Alight Smart-Choice Account(s) debit card and the "Get Reimbursed" feature.

The Alight Smart-Choice debit card is a signature-based debit card that can be used at medical, dental, and vision providers to pay for qualified medical expenses. The card is also accepted by most pharmacies. The funds available on your Alight Smart-Choice Account(s) debit card are equal to the balance in your HSA. While HSA debit cards do not require validation, you should save all receipts and records for tax purposes.

As an alternative to the Alight Smart-Choice debit card, you have the option of self-reimbursement through direct deposit. You can make deposits from your HSA directly into a personal checking, savings, or money market account through the Alight Smart-Choice Account(s) website at **www.smartchoiceaccounts.com**. There is no fee associated with this transaction. There is no ATM access with the HSA, and there is not an option for checks to be written against your HSA balance.

Eligible Medical Expenses

You can only use your HSA for qualified medical expenses, including out-of-pocket medical expenses subject to the CHDP plan deductible and coinsurance, and expenses for dental and vision services, health care supplies, and long-term care premiums. The list below is not intended to be exhaustive and should only be used as a general guide. Expenses incurred for services that are not considered medically necessary, such as cosmetic procedures, are not eligible. Also, any expenses incurred before your account began are not eligible. To learn more about eligible expenses, go to https://www.irs.gov/pub/irs-pdf/p502.pdf.

Account Options

Upon electing to contribute to the HSA, a base account is automatically opened on your behalf through UMB Bank. This account is an interest-bearing deposit account, is FDIC-insured, and is maintained in your name at UMB Bank. All contributions to the HSA will be initially credited to the base account and all distributions will be withdrawn from the base account. Interest is paid monthly according to UMB Bank's balance-based interest rate tiers.

Self-Directed Brokerage Account Option

Once you exceed a $1,000 balance in your base account you also have the opportunity to select and manage your investments through an online brokerage account. More than 170 mutual funds are available in seven nationally recognized fund families, and typically require an initial minimum investment of between $1,000 and $2,500. All funds are offered at net asset value (NAV) and all interest and earnings from the sale of securities are returned to your base account balance.

Investments in securities offered through the brokerage account are not FDIC-insured, may lose value, and have no bank guarantee.

There is a standard fee for any initial investment, as well as a reduced fee for recurring transitions. Fees are deducted from your base account balance. See the *Manage Your Investment* link on the Alight Smart-Choice Account(s) website at **www.smartchoiceaccounts.com** for details.

Disability Program

A disability can have a big impact on your life. It affects not only your health, but your finances as well. While you are away from work, everyday living expenses continue just as before, so you still need to receive an income to pay the bills. That is what our disability program is all about.

An eligible associate has two levels of disability protection available:

Short-term disability (STD) continues either 60% or 80% of your earnings. The amount paid depends on your length of service. You can receive up to 13 weeks (about three months) of STD benefits.

Long-term disability (LTD) coverage protects your income if you have an extended disability that lasts more than 14 weeks.

This section describes the benefits available under STD and LTD.

Short-Term Disability (STD)

If you are unable to work because of a non-work-related illness or injury, STD benefits can replace a portion of your pay. STD benefits are paid on a weekly basis. Once benefits begin, they may continue for up to 13 weeks per disability.

How Benefits Are Calculated

Your STD benefits are based on your length of service with Frontdoor as shown below:

Years of Service	STD Benefit
One year but less than five years	60% of Earnings
Fifth year anniversary	80% of Earnings

What “Earnings” Means

Your weekly pay while you are on STD is based on your annual earnings. Your annual earnings are determined on September 1 of the current year for the following plan year. For example, your coverage for 2022 is based on your annual earnings as of September 1, 2021.

Associates Who Are in an Eligible Class on August 31

“Annual earnings” means the greater of these amounts:

- Your gross annual income from your employer for the 12-month period starting September 1 of the previous year and ending August 31 of the current year; or
- Your annualized rate as of August 31 of the current year

Associates Who Are Not Employed or in an Eligible Class on August 31

“Annual earnings” means your annualized rate from your employer as of your date of hire or your effective date in the eligible class.

Gross annual income includes your total income before taxes and before any payroll deductions for benefits. It includes nondiscretionary bonuses and commissions that you have actually received but does not include overtime, discretionary bonuses, discretionary income, and any other extra income in other categories you receive from Frontdoor, or any income from another employer.

Coordination with State Disability Benefits

Your short-term disability benefit is reduced by actual or estimated state disability benefits you are eligible to receive. Currently, California, Hawaii, New Jersey, New York, Rhode Island and Washington have state disability programs.

If benefits are reduced by an estimate, Prudential will calculate the estimate using your annual earnings.

Use of Accrued Time Off

You may choose to use all accrued paid time off, to supplement your income during any portion of your leave that is unpaid, including the seven-day STD elimination period.

You may not use your accrued paid time off, to supplement your 60% or 80% STD payments so that you receive the equivalent of your pre-disability earnings.

Maximum Benefits

The maximum monthly STD benefit payable before any reduction for state disability income benefits is $15,000.

When Benefits Are Paid

You are eligible for STD benefits if you become disabled after you have completed six months of continuous service. The period before your coverage begins is called the “waiting period.”

When Benefits Start

Your STD benefits begin after seven days of disability. In other words, your first benefit is payable as of the eighth day of your disability leave, provided you have been approved for STD benefits and have been placed on an approved leave of absence. This period is called the “elimination period.” Note: there is no elimination period for pregnancy or an accident.

What “Disability” Means

Disability means an illness or injury that lasts more than seven calendar days. To be considered disabled you must be unable to perform the duties of your regular occupation because of the disability, and you must not be working in any occupation.

When Benefits End

STD benefits are generally payable for up to thirteen (13) weeks per disability per plan year. For maternity absences, benefits are paid for six (6) weeks following delivery (eight (8) weeks following cesarean delivery). Benefits will end before 13 weeks under any of the following conditions:

- A doctor certifies that you are medically able to return to work
- When you have received STD benefits for the normal recovery time for your condition
- If you return to work at Frontdoor, at another employer, or through self-employment
- Prudential asks you to be examined by a doctor of their choice and you refuse
- You fail to remain under the appropriate regular care and treatment of a physician, or you refuse to undergo medically necessary treatment
- You or your doctor do not give Prudential requested information or documentation concerning your disability
- You refuse a job that Frontdoor determines you are qualified for and medically capable of performing
- You are no longer employed with Frontdoor
- You die

How Benefits Work for Multiple Disabilities

If you are on disability leave, return to work, and then are disabled again, the plan has special rules to determine whether two or more absences are considered separate disabilities or one continuous disability.

Two or more disabilities will be considered as the same disability if they are due to the same or related illness, injury, or pregnancy related condition. In this case, STD benefits start immediately in the same amount that was paid during your first disability as long as it is within the 12-month recurrent claim period.

Disabilities that are due to unrelated causes and separated by one or more days of work are considered separate claims. In these cases, you'll need to satisfy the seven-day elimination period before benefits begin again.

When Benefits Are Not Paid

STD benefits are not payable for disability absences resulting from any of the following circumstances:

- Intentionally self-inflicted injury or attempted suicide, while sane or insane
- War, declared or undeclared, or any act of war
- Participation in an insurrection, rebellion, riot or civil commotion
- Participation in a felony or criminal act
- An illness or injury that occurs while you are on a personal leave of absence (excluding jury duty or vacation); or a disability that occurs while you are on strike, walk-out, suspension, layoff, or away from work because of union membership
- Cosmetic surgery (see the Glossary) except surgery made necessary by accidental injury incurred while covered under the plan. **Note:** The plan covers disability absence for elective surgery that is not considered cosmetic if you provide proper medical documentation, and the disability absence results from complications of elective and cosmetic surgery.
- Occupational illness or injury

Long-Term Disability (LTD) Benefits

The Long-Term Disability (LTD) plan replaces a percentage of your pay during an extended disability. The LTD plan offers 50% and 60% benefit coverage options to choose from. LTD benefits are paid on a monthly basis. See the *Claims* section starting on page 162 for information about how to file claims for LTD benefits and other disability income benefits.

Evidence of Insurability Required for Long-Term Disability

Under the Long-Term Disability (LTD) plan, you must provide evidence of insurability before you can be approved for coverage if you do not enroll when you are first eligible and decide to enroll later.

LTD Coverage for Pre-existing Conditions

If you are disabled due to a pre-existing condition during the first 12 months you are covered by the LTD plan, benefits may not be paid for that disability.

If you increase your benefit coverage option from 50% to 60%, have exhausted your initial pre-existing period, and are disabled due to a pre-existing condition during the first 12 months after the change to 60%, benefits payable for that disability are at the 50% coverage option.

Special Rules for an Increase in LTD Coverage

If your disability is caused by a pre-existing condition, your monthly benefit will be based on the amount of the monthly benefit that has been in effect for at least 12 months under this plan or any other prior coverage. You will not be eligible for any benefit increase if the disability starts within the first 12 months after you increase in coverage goes into effect.

How LTD Benefits Are Calculated

The LTD plan sets a target income amount equal to 50% or 60% of your monthly earnings, depending on which option you elect. The plan then considers other sources of income you receive because of your disability to reach this target. The plan first calculates the amount you receive from the other sources. Then the plan pays whatever amount is needed to make up the difference between the other sources and either 50% or 60% of your monthly earnings. In other words, if you are entitled to benefits for the same disability from the sources listed on page 126, your LTD benefit will be reduced by the other income sources.

Disability Income Sources that may reduce your LTD Disability Benefits

- Disability or retirement benefits that you or your dependents are entitled to receive under the Federal Social Security Act, the Railroad Retirement Act, Canada Pension Plan and Quebec Pension Plan
- Any state or public associate retirement or disability plan, or any pension or disability plan of any other nation or political subdivision thereof.
- Disability payments under an employer's retirement plan or voluntarily elected retirement plans
- Benefits you are entitled to receive under workers' compensation, occupational disease, or similar acts or laws
- Any third-party awards (after deducting attorney fees)
- Any salary continuation, STD, sick leave, or group insurance benefits
- Any other disability benefits you receive under any state benefit acts or laws, auto insurance policies, other group insurance plans, or government retirement systems
- Recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings
- 50% of any amounts you receive under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure
- Any income that you receive from working while disabled—including salary, commissions, overtime, bonus, or other extra pay arrangements from any source—to the extent such income reduces the amount of your monthly LTD benefit

Disability Income Sources Not Used to Reduce your LTD Benefits

The following sources of disability income will not reduce your LTD benefit. Any income you receive from these sources is in addition to your other benefits.

- Military and other government service pensions
- Retirement benefits from a former employer
- Veteran's benefits for service-related disabilities
- Individual disability income policies
- Retirement Federal Social Security Act
- Profit sharing plans
- Thrift or savings plans
- 401(k) plans
- Keogh plans
- Associate stock option plans
- 403(b) tax-sheltered annuity plans
- 457 deferred compensation plans
- Severance pay
- Individual disability income policies
- Individual Retirement Accounts (IRAs)
- Mortgage or credit disability income plans

What “Monthly Earnings” or “Predisability Earnings” Means

The coverage amount for LTD is based on your gross annual salary or wages. Your earnings are determined on September 1 of the current year for the following plan year. Your annual salary calculation will determine your monthly LTD benefit amount.

For example, your coverage for 2022 is based on your earnings as of September 1, 2021.

Associates Who Are in an Eligible Class on August 31

Monthly earnings are 1/12 of the greater of:

- Your gross annual income from your employer for the 12-month period starting September 1 of the previous year and ending August 31 of the current year; or
- Your annualized rate as of August 31 of the current year

Associates Who Are Not Employed or in an Eligible Class on August 31

Monthly earnings are 1/12 of your annualized rate from your employer as of your date of hire or your effective date in the eligible class.

Gross annual income includes your total income before taxes and before any payroll deductions for benefits. It includes nondiscretionary bonuses and commissions that you have actually received but does not include overtime, discretionary bonuses, discretionary income, and any other extra income in other categories you receive from Frontdoor, or any income from another employer.

An increase in insurance due to an increase in your earnings will take effect on the first day of the calendar year following the increase in your earnings if you are actively at work on that date. If you are not actively at work on that date, the increase will take effect on the date you return to active work. If your earnings should go down, the decrease will take effect on the first day of the calendar year following the decrease in your earnings, but it will not affect any benefits you are currently receiving.

Changes in your disability income will only apply to disabilities beginning on or after the date of the change.

An Example of How LTD Benefits Are Calculated

Here’s an example to show how an LTD benefit might be calculated. For the example, assume your annual earnings are $18,000, your monthly earnings are $1,500, and you are eligible for a monthly Social Security disability benefit of $650.

Your benefit would be calculated like this:

LTD Benefit Example	
Monthly LTD target equals 60% of your $1,500 monthly earnings (This is also called your monthly “gross LTD benefit”)	$900
Monthly Social Security benefit makes up part of the target	$650
Monthly LTD plan benefit makes up the remainder of the target	$250

If you are not eligible for Social Security or any other sources of income, your LTD plan benefit would be the entire amount needed to reach the target—or $900 a month.

Minimum and Maximum Benefits

Your benefit under the LTD plan, after subtracting any amounts from other disability income sources, will never be less than the greater of $100 or 10% of your monthly gross LTD benefit or, if less, 10% of the maximum monthly benefit.

The plan also has two benefit maximums:

- Your monthly gross LTD benefit cannot be more than $15,000 a month.
- The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your pre-disability earnings. If benefits exceed this amount, your LTD plan benefit will be reduced.

About Other Disability Income Sources

You are responsible for applying for all other sources of disability income that you might be entitled to receive. Prudential administrators will notify you if they believe you are eligible for other disability income for which you have not yet applied. In this case, you'll need to apply for the other disability income and sign a commitment to repay Prudential for any overpayments it makes while you're waiting for your claim for other disability income to be approved. (If your claim for other income is denied, you'll also be required to follow through on all levels of appealing your claim.) If you do not follow these requirements, your LTD benefits will be reduced by the estimated amount of the other disability income.

If you receive a lump-sum payment of other disability income, the payment will be prorated to a monthly amount over a reasonable period of time to reduce your LTD benefit.

Taxes on Your LTD Benefits

If you pay your LTD premiums with after-tax dollars, you do not pay taxes on that portion of the LTD benefit.

When Can I Receive LTD Benefits?

LTD benefits are payable if you have a disability that prevents you from working and you meet the plan's disability requirements. You're considered disabled if you have an illness or injury that:

- During the first 24 months of disability, limits you from performing the duties of your own occupation for any employer due to your sickness or injury. In cases where you may be able to work, you're considered disabled if you are unable to earn more than 80% or more of your pre-disability earnings due to the same sickness or injury.
- After 24 months of disability, you are unable to earn more than 80% of your pre-disability earnings at any gainful occupation for any employer in your local economy for which you're qualified by education, training, or experience.

In order to receive and to continue to receive LTD benefits, you must be under the care or supervision of a physician at all times for the disability. To confirm your disability status, Prudential may ask you to have a physical exam or interview by a doctor or other representative chosen by Prudential. Prudential will pay the costs of these exams. To continue to receive LTD benefits, you must take these examinations.

Losing a professional or occupational license or certification is not considered a disability.

The plan covers disabilities caused by mental illness or physical illness or injury. However, benefits are limited to 24 months for disabilities caused by mental illness or alcohol and/or drug abuse.

Responsibilities of a Participant

If you are disabled and eligible for disability benefits, it is your responsibility to cooperate with Prudential, to comply with all plan provisions, and to make your period of disability as manageable as possible. Your failure to do so may result in a loss of benefits. In addition to any other responsibilities described in this section, you are responsible for the following:

- You must obtain medical treatment and follow your doctor's medical advice.
- You must file a complete disability benefit application and provide any medical information requested.
- You must apply for Social Security disability benefits and appeal any denial of these benefits.
- You must promptly notify Prudential of any Social Security benefits, workers' compensation benefits, third-party awards, or any other disability income you are entitled to receive and provide the necessary documentation for these benefits or payments upon request.
- You must comply with Prudential's rehabilitation requests, including requests to participate in or pursue vocational and/or medical rehabilitation.
- You must make a diligent effort to return to work with Frontdoor or another employer—either as an associate or on rehabilitation status.
- You must notify Prudential of any and all information concerning your outside employment or income-producing activities.
- You must promptly notify Prudential if your address changes while you are receiving benefits.

It's a Crime!
It's a crime to knowingly make false statements or provide misleading information with intent to defraud or deceive Prudential. Fraudulent claims are one reason behind high insurance costs, so Prudential reviews claims for fraud. If you make statements that are incomplete or untrue, or if you file a claim that contains false, incomplete, or misleading information, Prudential may reduce or deny your claim or cancel your coverage from the original effective date. Prudential may also prosecute cases to the full extent under the law.

When LTD Benefits Are Not Paid

LTD benefits are not payable for a disability resulting from any of the following circumstances:

- Intentionally self-inflicted injury while sane or insane.
- War, declared or undeclared, or any act of war, insurrection, rebellion, or terrorism.
- Taking part in a riot or civil commotion.
- A disability that is caused by a pre-existing condition and that occurs during the three months before your coverage or coverage increase becomes effective. A pre-existing condition is a disease or an injury for which, during the three-month period before your effective date of coverage, you received a diagnosis, medical treatment or diagnostic services, or you took medications that were prescribed or recommended by a physician. Likewise, the plan does not cover benefits if you should become disabled due to a pre-existing condition within 12 months after your coverage goes into effect.
- Commission of or attempt to commit a felony.
- Motor vehicle accident caused by operating the vehicle while under the influence of alcohol at a level which meets or exceeds the legal limit in the state (outside the U.S. intoxication will be presumed if the blood alcohol level meets or exceeds 0.08 grams per deciliter).

When LTD Benefits Start and End

When Your LTD Benefits Start

LTD benefits start after you have been disabled for the greater of:

- The first 98 days of a period of disability, or
- The time period that disability benefits are payable from your employer-sponsored short-term disability plan

If you are disabled for less than one month, the plan pays 1/30th of your monthly benefit for each day you are disabled. LTD premiums are waived beginning the first of the month following the date your LTD benefits begin and continuing until you are no longer eligible for LTD benefits.

When LTD Benefits Stop

If you become disabled before age 61, benefits are paid until you reach age 65. If you become disabled at or after age 61, benefits are paid for up to a specific number of months, as shown on the following chart:

Age at Date of Disability	Maximum Payment Period for LTD Benefits
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months or until normal retirement age*

**As determined by the 1983 Amended Social Security Normal Retirement Age*.

Under the following conditions, benefits will end before the times shown in the chart on page 130. Benefits will end on the date:

- You no longer meet the LTD test of disability, as determined by Prudential
- You do not give Prudential proof that you meet the LTD test of disability
- You are no longer under the regular care of a physician
- Prudential determines you have withheld information about working, or being able to work, at a reasonable occupation (one that provides an income of more than 80% of your pre-disability earnings)
- You do not cooperate or participate in the plan's rehabilitation program or return to work program when requested by Prudential
- You refuse to be examined by or cooperate with an independent physician or a licensed and certified health care practitioner as requested
- An independent medical exam report or functional capacity evaluation does not, in Prudential's opinion, confirm that you are disabled

- You are not receiving effective treatment for alcoholism or drug abuse, if your disability is caused wholly or in part by alcoholism or drug abuse
- You refuse to cooperate or accept changes to your work site or job process designed to suit your identified medical limitations, or adaptive equipment or devices designed to suit your identified medical limitations, which would allow you to work at your own occupation or a reasonable occupation, provided that a physician agrees to such changes, adaptive devices or equipment to suit your particular medical limitations
- You refuse any treatment recommended by your attending physician that, in Prudential's opinion, would cure, correct, or limit your disability
- Your condition allows you to work, increase the hours you work, or increase the number of type of duties you perform in your own occupation and you refuse to do so
- You die

How Benefits Work for Multiple Disabilities

If you are on disability leave, return to work, and then are disabled again, the plan has special rules to determine whether two or more absences are considered separate disabilities or one continuous disability.

If you return to active work after completing your elimination period for a period of 180 days or less, and then become disabled again due to the same or related sickness or accidental injury, you are not required to complete a new elimination period. For the purpose of determining your benefits, we will consider such disability to be a part of the original disability and will use the same pre-disability earnings and apply the same terms, provisions, and conditions that were used for the original disability.

If you return to active work for a period of more than 180 days and then become disabled again, you will have to complete a new elimination period.

Disability Due to Mental or Nervous Disorders or Diseases

You can receive LTD benefits for a maximum of 24 months if your disability is primarily caused by a mental health or psychiatric condition, including physical manifestations of these conditions, but excluding:

- Conditions with demonstrable, structural brain damage, or
- Alcohol and/or drug abuse

Your benefits will be limited to the lesser of the maximum benefit period or 24 months. This limitation does not apply to a disability resulting from schizophrenia, dementia, or organic brain disease.

If you are confined in a hospital or mental health facility, at the end of the 24-month period for which benefits are to be paid, your benefits will continue during your confinement. If the inpatient confinement lasts less than 30 days, the disability will cease when you are no longer confined. If the inpatient confinement lasts 30 days or more, the disability may continue until 90 days after the date you have not been so continuously confined.

If you continue to be disabled after you have received 24 months of benefit payments and subsequently become confined in a hospital or mental health facility for at least 14 consecutive days, your benefits will continue until the end of your confinement.

Benefits will end after the period indicated above or the maximum benefit period, whichever occurs first.

Disability Due to Neuromuscular, Musculoskeletal, or Soft Tissue Disorder; and Chronic Fatigue Syndrome and Related Conditions

You can receive LTD benefits for a maximum of 24 months if your disability is due to Chronic Fatigue Syndrome and related conditions.

You can receive LTD benefits for a maximum of 24 months if your disability is due to a neuromuscular, musculoskeletal, or soft tissue, disorder including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the disability has objective evidence of:

- Seropositive arthritis
- Spinal tumors, malignancy, or vascular malformations
- Radiculopathies
- Myelopathies
- Traumatic spinal cord necrosis
- Myopathies

Your benefits will be limited to the lesser of the maximum benefit period or 24 months per occurrence.

Payments are not made beyond the dates described above or on page 130 under *When LTD Benefits Stop*.

The Rehabilitation and Return to Work Program

Participating in the Program

If Prudential determines that you are a suitable candidate for rehabilitation, it may require that you participate in a rehabilitation and return to work program. To participate, you must be medically able to return to work. If you are selected for a rehabilitation program, you must participate in the program to continue receiving LTD benefits. A rehabilitation program may include, but is not limited to, your participation in one or more of the following activities:

- Return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience, and past earnings
- On-site job analysis
- Job modification/accommodation
- Training to improve job-seeking skills
- Vocational assessment
- Short-term skills enhancement
- Vocational training
- Restorative therapies to improve functional capacity to return to work

Additional Benefits While You Participate in the Program

While you participate in a rehabilitation and return to work program, the plan pays the following additional benefits:

- A monthly benefit equal to 100% of your gross LTD benefit for the first 24 months. After the first 24 months following your elimination period this will be reduced to 50% of the amount you earned from working while disabled. This benefit is in addition to your LTD benefits or partial disability benefits.
- An additional three months of LTD benefits after your disability ends if you are not able to find employment after participating in the rehabilitation and return to work assistance program. The benefit payable is your gross LTD benefit.

These benefits are not reduced by other sources of disability income, but they are subject to the maximum benefits described on page 128.

Rehabilitation and return to work benefits end when Prudential determines that you are no longer eligible for the rehabilitation program or when benefits otherwise would end under the provisions described earlier in this section.

Life and Accident Insurance

Frontdoor offers life and accident insurance plans that protect you financially in case of death or serious injury. Some plans are automatic and paid for by Frontdoor. You can choose additional coverage that you pay for yourself.

This section of your guide describes these insurance plans in more detail. Here is an overview of the life and accident insurance plans Frontdoor provides:

Group Term Insurance
All the life and accident insurance currently offered is group term insurance. There is no cash accumulation for term life insurance.

Type of Coverage	Who Is Covered	Who Pays for Coverage	Coverage Amount / Choices	Coverage Maximum
Basic Life: Pays a benefit if you die	You	Frontdoor	1.5 times annual earnings (rounded to the nearest $1,000)	$300,000
Supplemental Life: Pays a benefit if you die	You	You	1, 2, 3, 4, or 5 times annual earnings (rounded to the nearest $1,000)	$2 million maximum benefit amount combined with basic life coverage
Dependent Life: Pays a benefit if your covered spouse or child dies	Your spouse and/or children	You	Spouse /children: $15,000 / $2,000 $25,000 / $5,000 $50,000 / $10,000 $75,000 / $15,000 $100,000 / $25,000	Spouse /child: $100,000 / $25,000 A dependent's coverage cannot be more than 100% of your combined coverage
Accidental Death and Dismemberment (AD&D): Pays a benefit in the event of certain serious injuries or death due to an accident	You, your spouse, and/or children	You	You: $20,000–$100,000 in multiples of $10,000; $150,000–$750,000 in multiples of $50,000 Spouse: 60% of your insurance amount (rounded to the nearest $1,000) Children: 30% of your insurance amount (rounded to the nearest $1,000)	You: The lesser of 10 times your annual earnings or $750,000 Your spouse: $450,000 Your children: $25,000
Business Travel Accident (BTA): Pays a benefit in the event of certain serious injuries or death due to an accident while traveling on approved Frontdoor business	You, your spouse, and/or children	Frontdoor	$100,000 per covered person	$100,000

Life Insurance

Basic Life Insurance

Basic life insurance covers you and pays a benefit to your named beneficiary if you die. Coverage is automatic. Frontdoor pays the full cost of this insurance. If you do not name a beneficiary, the plan pays benefits in accordance with its provisions.

Coverage Amount

Your coverage amount is 1.5 times your annual earnings. The coverage amount is rounded to the nearest multiple of $1,000. Maximum coverage is $300,000.

An Example

Say your annual earnings are $18,275. 1.5 times $18,275 equals $27,413. Rounded to the nearest multiple of 1,000, your coverage amount would be $27,000.

Supplemental Life Insurance

Supplemental life insurance covers you and pays a benefit to your named beneficiary if you die. Coverage is optional. You pay the full cost of this insurance.

Coverage Amount

You can choose a coverage amount of 1, 2, 3, 4, or 5 times your earnings. You can change your coverage amount during open enrollment periods. You can only increase coverage by one level at a time; that is, if you have coverage of 2 times your earnings, you can only increase it to 3 times your earnings. You can decrease your coverage as much as you want, subject to plan minimums.

The coverage amount is rounded to the nearest multiple of $1,000. **For example:** Say your annual earnings are $25,900 and you elect coverage of 4 times your earnings. 4 times $25,900 equals $103,600. Rounded to the nearest multiple of $1,000, your coverage amount would be $104,000.

Maximum coverage is $2 million, combined with your basic life coverage amount.

If you do not enroll when you are first eligible, and decide to enroll later, you can only choose 1 times your earnings and you must submit evidence of insurability.

Premiums Based on Smoker Status

Your premiums for supplemental life insurance are based on whether or not you use tobacco. You are considered to use tobacco if, in the last 12 months, you have used any tobacco product that is smoked, chewed, or otherwise used as a nicotine delivery system, including pipes and cigars.

Annual Earnings

Coverage amounts for basic and supplemental life insurance are based on your annual earnings. Your annual earnings are determined on September 1 of the current year for the following plan year. For example, your coverage for 2022 is based on your annual earnings as of September 1, 2021.

Associates who are in an eligible class as of August 31:
"Annual earnings" means the greater of your gross annual income from your employer for the 12-month period of September 1 of the previous year through August 31 of the current year, or your annualized rate as of August 31 of the current year.

Associates not employed or in an eligible class on August 31:
"Annual earnings" means your annualized rate from your employer as of your date of hire or the date you became a member of an eligible class.

Gross annual income includes your total income before taxes and before any payroll deductions for benefits. It includes nondiscretionary bonuses and commissions that you have actually received but does not include overtime, discretionary bonuses, discretionary income, and any other extra income in other categories you receive from Frontdoor, or any income from another employer.

If you are away from work due to a sickness or injury on the date an increase in earnings is scheduled to take effect, the increase will take effect on the date you return to work. If evidence of insurability is required for the increased coverage, the increase will not take effect until the first day of the month following the date Prudential approves your evidence of insurability form.

If your earnings should go down, the decrease will take effect on the scheduled date, but it will not affect a payable claim that occurs prior to the decrease.

Accelerated Death Benefit

If you become terminally ill and life expectancy is 24 months or less, or if you have been diagnosed with one of the conditions listed below, you can request an accelerated death benefit under your basic or supplemental life insurance, or both. An "accelerated benefit" means that your insurance pays a benefit before your death.

Qualifying conditions for the accelerated death benefit include:

- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- End stage heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate
- A medical condition requiring artificial life support, without which you would die
- A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a hospital or skilled nursing facility

You must request an accelerated death benefit in writing to Prudential. The request must include:

- A statement of the amount requested, and
- A physician's statement verifying that you are suffering from a non-correctable terminal illness or are suffering from one of the listed medical conditions listed above that is expected to result in a drastically limited life span. The statement must also include all medical test results, laboratory reports, and all supporting documentation and information on which the physician's statement is based.

Upon review of your request, Prudential may require – at its expense – that you submit to an independent medical exam by a physician of Prudential's choosing. In this case, Prudential will not process your request until the exam has been completed and Prudential has received the results.

Prudential may refuse your accelerated death benefit request if:

- The group policy terminates before Prudential approves your request (even if all or part of your life insurance coverage continues for any reason)
- All your life insurance coverage terminates under the group policy for any reason before Prudential approves your request
- You die before Prudential issues the payment

If You Work Past Age 65

Your basic and supplemental life insurance coverage reduces when you reach age 65 and again when you reach age 70:

- When you reach age 65, your coverage reduces to 70% coverage
- When you reach age 70, your coverage reduces to 50% coverage

The reduction will take effect on the first day of the calendar year following the date in which you attain the limiting age.

An Example

Suppose your basic and supplemental life insurance before age 65 is $80,000. At age 65, your coverage will be 70% of $80,000, or $56,000. At age 70, your coverage will be 50% of $80,000, or $40,000.

Life Insurance While Totally Disabled

If you become totally disabled prior to turning age 60, you may be eligible to have your supplemental life insurance continued. If continued, premium payment will not be required. For purposes of life insurance, “total disability” means that due to an injury or sickness you are unable to perform the material duties of your regular job and you are unable to perform any other job for which you are fit by education, training, or experience.

Your supplemental life insurance coverage will continue if:

- You are covered under life insurance when you stop active work due to your disability; and
- Prudential receives proof that your total disability continued without interruption from the date you became totally disabled through the end of the waiting period, which is six months

You must provide Prudential written notice of your claim for this continued benefit, and Prudential must receive your notice within 12 months from the date you stop active work. If your written notice is not received within 12 months of the date you stop active work, you will not be eligible for this continuation.

Your life insurance will not continue beyond the date the first of any these events occur:

- The date Prudential sends you a request for an exam or proof that you are still permanently and totally disabled, and you do not go to the exam or provide proof of your continued disability within 31 days of that date
- You are able to work at any reasonable job
- You begin working at any job for pay or profit

After your insurance has been extended continuously for two years, Prudential will not require an exam or proof of disability more than once in a 12-month period.

If your life insurance terminates while you are disabled, you have a conversion privilege and are able to port your coverage, unless you return to active work and again are insured for life insurance.

The plan’s permanent and total disability feature is available to you only and is not available to any of your covered dependents.

When Benefits Are Not Paid

The plan does not cover any losses where death is caused by, contributed to by, or results from:

- Suicide, while sane or insane, or from an intentionally self-inflicted injury, occurring within two years after your initial effective date of insurance
- Suicide, while sane or insane, or from an intentionally self-inflicted injury, occurring within two years after the date any increases or additional insurance become effective for you

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium and any amounts that are subject to evidence of insurability.

After Coverage Ends

In some cases, you can continue coverage for you and/or your dependents through the plan's portability or conversion features. See page 18 for more information.

Dependent Life Insurance – Spouse

Dependent life insurance covers your spouse and pays a benefit to you if your spouse dies. Dependent life insurance is optional. You pay the full cost of any coverage you elect. You are automatically the beneficiary for any coverage.

Coverage Amounts

Except as noted below, you can choose any of these coverage amounts:

For Your Spouse
$15,000
$25,000
$50,000
$75,000*
$100,000*

**Election requires evidence of insurability for your spouse regardless of when the coverage is elected. Evidence of insurability does not need to be submitted for dependent children.*

The maximum coverage amount for your spouse is $100,000; however, your spouse cannot have a coverage amount that is more than 100% of your basic and supplemental life insurance combined.

Evidence of insurability (EOI) is required for either $75,000 or $100,000 of spouse dependent life insurance. If EOI is not completed as required, your spouse will automatically be covered at the $50,000 level, which is the highest coverage amount that does not require EOI.

If you do not enroll when you are first eligible and decide to enroll later, you can only choose coverage for your spouse of $15,000. In addition, you can only increase your coverage amount by one level during each subsequent enrollment event, including open enrollment.

If your spouse also works at Frontdoor and is eligible for basic life insurance as an associate, you cannot cover your spouse under the dependent life insurance program.

When Benefits Are Not Paid

The plan does not cover any losses where death is caused by, contributed to by, or results from:

- Suicide, while sane or insane, or from an intentionally self-inflicted injury, occurring within two years after your dependent’s initial effective date of insurance
- Suicide, while sane or insane, or from an intentionally self-inflicted injury, occurring within two years after the date any increases or additional insurance become effective for your dependent

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium and any amounts that are subject to evidence of insurability.

Accelerated Death Benefit

If your spouse becomes terminally ill and life expectancy is 24 months or less or has been diagnosed with one of the conditions listed below, you can request an accelerated death benefit.

Qualifying conditions for the accelerated death benefit include:

- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- End stage heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate
- A medical condition requiring artificial life support, without which you would die
- A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a hospital or skilled nursing facility

You must request an accelerated death benefit in writing to Prudential. The request must include:

- A statement of the amount requested, and
- A physician's statement verifying that you are suffering from a non-correctable terminal illness or are suffering from one of the listed medical conditions listed above that is expected to result in a drastically limited life span. The statement must also include all medical test results, laboratory reports, and all supporting documentation and information on which the physician's statement is based.

Upon review of the request, Prudential may require – at its expense – that your spouse submit to an independent medical exam by a physician of Prudential's choosing. In this case, Prudential will not process the request until the exam has been completed and Prudential has received the results.

When your spouse dies, any benefit payable will be reduced by the amount of the accelerated death benefit already paid out, plus interest.

Your spouse is not eligible for an accelerated benefit if the law requires you to use the benefit to meet creditors' claims, or if the benefit meets a government agency requirement for applying for, getting, or keeping a government benefit or entitlement.

Prudential may refuse your accelerated death benefit request if:

- The group policy terminates before Prudential approves your request (even if all or part of your life insurance coverage continues for any reason)
- All of your spouse's life insurance coverage terminates under the group policy for any reason before Prudential approves your request
- Your spouse dies before Prudential issues the payment

After Coverage Ends

In some cases, you can continue coverage through the plan's portability or conversion features. See page 18 for more information.

Dependent Life Insurance – Child(ren)

Dependent life insurance covers your children and pays a benefit to you if a covered dependent dies. Dependent life insurance for your child(ren) is optional. You pay the full cost of any coverage you elect. You are automatically the beneficiary for any dependent coverage.

Coverage Amounts

Except as noted below, you can choose any of these coverage amounts:

For Your Children
$2,000
$5,000
$10,000
$15,000
$25,000

The maximum coverage amount for your child(ren) is $25,000 per child. No dependent can have a coverage amount that is more than 100% of your basic and supplemental life insurance combined.

If you do not enroll when you are first eligible and decide to enroll later, you can only choose coverage for your child(ren) of $2,000. In addition, you can only increase your coverage amount by one level during each subsequent enrollment event, including open enrollment.

If your child also works at Frontdoor and is eligible for basic life insurance as an associate, you cannot cover that dependent under the dependent life insurance program.

If you and your spouse are both associates, only one associate can cover your child(ren) as dependent(s) on the plan.

When Benefits Are Not Paid

The plan does not cover any losses where death is caused by, contributed to by, or results from:

- Suicide, while sane or insane, or from an intentionally self-inflicted injury, occurring within two years after your dependent's initial effective date of insurance
- Suicide, while sane or insane, or from an intentionally self-inflicted injury, occurring within two years after the date any increases or additional insurance become effective for your dependent

After Coverage Ends

In some cases, you can continue coverage for your dependents through the plan's portability or conversion features. See page 18 for more information.

Accidental Death and Dismemberment Insurance (AD&D)

Accidental death and dismemberment insurance pays a benefit in the event of certain serious injuries or death due to an accident.

AD&D is optional. You pay the full cost of any coverage you elect. You can cover yourself, your spouse, and/or your children. You must elect coverage for yourself before you can cover your dependents. You are automatically the beneficiary for any benefits paid if a covered dependent dies.

Coverage Amounts

You can choose coverage for yourself from $20,000 to $100,000 in multiples of $10,000, or from $150,000 to $750,000 in multiples of $50,000. The maximum amount of coverage for you is the lesser of 10 times your annual earnings or $750,000.

Your spouse's coverage is 60% of your coverage. Maximum coverage for your spouse is $450,000.

Each child's coverage is 30% of your coverage. Maximum coverage per child is $25,000.

When Benefits Are Paid

This coverage pays a benefit only if death or certain serious injuries occur as the result of an accident. Death must occur within 365 days of the accident. Injury sustained in the accident must result in one covered loss or more within 365 days of the accident. The accident must occur while you or your dependent is covered under the plan.

Total Disability Death Benefit

If you become totally disabled as the result of an accidental injury, are continuously disabled from the date of the accident until your death, and you die while covered by the plan, the plan will pay a benefit equal to the principal sum of your coverage.

You are considered totally disabled if you are unable to work at your own job, are not able to work at any gainful occupation for which you are fitted by education, training and experience, and if you are under age 60 at the time of the accident.

Prudential must be notified of your death within 12 months. Any payment issued to your beneficiary will be reduced by any other payment the plan makes for the same accident.

Coverage Changes at Ages 65 and 70

Your coverage amounts are limited when you reach age 65 and again when you reach age 70.

When you reach age 65, your coverage is limited to 70% of your coverage.

When you reach age 70, your coverage is limited to 50% of coverage.

The reduction will take effect on the first day of the calendar year following the date in which you reach age 65 or 70.

Conversion

In some cases, you can continue coverage for you and/or your dependents through the plan's conversion feature. See page 18 for more information.

Business Travel Accident Insurance

Business travel accident (BTA) insurance pays a benefit if you die or sustain certain serious injuries in an accident while traveling on approved company business. It also pays a benefit if your spouse or children have been approved to accompany you and die or sustain certain serious injuries in an accident while accompanying you on company business travel.

Coverage is automatic. Frontdoor pays the full cost of this insurance.

What Is "Business Travel"?
Business travel is travel authorized by Frontdoor that takes you away from your city of permanent assignment. This plan covers you the entire time you are traveling and during your stay.

You are not covered during any personal travel you combine with your business trip.

Business travel does not include your commute between your home and workplace.

Losses Covered and Benefit Amounts

You and each dependent have BTA coverage of $100,000 while traveling on company business. The plan pays the full amount for death and certain injuries, or part of that amount for other injuries, as the chart below shows.

Covered Loss	Benefit Amount
Life	Full amount
Both hands or both feet	Full amount
One hand and one foot	Full amount
One hand or one foot plus the loss of sight of one eye	Full amount
Sight (both eyes)	Full amount
Speech and hearing	Full amount
Speech or hearing	50% of the full amount
One hand, one foot, or sight of one eye	50% of the full amount
Thumb and index finger of the same hand	25% of the full amount
Quadriplegia (total paralysis of both upper and lower limbs)	Full amount
Total paralysis of three limbs	75% of the full amount
Total paralysis of two limbs	66 2/3% of the full amount
Total paralysis of one limb	50% of the full amount

“The full amount” means the total amount of coverage you or your dependent has. If you or your dependent suffers more than one loss from an accident, the plan will pay only the larger benefit. Death must occur within one year of the date of the accident. Injury sustained in the accident must result in one covered loss or more within one year of the date of the accident.

“Loss of a hand or foot” means that the hand or foot is completely severed at or above the wrist or ankle joint.

“Loss of an eye” means the total and permanent loss of sight.

“Loss of speech” means the total and permanent inability to communicate audibly in any degree.

“Loss of hearing” means the total and permanent inability to hear, which cannot be corrected by any hearing aid or device.

“Loss of thumb and index finger” means severance through or above the metacarpophalangeal joint. In California, “loss of thumb and index finger” means loss by complete severance of at least one whole phalanx of each. In South Carolina, the loss of four whole fingers from one hand equals the loss of one hand. “Paralysis” means loss of use, without severance, of a limb. “Severance” means complete separation and dismemberment of the limb from the body.

The maximum combined benefit payable for any one accident is $2 million.

Additional Benefits

If you or your dependent suffers a covered loss while driving or riding in a private passenger car, the plan may pay an additional benefit if:

You or your dependent dies and was in a seat protected by an air bag. The benefit is 10% of the coverage amount up to a maximum of $10,000.

You or your dependent suffers one or more covered losses due to the same carjacking. The benefit is 10% of the coverage amount up to a maximum of $25,000.

The official police accident report must certify the proper use of seat belts and/or air bags or the occurrence of a carjacking.

Coma Benefit

The plan will pay a coma benefit if you or your dependent is injured during a covered accident and within one year of the covered accident the injury results in a coma lasting at least 31 consecutive days. The coma benefit is equal to 1% of the full coverage amount and will be paid each month you or your dependent remains in a coma following the initial 31-day period. The coma benefit will end the earlier of when you or your dependent is no longer in a coma, or after the coma benefit has been received for 100 months.

Critical Burn Benefit

The plan will pay a critical burn benefit equal to the lesser of 10% of the full coverage amount or $10,000 if you or your dependent is injured during a covered accident and:

- You or your dependent received second degree or higher burns over 25% of the body; and
- You or your dependent has undergone reconstructive surgery to treat the burned area of the body; and
- The reconstructive surgery has taken place within one year of the date of the accident.

Home Alteration and Vehicle Modification Benefit

The plan will pay a home alteration and vehicle modification benefit if you or your dependent is injured and the injury results in a covered loss. The plan will pay an additional benefit for home alterations and/or vehicle modifications if:

- You or your dependent is required to use a wheelchair to be ambulatory on a permanent basis; and
- The injury that caused the payment of the accidental dismemberment and covered loss of use benefit is the same injury that requires you or your dependent to need the wheelchair.

The amount paid will be equal to the one-time cost of alterations to you or your dependent's primary residence to make it wheelchair accessible and inhabitable and the one-time cost of modifications necessary to you or your dependent's motor vehicle to make the vehicle accessible or drivable.

Benefits will not be paid unless the alterations and/or modifications are made by persons experienced in such alterations and/or modifications and those persons are recommended by a recognized organization providing support and assistance to wheelchair users. Proof of payment must be provided to Zurich in order to receive benefits.

The maximum benefit payable is the lesser of 10% of the coverage amount or $10,000.

Natural Disaster Benefits

If you or your dependent suffers a covered loss as the result of a natural disaster, the plan will pay an additional benefit of 10% of the coverage amount up to a maximum of $10,000. "Natural disasters" means a storm (wind, rain, snow, sleet, hail, lightning, dust, or sand), earthquake, flood, volcanic eruption, wildfire, or other similar event.

Rehabilitation Benefit

If you or your dependent suffers an injury resulting in a covered loss, the plan will pay an additional benefit for the reasonable and customary expenses, as determined by the insurance company, incurred for rehabilitation training in an amount the lesser of:

- The actual expenses for the rehabilitation training that are incurred within one year of the accident;
- 10% of the coverage amount; or
- $10,000

Rehabilitation training is a program that is prescribed by a licensed physician acting within the scope of his or her license as approved by Zurich prior to receiving services, required due to the injury, and prepares you or your dependent for an occupation you would have held if not for the injury.

Losses Not Covered Under the Plan

Your plan does not cover accidental losses caused by, contributed to, or resulting from:

- Suicide, attempted suicide, or intentionally self-inflicted injury or any attempt at self-inflicted injury
- War or acts of war, whether or not declared
- Active military service
- Illness, disease, or infection
- Pregnancy, including childbirth (not including complications)
- Parasailing, bungee jumping, or any other extra-hazardous activity
- Participating in the commission or attempted commission of a felony or assault
- Being intoxicated while operating a motor vehicle
- Being under the influence of any prescription drug, narcotic or hallucinogen, unless prescribed by a physician and taken in accordance with the prescribed dosage
- Travel or flight in any aircraft without a valid airworthiness certificate as defined by the Federal Aviation Association or equivalent certificate from a foreign government
- Travel or flight in any aircraft not operated by a pilot with a current and valid medical certificate and pilot certificate with a proper rating to pilot the aircraft

Legal Services Plan

The legal services plan allows you and your eligible dependents to obtain personal legal services. You must enroll in the plan to be eligible for benefits.

How the Legal Services Plan Works

MetLaw®, through MetLife Legal Plans, offers a network of plan attorneys who provide a comprehensive range of legal services. There are some limitations and conditions, which are described under Covered Services Under the Legal Services Plan.

Here is how to access your legal services benefits:

Visit the MetLife Legal Plans' website at **members.legalplans.com** to initiate a case or find an attorney. You can also call the MetLife Legal Plans' Client Service Center at **800-821-6400**, Monday through Friday from 7 a.m. to 6 p.m., Central time. Whether you use the phone or the website, you will need your Social Security number (or, if you are a dependent, the Social Security number of the associate through whom you are eligible).

After receiving a case number, you can call the plan attorney for an appointment. If you choose, you can select an out-of-network attorney. The plan will provide a fee reimbursement schedule that shows the maximum amount payable for specific services under the plan.

How Benefits Are Paid

Unless indicated otherwise in the list of services on the following pages, plan legal services are covered in full. You have the option to select an out-of-network attorney. Or, if there are no plan attorneys in your area, you will need to choose an out-of-network attorney. In both cases, the plan will reimburse you for out-of-network attorney fees according to a set fee schedule. The plan will provide a fee reimbursement schedule that shows the maximum amount payable for specific services under the plan. You are responsible for all fees over and above the set fee the plan pays.

Covered Services Under the Legal Services Plan

Service	What the Plan Attorney Provides	Limitations and Conditions
Office or Telephone Consultation	**Office Consultation** This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The plan attorney will explain the participant's rights, point out his or her options, and recommend a course of action. The plan attorney will identify any further coverage available under the plan and will undertake representation if the participant so requests. If representation is covered by the plan, the participant will not be charged for the plan attorney's services. If representation is recommended, but is not covered by the plan, the plan attorney will provide a written fee statement in advance. The participant may choose whether to retain the plan attorney at his or her own expense, seek outside counsel, or do nothing. **Telephone Advice** This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The plan attorney will explain the participant's rights, point out his or her options, and recommend a course of action. The plan attorney will identify any further coverage available under the plan and will undertake representation if the participant so requests. If representation is covered by the plan, the participant will not be charged for the plan attorney's services. If representation is recommended, but is not covered by the plan, the plan attorney will provide a written fee statement in advance. The participant may choose whether to retain the plan attorney at his or her own expense, seek outside counsel, or do nothing.	There are no restrictions on the number of times per year a participant may use this service; however, for a non-covered matter, this service is not intended to provide the participant with continuing access to a plan attorney in order to seek advice that would allow the participant to undertake his or her own representation.
Consumer Protection matters	This service covers the participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction. The controversy must be evidenced by a written document such as a sales slip, contract, note, or warranty.	This service does not include disputes over real estate, construction, insurance, or collection activities after a judgment.
Personal Property Protection	This service covers counseling the participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.	
Small Claims Assistance	This service covers counseling the participant on prosecuting a small claims action; helping the participant prepare documents; advising the participant on evidence, documentation, and witnesses; and preparing the participant for trial.	The service does not include the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.
Debt Collection Defense	This service provides participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession, or garnishment, up to and including trial if necessary	It does not include vacating a judgment; counter, cross, or third-party claims; bankruptcy, any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the sponsor or employer.

Service	What the Plan Attorney Provides	Limitations and Conditions
Identity Theft Defense	This service provides the participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus, and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft, such as foreclosure, repossession, or garnishment, up to and including trial if necessary. The service also provides the participant with online help and information about identity theft and prevention.	It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post-decree matters, or any matter where the creditor is affiliated with the sponsor or employer.
Personal Bankruptcy or Wage Earner Plan	This service covers the associate and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials.	This service is not available if a creditor is affiliated with the employer, even if the associate or spouse chooses to reaffirm that specific debt.
Tax Audits	This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the participant's tax return; negotiating with the agency; advising the participant on necessary documentation; and attending an IRS or a state or local taxing authority audit.	This service does not include prosecuting a claim for the return of overpaid taxes, or the preparation of any tax returns.
Administrative Hearing Representation	This service covers participants in defense of civil proceedings before a municipal, county, state, or federal administrative board, agency, or commission. It does not apply where services are available or are being provided by virtue of an insurance policy.	It does not include divorce or post-decree matters; paternity, support, or custody matters; or litigation of a job-related incident.
Civil Litigation Defense	This service covers the participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state, or federal administrative board, agency, or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy.	It does not include divorce or post-decree matters; paternity, support, or custody matters; or litigation of a job-related incident. Services do not include bringing counter claims, third-party or cross claims.
Incompetency Defense	This service covers the participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the participant incompetent.	
Affidavits	This service covers preparation of any affidavit in which the participant is the person making the statement.	
Deeds	This service covers the preparation of any deed for which the participant is either the grantor or grantee.	
Demand Letters	This service covers the preparation of letters that demand money, property, or some other property interest of the participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the participant. Negotiations and representation in litigation are not included.	
Mortgages	This service covers the preparation of any mortgage or deed of trust for which the participant is the mortgagor.	This service does not include documents pertaining to business, commercial, or rental property.

Service	What the Plan Attorney Provides	Limitations and Conditions
Notes	This service covers the preparation of any promissory note for which the participant is the payor or payee.	
Document Review	This service covers the review of any personal legal document of the participant, such as letters, leases, or purchase agreements.	
Elder Law Matters	This service covers counseling the participant over the phone or in the office on any personal issues relating to the participant's parents as they affect the participant. The service includes reviewing documents of the parents to advise the participant on the effect on the participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.	
Adoption and Legitimization (Contested and Uncontested)	This service covers all legal services and court work in a state or federal court for an adoption for the plan member and spouse. Legitimization of a child for the plan member and spouse, including reformation of a birth certificate, is also covered.	
Name Change	This service covers the participant for all necessary pleadings and court hearings for a legal name change.	
Premarital Agreement	This service covers the preparation of an agreement by an associate and his or her fiancé prior to their marriage, outlining how property is to be divided in the event of separation, divorce, or death of a spouse. Representation is provided only to the associate. The fiancé must have separate counsel or must waive representation.	
Protection from Domestic Violence	This service covers the associate only, not the spouse or dependents, as the victim of domestic violence. It provides the associate with representation to obtain a protective order, including all required paperwork and attendance at all court appearances.	The service does not include representation in suits for damages, defense of any action, or representation for the offender.
Guardianship or Conservatorship (Uncontested and Contested)	This service covers establishing a guardianship or conservatorship over a person and his or her estate when the plan member or spouse partner is appointed as guardian or conservator. It includes obtaining a guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.	This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.
Uncontested Adoption	This service covers all uncontested governmental agency and stepparent adoptions for the associate and spouse If an adoption becomes contested, the associate or spouse partner must pay all additional legal fees.	
Uncontested Guardianship or Conservatorship	This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the plan member or spouse is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing, and preparing the initial accounting. If the proceeding becomes contested, the plan member or spouse must pay all additional legal fees.	This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

Service	What the Plan Attorney Provides	Limitations and Conditions
Immigration Assistance	This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents, and helping the participant prepare for hearings.	
Personal Injury	Subject to applicable law and court rules, plan attorneys will handle personal injury matters (where the participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the participant's responsibility to pay this fee and all costs.	The plan attorney's maximum fee is 25% of the gross award. You are responsible for paying this fee and all costs.
Boundary or Title Disputes	This service covers negotiations and litigation arising from boundary or title disputes involving a participant's primary residence, where coverage is not available under the participant's homeowner or title insurance policies.	Primary residence only.
Eviction and Tenant Problems	This service covers the participant as a tenant for matters involving leases, security deposits, or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.	Primary residence only where you are the tenant. Does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord.
Home Equity Loans	This service covers the review or preparation of a home equity loan on the participant's primary residence.	Primary residence only.
Property Tax Assessment	This service covers the participant for review and advice on a property tax assessment on the participant's primary residence. It also includes filing the paperwork, gathering the evidence, negotiating a settlement, and attending the hearing necessary to prosecute an appeal of the assessment.	Primary residence only
Refinancing of Home (primary residence)	This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation, and taxation), which are involved in refinancing of or in obtaining a home equity loan on a participant's primary residence. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, rental property, or property held for business or investment.	Primary residence only. Does not include services by an attorney representing a lending institution or title company; or refinancing of a second home, vacation home, or property, or property held for business or investment.
Sale or Purchase of Home (primary residence)	This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the construction documents for a new home; the purchase agreement, mortgage, and deed; and documents pertaining to title, insurance, recordation, and taxation), which are involved in the purchase or sale of a participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business, or investment or leases with an option to buy.	Primary residence only. Does not include services by an attorney representing a lending institution or title company; or the sale or purchase of a second home, vacation home, or property, or property held for business or investment, or leases with an option to buy.

Service	What the Plan Attorney Provides	Limitations and Conditions
Security Deposit Assistance (primary residence – tenant only)	This service covers counseling the participant as a tenant in recovering a security deposit from the participant's residential landlord for the participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the participant for the small claims trial. This service does not include the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.	
Zoning Applications	This service provides the participant with the services of a lawyer to help get a zoning change or variance for the participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the participant, preparing applications, and preparing for and attending the hearing to change zoning.	Primary residence only.
Juvenile Court Defense	This service covers the defense of an associate's dependent child in any juvenile court matter, provided there is no conflict of interest with the associate, in which case this service provides an attorney for the associate only.	
Traffic Ticket Defense	This service covers representation of the participant in defense of any traffic ticket except driving under the influence or vehicular homicide, including court hearings, negotiation with the prosecutor, and trial.	Does not include driving under the influence (DUI) or vehicular homicide.
Restoration of Driving Privileges	This service covers the participant with representation in proceedings to restore the participant's driving license.	
Living Trusts, Living Wills, and Powers of Attorney	**Living Trusts** This service covers the preparation of a living trust for the participant. It does not include tax planning or services associated with funding the trust after it is created. **Living Wills** This service covers the preparation of a living will for the participant. **Powers of Attorney** This service covers the preparation of any power of attorney when the participant is granting the power.	Does not include tax planning or funding services for a trust after it is created. For a power of attorney, you must be granting the power.
Probate	Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee 10% less than the plan attorney's normal fee. It is the participant's responsibility to pay this reduced fee and all costs.	The plan attorney's fee is 10% less than his or her normal fee. You are responsible for paying this fee and all costs.
Wills and Codicils	This service covers the preparation of a will for the participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments.	Does not include tax planning.

Services Not Covered Under the Legal Services Plan

Services not listed are not provided. No services, not even a consultation, are provided for:

- Employment-related matters, including company or statutory benefits
- Matters involving Frontdoor, MetLife and affiliates, and plan attorneys
- Your spouse or dependents for matters in which there is a conflict of interest between you and your spouse or dependents
- Appeals and class actions
- Farm and business matters, including rental issues where you are the landlord
- Patent, trademark, and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters in which an attorney-client relationship existed before you became eligible for the plan

Plan Confidentiality, Ethics, and Independent Judgment

Your use of the plan and the legal services is confidential. The plan attorney is required to maintain strict confidentiality of the traditional attorney-client relationship. Your employer will not be informed of your legal problems or the services you use under the plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the plan.

The plan will **not** interfere with your plan attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the plan are subject to ethical rules established for lawyers. The attorney is required to adhere to the rules of the plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the plan. MetLife Legal Plans, Inc., or the law firm providing services under the plan, is responsible for all services provided by their attorneys.

You should understand that neither your employer nor the plan has any liability for the conduct, acts, or omissions of any plan attorney. You may have the right to file a complaint with the state bar concerning attorney conduct pursuant to the plan. You also have the right to retain at your own expense any attorney authorized to practice law in this state.

Plan attorneys may refuse to provide services if the matter is clearly without merit, frivolous, or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at **800-821-6400**. Your complaint will be reviewed, and you should receive a response within two business days of your call.

Other Special Rules

There are certain rules under the plan for special situations.

If other coverage is available to you:
If you are entitled to receive legal representation provided by any other organization, such as an insurance company or government agency, or if you are entitled to legal services under any other legal plan, this plan will not provide coverage. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this plan.

If you are involved in a legal dispute with your dependents:
You may need legal help with a problem involving your spouse or your children. In some cases, both you and your dependent may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation under the plan. Your dependent will not be covered.

If you are involved in a legal dispute with another associate:
If you or your dependents are involved in a dispute with another eligible associate or that associate's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

If the court awards attorneys' fees as part of a settlement:
If you are awarded attorneys' fees as part of a court settlement, you must repay the plan from this award for any attorneys' fees it paid.

Claims

How to File Claims for Health Care Expenses

Filing claims for medical, prescription drug, dental, and vision expenses is easy if you follow these steps.

When You Use Network Providers

You do not need to file a claim when you use in-network providers. In most cases, just show the provider your ID card and the provider will file the claim for you. Under the medical plans, the claims administrator processes your claim, sends your provider its payment, and sends you an Explanation of Benefits (EOB) statement that shows the amounts paid and any amounts you owe.

If You Use Providers Outside the Networks

If you use out-of-network providers, you will usually need to file a claim to receive benefits. To file a claim, follow these instructions.

Save Your Bills. Save all health care bills for you and your covered family members. Each bill should include the following:

- The full name of the person being treated
- The diagnosis of the illness or injury or explanation of treatment
- The date and description of the service received
- Any itemized charges
- The name and address of the provider performing the service
- For prescription drug claims, the Rx number and name of medication

Keep a Record of Expenses. Keep separate records of your expenses and those of each of your dependents, because benefits, deductibles, and maximum payments apply separately to each of you.

Obtain Claim Forms. To get claim forms, call the claims administrator (see pages 3 and 4) or print out the form from the claims administrator's website. Claim forms need to be filed separately with the appropriate claims administrator.

Reimbursement from Your Health Care Flexible Spending Account

Certain expenses that are not covered or not fully reimbursed from the health care plans may be eligible for reimbursement under the health care flexible spending account.

These charges might include deductibles, copayments, charges that are over and above plan limits and charges not covered by the health care plans.

Determine the Type of Claim. There are four types of health care claims, and the claim process varies with each type. The four types of claims are:

- **Post-service care claim.** A post-service care claim is a claim for a benefit that is made after you receive health care services.
- **Pre-service care claim.** A pre-service care claim is a claim for a benefit for which the plan requires approval before you receive the medical services or treatment (for example, preadmission review, predetermination of benefit, and/or notification of out-of-network services).

- **Urgent care claim.** An urgent care claim is any claim for health care or treatment for which the lack of immediate processing of the claim could seriously jeopardize the life or health of you or your covered dependent. The determination of the claim as an urgent care claim is made at the discretion of the claims administrator or may be characterized as such by the treating physician. This type of claim generally includes those involving emergency care. If you have an urgent care claim, you can initiate the claim yourself if you are able to do so, or your physician can file it for you.
- **Concurrent care claim.** A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

Make Copies of Your Claim Forms and Bills. The claims administrator cannot return original claims to you.

Submit the Claim. Submit the claim to the claims administrator address indicated on the claim form. Make sure you are submitting bills for which benefits are payable.

Benefits for in-network providers generally are paid directly to the provider. Otherwise, benefits usually are paid to you, and you are responsible for paying the provider.

Important!
Be sure to file your claim as soon as possible after you incur health care expenses. The plans will not pay benefits if you do not submit your claims within 12 months from the date of service.

Coordination of Benefits/Maintenance of Benefits

Coordination with Other Health Care Plans

The medical and dental plans are coordinated with other group insurance plans to which you or your covered dependents belong. This means that all plans together pay no more than 100% of health care expenses.

Coordination of benefits does not apply to individual or private insurance policies maintained by you.

Here's how benefits are coordinated when a claim is made:

It's a Crime!
It's a crime to knowingly make false statements or provide misleading information with intent to defraud or deceive Frontdoor or a claims administrator.

If you file a claim that contains false, incomplete, or misleading information, a plan may reduce or deny your claim or cancel your coverage from the original effective date.
A plan may also prosecute these cases under the law.

- First, the primary plan pays its benefits without regard to any other plan.
- Then, the secondary plan adjusts its benefits so that the total benefit available will not be greater than the allowable expense of the secondary plan.
- No plan pays more than it would without the coordination provision.
- The following provisions determine which plan is primary (and pays benefits first):
    - A plan without a coordination provision is always the primary plan.
    - The plan covering the patient as an associate rather than as a dependent will be the primary plan.

If a child is covered under both parents' plans, the plan of the parent whose birthday is earlier in the year pays first. The plan of the parent whose birthday is second during the year pays second. If both parents' birthdays fall on the same date, the plan of the parent who has worked at his or her company longer is the primary plan.

If the parents are divorced and there is no court decree that establishes financial responsibility, the plan covering the parent who has custody of the child is the primary plan.

When Frontdoor's health care plan is the primary plan, it pays the benefits described in this guide. When Frontdoor's health care plan is the secondary plan, it first calculates the benefit described in this guide, and then subtracts the benefit payable from the primary plan.

Coordination with Medicare

If you or a dependent are eligible for Medicare, your benefits from the Frontdoor medical plan and Medicare are coordinated. While you are an active associate, the Frontdoor plan usually is primary and Medicare is secondary. If you or a dependent have end-stage renal disease and qualify for Medicare, Medicare coverage is primary.

When Frontdoor's medical plan provides primary coverage, it pays the benefits described in this guide. If Medicare provides primary coverage, your medical benefits from Frontdoor's plan are reduced by any benefits payable from Medicare whether or not you actually enroll for Medicare or receive benefits. It's important to enroll for Medicare Part A, Part B, and Part D as soon as you are eligible.

How to File Other Benefit Claims

Disability Benefits

Contact Your Supervisor

Be sure to call your supervisor as soon as possible if you cannot be at work because of an illness or injury. You must be on an approved leave of absence to receive STD benefits. To request a leave of absence or file a disability claim, call Prudential at877-367-7781. You should keep your supervisor informed at all times about when you expect to return to work.

Short-Term Disability (STD) Claims

You must call Prudential or log on to Prudential website to file a claim for STD benefits. Generally, it takes several days to process a STD claim, so you should call as soon as you think you will be absent for more than seven days but no later than 90 days from your disability date. When you file your claim, Prudential will ask you to provide information so they can contact your doctor to confirm your disability.

Long-Term Disability (LTD) Claims

As soon as your doctor thinks that your disability may last three months or longer, you should start the process of filing an LTD claim by contacting Prudential by phone or online. Generally, you should start this process within 30 days for a serious disability, and no longer than 90 days after your elimination period. If you do not file a claim for benefits on a timely basis, benefits could be delayed or denied.

If necessary, Prudential will send you a claim form for LTD benefits. To complete the LTD claim, information may be requested from you, your physician, and/or the Frontdoor People Support Center.

Apply for Social Security and Other Disability Income Benefits

Social Security disability benefits are payable after six months of disability. It can take several months to process a Social Security claim, so it's a good idea to apply as soon as you think your disability may last for at least six months. You should contact your local Social Security office to apply for these benefits.

When You File Disability Claims
You'll need to provide the following:

- Proof that you're under the regular care of a physician
- Documentation of your monthly earnings
- The date your disability began, the cause of the disability, and the extent of the disability (including restrictions and limitations preventing you from performing your regular occupation)
- Names and addresses of all attending physicians, hospitals, or institutions where you have received treatment
- Other information requested by Prudential

Taxes on Your Benefits
Because your STD benefits are paid for by Frontdoor, you are responsible for the taxes on any benefit you receive.

Because you pay your LTD premiums with after-tax dollars, you do not pay taxes on your LTD benefits.

You should always apply for workers' compensation if your disability is related to your work. Workers' compensation benefits are provided under state laws, and they vary from state to state. Be sure to review the lists of other disability income sources that the STD and LTD benefits take into account and apply for any other benefits for which you may be entitled. As with Social Security, it can take some time to file these claims, so you should apply as soon as possible.

When you know the amount of your Social Security, workers' compensation, or other benefits, or if your claim for Social Security benefits or other benefits that you think you're entitled to receive is denied, contact Prudential. Prudential may be able to help you with your claims for other disability benefits.

Your STD and LTD benefits will be reduced by any state disability program. Prudential may estimate the amount of your state disability benefits and reduce your STD and LTD benefits by that estimate.

If you do not apply for Social Security benefits when eligible, Prudential may estimate the amount of your Social Security benefits and reduce your LTD benefits by that estimate. Your LTD benefit will be adjusted accordingly when you provide Prudential with required information concerning the approval or denial of your claim for Social Security. All statutory claims should be called in directly to the state and to Prudential.

Source of Payments

STD and LTD benefits are paid through an insurance policy with Prudential.

Life, AD&D, and BTA Insurance

If you or a dependent has a covered loss under life insurance, dependent life insurance, or accidental death and dismemberment, you or the beneficiary should notify Prudential at 800-524-0542 Prudential will then send you or the beneficiary a claims package to complete and request other information be sent to Prudential. This information will include a death certificate and in some cases the insurance company may require additional information in support of a claim, including an autopsy. For losses other than death, your doctor will need to complete a section of the form and the insurance company may want the names of all hospitals and doctors who have treated you.

If you or a dependent has a covered loss under business travel accident, you or the beneficiary should call Zurich at **866-263-0261** to request a claim form. To file a claim, complete the form and return it to Zurich along with proof of the covered loss.

Claims should be filed within 90 days following death or other loss.

If you become totally disabled prior to turning age 60, you will receive an application to continue your basic and supplemental life insurance coverage from Frontdoor after you have been disabled for four months. You will be required to complete the application and return it to Prudential along with any required proof that Prudential requests.

Source of Payments

Life insurance and AD&D insurance benefits are paid through insurance policies with Prudential, and business travel accident insurance benefits are paid through an insurance policy with Zurich.

Life and AD&D insurance can be paid in a lump sum or through the establishment of an account from which a beneficiary can make withdrawals. Business travel accident insurance is paid in a lump sum.

Health Care and Dependent Day Care Flexible Spending Accounts

If you participate in the health care or dependent day care flexible spending accounts, you only need to file a claim when you pay for an expense out-of-pocket. You can only file claims for eligible expenses. For a list of eligible expenses, see pages 88 and 103 of the Flexible Spending Accounts section in this guide.

To file a claim, obtain a claim form online at **www.smartchoiceaccounts.com** or call **833-769-4782** to have one mailed to you. Fax or mail the completed form as instructed on the form. You must provide appropriate proof of the expense along with your claim form.

Acceptable Proofs of Expense

For some health care expenses, you must provide a receipt, bill, invoice, Explanation of Benefits (EOB) or other document that clearly indicates the expense is eligible.

Some health care expenses require, in addition to the above, a written statement from your provider indicating the diagnosis and the medical necessity of the expense. Two examples are exercise equipment and massage therapy.

Certain health care expenses require both of the above types of proof, plus proof of a difference in cost between standard care or services and specialized care or services. An example is modified equipment. Only the difference in cost will be reimbursed if the expense is approved.

You will find the kinds of proof needed for each type of expense shown in the list of eligible health care expenses on page 88 of the Flexible Spending Accounts section in this guide.

For all dependent day care expenses, you must provide at least one of the following:

- Your provider's signature on your claim form.
- A photocopy of your canceled check (front and back)
- A formal or informal statement or bill from your provider

You have until March 15 of the following plan year to incur expenses that can be reimbursed from your health care flexible spending account and until May 31 of the following plan year to submit your health care claims. Per IRS regulations, you will forfeit any money left in your account for which you do not file a claim by May 31.

You have until December 31 of the current plan year to incur expenses that can be reimbursed from your dependent day care flexible spending account and until May 31 of the following plan year to submit your dependent day care flexible spending claims. Per IRS regulations, you will forfeit any money left in your account for which you do not file a claim by May 31.

Save Your Receipts
Save all your receipts, bills, invoices, and any other documentation of expenses reimbursed through your account. You are responsible for providing proof that you incurred an expense and that it was eligible.

What Is a "Claim"?
A "benefit claim" is a request for a particular benefit under a plan (for example, a claim for a certain type of surgery under the medical plan).

A benefit claim typically includes your initial request for benefits. Benefit claims are filed with the claims administrator according to the procedures outlined earlier in this section.

If Your Contributions Stop

If your contributions to the health care flexible spending account stop during the year for any reason, only expenses that you incur before your participation ends are eligible for reimbursement. You forfeit any remaining balance.

If your contributions to the dependent day care flexible spending account stop during the year for any reason, you can continue to submit claims for expenses incurred before your participation ended, up to the amount of the remaining balance.

Legal Services Plan

The legal services plan covers all eligible services in full. You do not need to file a claim for reimbursement if you use network attorneys.

Frontdoor LifeManagement Program

Frontdoor pays the full cost of covered services under the LifeManagement Program. You pay no costs for services, and you do not have to file any claims. In addition, there are no copayments, coinsurance, or deductibles.

If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See *Claim Review and Appeal Process* on page 169.

Claim Review and Appeal Process

The plans have a claim review process that is followed whenever you submit a benefit claim.

Initial Decision

When you file a claim, the claims administrator reviews the claim and, in accordance with plan provisions, either approves or denies the claim (in whole or in part). The claims administrator will notify you of this action. In some situations, the plan may need an extension of time to process the claim (for example, if the plan needs additional information). In these cases, you'll be notified of the extension and the additional information needed as described in the chart below.

When You Receive the Initial Notification

Type of Claim	Notice of Claim Decision or Extension	Extension Rules
Health care claims (medical, prescription, vision, and dental): **Urgent care claim.** An "urgent care claim" is a claim for medical care or treatment where a delay in making a determination: • Could jeopardize the life or health of you or your dependent; • Could jeopardize the ability of you or your dependent to regain the maximum function; or • In the opinion of your or your dependent's physician, would subject you or your dependent to severe pain that could not be adequately managed without the requested treatment.	As soon as possible and within 24 hours (unless insufficient information is provided)	If additional information is needed, you'll be notified within 24 hours as to what additional information is needed, and you'll have a reasonable amount of time (not less than 48 hours) to provide the information. You'll then be notified of the plan's decision as soon as possible, but not later than 48 hours after the plan receives the additional information or 48 hours after the end of the period you're given to provide the additional information (whichever is earlier).
Concurrent care decisions. "Concurrent care decisions" are decisions for treatment over a period of time or for a specified number of treatments. Examples include an extended number of days in a hospital, an extended number of physical therapy treatments, or a situation where the plan reduces the number of treatments previously agreed upon.	Within 30 days	If necessary, the period can be extended for 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have 45 days to provide the information. If the concurrent care is considered urgent, it will fall under the urgent care rules.
Pre-service claims. A "pre-service claim" is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include preauthorization for hospital stays, second surgical opinions, etc.	Within 15 days	If necessary, the period can be extended for an additional 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have 45 days to provide the information.

Type of Claim	Notice of Claim Decision or Extension	Extension Rules
Post-service claims. A "post-service claim" is any claim that is processed after a service is provided.	Within 30 days	If necessary, the period can be extended for an additional 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have 45 days to provide the information.
Disability claims	Within 45 days	If necessary, the period can be extended two times for up to 30 days each. The extension notice(s) will explain the standards upon which eligibility is based, the unresolved issues that prevent a decision, and any additional information needed to resolve the issues. You'll have 45 days to provide the information.
Health care and dependent day care flexible spending account claims	Within 30 days	If necessary, the period can be extended for an additional 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have 45 days to provide the information.
Legal services claims Although you do not typically have to submit a claim for coverage, if coverage is denied, you can request an explanation in writing.	Within 30 days	Not applicable
All other claims Life, AD&D, and BTA insurance)	Within 90 days	If special circumstances require an extension, the period can be extended for an additional 90 days.

Claim Denial Notice

If your claim is denied, you will receive a written notice that explains:

- The specific reasons for the denial.
- The plan provisions on which the denial is based. If an internal rule, guideline, or protocol was relied upon to determine a health or that you can request a copy free of charge. If the denial is based on a provision such as what is considered a covered health service, experimental treatment, or a similar exclusion or limit, you'll receive an explanation of the scientific or clinical judgment for the determination based on the terms of the plan and your medical circumstances, or a statement that you can receive the explanation free of charge.
- A description of any additional material or information needed and an explanation of why it is necessary.
- An explanation of the plan's claim review procedures, applicable time limits, and your rights to bring a civil action following a denial (for an urgent care claim under a health care plan, an explanation of the expedited claim review procedure).
- In the case of an urgent care claim, the plan can notify you by phone or fax and follow up with a written notice.

Appeal for Review if Your Claim Is Denied

After receiving the notice, you, your beneficiary, or your legal representative can ask for a full and fair review of the decision by writing to the claims administrator. You must make this request within 180 days for a health care, dental, flexible spending account, or disability claim or within 60 days for all other claims. Note: See Grievance Procedure for details about filing an appeal on health care claims. During the 60- or 180-day period, you or your authorized representative will be given reasonable access to documents and information relevant to the claim, and you can request copies free of charge. You can also submit written comments, documents, records, and other information to the claims or plan administrator.

For an urgent care claim, information can be provided by phone or fax.

In most cases, you'll receive the claims or plan administrator's decision within the following time frames:

Type of Claim	Notice of Decision or Extension
Disability claims	Within a reasonable time, but not later than 45 days after receipt of your request for review. If necessary, the period can be extended for an additional 45 days.
All other claims (dental, flexible spending accounts; legal services; and Life, AD&D, and BTA insurance)	Within a reasonable time, but not later than 60 days after receipt of your request for review (30 days for dental and legal services claims). If necessary, the period can be extended for an additional 60 days.

Grievance Procedure for Health Care Claims

Introduction

BlueCross BlueShield of Tennessee's Grievance Procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with the Plan. Such disputes include: any matters that cause you to be dissatisfied with any aspect of your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other Claim, controversy, or potential cause of action you may have against the Plan. Please contact the customer service department at the number listed on the membership ID card: (1) to file a Claim; (2) if you have any questions about this SPD or other documents related to your coverage (e.g., an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a dispute.

This Procedure is the exclusive method of resolving any dispute. Exemplary or punitive damages are not available in any grievance or litigation, pursuant to the terms of this SPD. Any decision to award damages must be based upon the terms of this SPD. The Procedure can only resolve disputes that are subject to our control. You cannot use this Procedure to resolve a claim that a provider was negligent. Network providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of your relationship with providers.

This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims ("Claims") that are in the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation").

An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered service. If a provider does not render a service or reduces or terminates a service that has been rendered, or requires you to pay for what you believe should be a covered service, you may submit a Claim to BlueCross BlueShield of Tennessee to obtain a determination concerning whether the Plan will cover that service. Providers may be required to hold you harmless for the cost of services in some circumstances.

Providers may also appeal an Adverse Benefit Determination through our provider dispute resolution procedure.

A Plan determination will not be an Adverse Benefit Determination if: (1) a provider is required to hold you harmless for the cost of services rendered; or (2) until a final Adverse Benefit Determination has been rendered in a matter being appealed through the provider dispute resolution procedure. You may request a form from the Plan to authorize another person to act on your behalf concerning a dispute.

BlueCross BlueShield of Tennessee, the Plan, and you may agree to skip one or more of the steps of this Procedure if it will not help to resolve the dispute. Any dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Administrative Services Agreement (ASA), and this SPD.

Description of the Review Procedures

Inquiry

An inquiry is an informal process that may answer questions or resolve a potential dispute. You should contact the customer service department if you have any questions about how to file a Claim or to attempt to resolve any dispute. Making an inquiry does not stop the time period for filing a Claim or beginning a dispute. You do not have to make an inquiry before filing a grievance.

First Level Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination or take a requested action to resolve another type of dispute (your "Grievance"). You must begin the dispute process within 180 days from the date BlueCross BlueShield of Tennessee issues notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing you to be dissatisfied with the Plan. If you do not initiate a grievance within 180 days of when BlueCross BlueShield of Tennessee issues an Adverse Benefit Determination, you may give up the right to take any action related to that dispute.

Contact the customer service department at the number listed on your membership ID card for assistance in preparing and submitting your Grievance. They can provide you with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory. BlueCross BlueShield of Tennessee is a limited fiduciary for the first level Grievance.

1. **Grievance Process**
   After we have received and reviewed your Grievance, our first level Grievance committee will meet to consider your Grievance and any additional information that you or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service claims, we will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning your dispute are not eligible to be voting members of the first level Grievance committee or reviewers. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Plan is not otherwise governed by ERISA.

2. **Written Decision**
   The committee or reviewers will consider the information presented, and you will receive a written decision concerning your Grievance as follows:
   (a) For a pre-service claim, within 30 days of receipt of your request for review;
   (b) For a post-service claim, within 60 days of receipt of your request for review; and
   (c) For a pre-service, urgent care claim, within 72 hours of receipt of your request for review.

The decision of the Committee will be sent to you in writing and will contain:

(a) A statement of the committee’s understanding of your Grievance;
(b) The basis of the committee’s decision; and
(c) Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

Second Level Grievance

You may file a written request for reconsideration with us within ninety (90) days after we issue the first level Grievance committee's decision. This is called a second level Grievance. Information on how to submit a second level Grievance will be provided to you in the decision letter following the first level Grievance review.

If the Plan is governed by ERISA, you also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA ("ERISA Actions") after completing the mandatory first level Grievance process.

The Plan may require you to exhaust each step of this procedure in any dispute that is not an ERISA action.

Your decision concerning whether to file a second level Grievance has no effect on your rights to any other benefits under the Plan. If you file a second level Grievance concerning an ERISA action, the Plan agrees to toll any time defenses or restrictions affecting your right to bring a civil action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning your dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

1. **Grievance Process**
   You may request a telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if you do not want to participate in a hearing concerning your Grievance. If you wish to participate, our representatives will contact you to explain the hearing process and schedule the time, date and place for that hearing.

   In either case, the second level committee will meet and consider all relevant information presented about your Grievance, including:

   (a) Any new, relevant information that you submit for consideration; and
   (b) Information presented during the hearing. Second level Grievance committee members and you will be permitted to question each other and any witnesses during the hearing. You will also be permitted to make a closing statement to the committee at the end of the hearing.

2. **Written Decision**
   After the hearing, the second level committee will meet in closed session to make a decision concerning your Grievance. That decision will be sent to you in writing. The written decision will contain:

   (a) A statement of the second level committee's understanding of your Grievance;
   (b) The basis of the second level committee's decision; and
   (c) Reference to the documentation or information upon which the second level committee based its decision. Upon written request, we will send you a copy of any such documentation or information, without charge.

Independent Review of Medical Necessity Determinations

If your Grievance involves a Medical Necessity determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance followed by completion of the second level Grievance, you may request that the dispute be submitted to a neutral third party, selected by us, to independently review and resolve such dispute(s). If you request an independent review following the mandatory first level Grievance, you waive your right to a second level Grievance and your right to present oral testimony during the Grievance process. Your request for independent review must be submitted in writing within 180 days after the date you receive notice of the decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the decision.

Any person involved in making a decision concerning your dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on your rights to any other benefits under the Plan. If you request independent review of an ERISA action, we agree to toll any time defenses or restrictions affecting your right to bring a civil action against Frontdoor or the Plan, until the independent reviewer makes its decision.

The Frontdoor will pay the fee charged by the independent review organization and its reviewers if you request that the Plan submit a dispute to independent review. You will be responsible for any other costs that you incur to participate in the independent review process, including attorney's fees.

We will submit the necessary information to the independent review entity within 5 business days after receiving your request for review. We will provide copies of your file, excluding any proprietary information to you, upon written request. The reviewer may also request additional medical information from you. You must submit any requested information, or explain why that information is not being submitted, within 5 business days after receiving that request from the reviewer.

The reviewer must submit a written determination to us, and we will submit the determination to you within 45 days after receipt of the independent review request. In the case of a life-threatening condition, the decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by us or you.

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this SPD and the ASA; (2) your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of coverage of the Administrative Services Agreement (ASA).

Notice of Benefit Determination Appeal

If your appeal is denied, the plan will send you a statement containing the following:

- Specific reasons for the denial
- Specific references to pertinent plan provisions
- A statement indicating that you can have access to receive, upon request and at no charge, copies of document, records, and information relevant to your claim
- A statement describing your right to bring an action in federal court under Section 502(a) of ERISA

In addition to the information above, if your claim is a disability claim, the notice will contain any information regarding an internal rule, guideline, or protocol used in making the decision, and an explanation of the scientific or clinical judgment used in the denial. If the notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge.

Depending on the plan, there may be an additional review before a final decision is made. If an additional review is available, the denial notice will outline your rights and responsibilities for the final review.

Note: You cannot start a legal proceeding against the Plan, Frontdoor, the claims administrator, or any other fiduciary unless you first follow the claim appeal procedures. All actions and claims for benefits filed in a court shall be determined based upon a review of the administrative record which was presented to or considered by the claims administrator during the claim procedure process and all other records that were before the claims administrator when the claim was decided, and no person shall be entitled to a trial de novo before any court whereby that person is claiming entitlement to benefits under this plan.

No legal proceeding can be maintained against the Plan, Frontdoor, the claims administrator, or any other fiduciary after two (2) years following the first of the following to occur: (i) the occurrence of the event(s) giving rise to the claim, or (ii) the date on which the claim was originally filed with the claims administrator; provided, however, that if a shorter period is provided under the actual plan documents and contracts with insurers for the benefits plans, then such shorter period shall apply with respect to the applicable benefit plans.

Dependent Verification Appeals

Level 1 Appeals

The plans have an appeal process that is followed, in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), whenever you submit a dependent verification appeal.

A Level 1 Appeal may be filed with the Frontdoor Claims and Appeals Management Team (appeal administrator) in the following instances:

- You missed the deadline to provide documentation to verify your dependent(s') eligibility for coverage
- You failed to provide complete documentation to verify your dependent(s') eligibility during the dependent verification period

When you file a Level 1 Appeal, the Frontdoor Claims and Appeals Management Team reviews the claim and, in accordance with plan eligibility provisions and verification document requirements, either approves or denies the claim (in whole or in part). The appeal administrator will notify you in writing of this action. In some situations, the administrator may need an extension of time to process the claim (for example, if the administrator needs additional information). In these cases, you'll be notified in writing of the extension and the additional information needed.

If the Level 1 Appeal is filed within 60 days of the dependent coverage cancellation date and the dependent(s') eligibility is verified based on the documentation submitted with the appeal, coverage for the verified dependent(s) will be reinstated back to the date coverage originally ended.

If the Level 1 Appeal is filed more than 60 days after the dependent coverage cancellation date and the dependent(s') eligibility is verified based on the documentation submitted with the appeal, coverage for the verified dependent(s) will be reinstated effective as of the date the appeal was submitted to the appeal administrator.

Filing a Level 1 Appeal

To file a Level 1 Appeal with the Frontdoor Claims and Appeals Management Team, you must submit a Dependent Verification Claim Initiation Form to the address below:

Frontdoor Claims Appeals Management Team
P.O. Box 660114
Dallas, TX 75266-0114

Dependent Verification Claim Initiation Forms may be requested by calling the Frontdoor People Support Center at **866-851-1211**.

Level 2 Appeals

If a Level 1 Appeal is denied by the Frontdoor Claims and Appeals Management Team, you have 180 days from the date of the Level 1 Appeal denial to file a Level 2 Appeal with the Frontdoor Benefits Department.

If the Level 2 Appeal is filed within 180 days of the Level 1 Appeal denial and the dependent(s') eligibility is verified based on the documentation submitted with the appeal, coverage for the verified dependent(s) will be reinstated based upon the date the Level 1 Appeal was received.

If the Level 1 Appeal was received within 60 days of the original dependent coverage cancellation date, the coverage will be reinstated back to the date coverage originally ended.

If the Level 1 Appeal is received more than 60 days after the original dependent coverage cancellation date, the coverage will be reinstated back to the date the Level 1 Appeal was received.

Filing a Level 2 Appeal

To file a Level 2 Appeal with the Frontdoor Benefits Department, you must submit a written appeal letter with the required dependent verification documentation to the address below:

Frontdoor Benefits Department – Dependent Verification Appeals
150 Peabody Place
Memphis, TN 38103-3720

benefits@frontdoorhome.com

If you need additional information, please contact the Frontdoor People Support Center at **866-851-1211**.

Right of Recovery and Subrogation

Right of Recovery

Frontdoor and the benefit plans have the right to recover any overpayments due to errors or to fraud. If you receive an overpayment, it's important to notify the Frontdoor People Support Center as soon as possible. You'll be responsible for repaying any overpayments.

Subrogation Rights

Subrogation rights apply when another party is responsible for your injury or illness and one of our plans pays benefits for that illness or injury**.** For example, if you are injured in an automobile accident, you may receive medical, dental, and disability benefits as a result of the accident. If the accident is the fault of another party, Frontdoor and the benefit plans have the right to recover amounts paid to you from the third party.

In this case, the Frontdoor medical plan has the right to recover those benefit amounts from funds that you or your dependent receives from the responsible third party, whether or not you believe that you have been fully compensated for your losses. The medical plan also has the right to recover amounts directly from the responsible third party. The plan will be subrogated to all claims, demands, actions, and right of recovery against any entity, including third parties and insurance companies, to the fullest extent of the plan's right of recovery. You and your dependents must notify the plan administrator, in writing, of whatever benefits are paid under this plan that may be subject to subrogation by the plan. You are required to cooperate with the plan administrator and produce any documents or papers and do whatever else is necessary to ensure this right of recovery.

Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the plan shall have first lien and right to reimbursement. The plan's first lien supersedes any right that you may have to be "made whole". In other words, the plan is entitled to the right of first reimbursement out of any recovery you might procure regardless of whether you have received compensation for any of your damages or expenses, including your attorneys' fees or costs. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. In addition, you agree to do nothing to prejudice or oppose the plan's right to subrogation and reimbursement and you acknowledge that the plan precludes operation of the "made-whole", "attorney-fund", and "common-fund" doctrines. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

- Any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from Your own insurance and/or from the third party (or their insurance)
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured motorist coverage
- Business and homeowner medical liability insurance coverage or payments

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from those members. This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether the ,ember is a minor. This priority right of reimbursement will not be reduced by attorney fees and costs you incur. The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available insurance coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Plan Administration

How the Plans Are Administered

The information in this section is required by law. It includes information about how your benefits are administered and your legal rights.

Here are details about how the plans are administered.

Plan Sponsor and Administrator

The plans are sponsored by and administered by:

Frontdoor
150 Peabody Place
Memphis, TN 38103-3720

901-701-5369

The plan administrator has discretionary authority to interpret the terms of the plans and to determine eligibility and entitlement to plan benefits in accordance with those terms. The plan administrator makes decisions and resolves conflicts regarding claims for benefits, the operation of the plans, and the interpretation of plan terms. In certain instances, Frontdoor has delegated some of these responsibilities and authorities to third parties, including claims administrators listed in the chart on pages 181 and 182.

Employer Identification Number

Frontdoor's employer identification number is 13-2686654.

Plan Year

All of the plans operate on a calendar-year basis, beginning January 1 and ending December 31.

Agent for Service of Legal Process

Frontdoor is the agent for service of legal process on the plans. The address is:

Frontdoor
Attn: General Counsel
150 Peabody Place
Memphis, TN 38103-3720

901-701-5261

Service of legal process can also be made upon the plan administrator.

Types of Plans/Plan Identification

The chart below shows the plan name and the plan number for each of our benefit plans. The plan name, plan number, and Frontdoor's EIN identify the plan with the federal agencies governing benefit operations. The chart also lists the claims administrators that make benefit payments as authorized by the plan.

Formal Plan Name	Informal Name/ Description	Plan Number	Insurance Company	Claims/Third-Party Administrator	Plan Funding
The Frontdoor Health and Welfare Benefit Plan	Medical Program	501	None. The plan is self-funded by Frontdoor.	BlueCross BlueShield of Tennessee Claims One Cameron Hill Circle Chattanooga, TN 37402	Frontdoor and associate before-tax contributions
The Frontdoor Health and Welfare Benefit Plan	Prescription Drug Program	501	None. The plan is self-funded by Frontdoor.	Express Scripts Inc. Attn: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872	Frontdoor and associate before-tax contributions
The Frontdoor Health and Welfare Benefit Plan	Dental PPO Program	501	Delta Dental of Tennessee	Delta Dental of Tennessee 240 Venture Circle Nashville, TN 37228-1604	Associate before-tax contributions
The Frontdoor Health and Welfare Benefit Plan	Vision Program	501	Combined Insurance Company of America	EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111	Associate before-tax contributions
The Frontdoor Company Cafeteria Plan					
	Health Care Flexible Spending Account Dependent Day Care Flexible Spending Account* Health Savings Account*	501	None	Your Spending Account P.O. Box 785040 Orlando, FL 32878	Associate before-tax contributions
The Frontdoor Health and Welfare Benefit Plan	Short-Term Disability	501	Prudential	Prudential	Frontdoor

Formal Plan Name	Informal Name/ Description	Plan Number	Insurance Company	Claims/Third-Party Administrator	Plan Funding
The Frontdoor Health and Welfare Benefit Plan	Long-Term Disability	501	Prudential	Prudential	Associate after-tax contributions
The Frontdoor Health and Welfare Benefit Plan	Basic Life Supplemental and Dependent Life	501	Prudential	Prudential	Frontdoor Associate after-tax contributions
The Frontdoor Health and Welfare Benefit Plan	AD&D	501	Prudential	Prudential	Associate after-tax contributions
The Frontdoor Health and Welfare Benefit Plan	Business Travel Accident	501	Zurich American Insurance Company	Zurich American Insurance Company 1400 American Lane Schaumberg, IL 60196	Frontdoor
The Frontdoor Health and Welfare Benefit Plan	Legal Services Plan	501	Metropolitan Life Insurance Company	MetLife Legal Plans 1111 Superior Avenue Cleveland, OH 44114-2407	Associate after-tax contributions
The Frontdoor Health and Welfare Benefit Plan	Frontdoor LifeManagement Program	501	Magellan Health Services	Magellan Health Services, Inc. 55 Nod Road Avon, CT 06001	Frontdoor

Privacy of Health Information

Frontdoor, along with all of the administrators for our plans (plan administrators, claims administrators, or insurance companies), follow privacy standards as required by law. The administrators may disclose information to Frontdoor for the purpose of carrying out plan administration functions; obtaining premium bids for providing health insurance coverage; or modifying, amending, or terminating a plan. Usually the administrators provide health information only in summary format, so information about a particular person's health or treatment cannot be identified. However, in the event a person's individual health information can be identified, Frontdoor will not use or disclose the information for employment-related actions, decisions in connection with other benefits, or any reason other than what is permitted by law. The law also gives you the right to review protected health information, to amend that information, and to receive a detailed notice of Frontdoor's privacy standards. The notice is sent to all associates automatically. You may request an additional copy of the notice by calling the Frontdoor People Support Center at **866-851-1211.**

Continuation of Health Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Health and Welfare Coverage

If you are absent from work because of your service in the uniformed services (including Reserve and National Guard duty) and you are on an approved military leave of absence, you can continue health and welfare coverage for yourself and your covered dependents under the provisions of the Frontdoor Military Reservist Policy.

Notification of Uniformed Service

You must notify your manager that you will be absent from employment due to military service under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable.

Continuation of Benefits While on a Military Leave of Absence

If you are absent from work and on an approved military leave of absence because of your service in the uniformed services (including Reserve and National Guard duty), the following explains what happens to your health and welfare benefits (medical, dental, vision, life, AD&D, legal services plan, disability coverage, and your participation in the flexible spending accounts).

You may continue to participate in the Frontdoor health and welfare benefits for up to six months from the date of your military leave. You will receive monthly Direct Billing and Payment notices from the Frontdoor People Support Center. To continue benefits, you (or your responsible party) must submit benefit premium payments to the Frontdoor People Support Center. During your approved leave, the company will continue to pay its portion of the applicable benefit premiums.

Continuation of Medical, Dental, and Vision Under USERRA

Once your benefits end under the Frontdoor Reservist Policy, you may continue medical, dental, and vision benefits under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Paying for Coverage

You may be required to pay all or a portion of the cost of your coverage.

If your military service is 30 days or less: You are required to pay no more than your usual share of the cost for this period of coverage.

If your military service is more than 31 days: You must pay the entire cost of the coverage (not to exceed 102% of the applicable premium, similar to the manner in which the cost for COBRA continuation coverage is calculated).

How Long Coverage Continues

Generally, the length of time coverage continues depends on the date your military leave of absence begins:

Date Military Leave Starts	Length of USERRA Coverage Continuation
Before December 10, 2004	18 months
On or after December 10, 2004	24 months

When you are discharged, you are required to apply for a return to work within a certain period of time, depending on the length of your uniformed service. If you do not apply for a return to work within these time frames, your coverage will end on the next day. Here are the time frames for applying to return to work:

If your uniformed service is 30 days or less: You are generally required to apply to return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)

If your uniformed service is between 31 and 180 days: You are generally required to apply to return to work within 14 days of your discharge.

If your uniformed service is at least 181 days: You are generally required to apply to return to work within 90 days of your discharge.

Generally, an exclusion or waiting period cannot be imposed on you in connection with the reinstatement of your health and welfare coverage upon reemployment. However, such an exclusion or waiting period can be imposed if it relates to an illness or injury that was incurred in, or aggravated during, performance of service in the uniformed service.

Your Rights Under ERISA

As a participant in the Frontdoor Health and Welfare Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which are listed below.

Receive Information About Your Plan and Benefits

As a plan participant, you are entitled to:

Examine, without charge, at the plan administrator’s office and at other specified locations, such as work sites, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator can make a reasonable charge for the copies.

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

If you or your dependents lose health coverage as a result of a qualifying event, you or your dependents have the right to continue health care coverage. You or your dependents may have to pay for such coverage. For rules governing your COBRA continuation coverage rights, see page 20 of the participation section or the plan documents governing the plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the individuals responsible for the operation of the plans. The individuals who operate your plans, called “fiduciaries” of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Claim Review

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done; to obtain, without charge, copies of documents relating to the decision; and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from a plan and do not receive it within 30 days, you can file suit in a federal court. In such a case, the court can require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. In addition, if you disagree with a plan's decision or lack thereof concerning the qualified status of a domestic relations order, you can file suit in a federal court.

If it should happen that plan fiduciaries misuse a plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court can order the person you have sued to pay these costs and fees. If you lose, the court can order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the plan, you should call the Frontdoor People Support Center at **866-851-1211** or contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact one of the following:

The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory (or call **866-444-3272** to obtain the address and phone number).

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

The Plan Documents as Final Authority

This guide covers the main points of the benefit plans in general terms. This summary is not intended to cover every plan detail. If any discrepancy ever should exist between this or any summary and the provisions of the plan documents, the plan documents would control. You can contact the plan administrator for the plan documents.

Glossary

Active Work or Actively at Work
You are an active associate, or actively at work, if you are at work performing the essential functions of your job on a full-time basis. You are also considered actively at work if you are away from work due to a holiday or vacation, and you are not considered to be disabled. If you are away from work due to a disability, you are considered to be actively at work for the medical, dental, vision, and legal services plans, flexible spending accounts and health savings account. You are not considered to be actively at work if you are absent because of a temporary layoff or leave of absence.

AD&D Insurance
Accidental death and dismemberment insurance that pays benefits if you should die or be dismembered in a covered accident.

After-Tax Contributions
Payment of your share of coverage costs by payroll deduction after federal income, Social Security, and, if applicable, state income taxes are calculated on the full amount of your pay.

Open Enrollment Period
A period that occurs on an annual basis (generally in the fall), during which you can make or change benefit elections for the next plan year.

Arrears
Benefit deduction amounts that accumulate if you are in an active employment status but do not receive enough gross wages to cover the full cost of your benefit premiums. Arrears are deducted at a rate of 50% of your standard benefit premium rate. This additional 50% is added to your standard benefit deduction until the arrears balance has been paid in full.

Before-Tax Contributions
Payment of your share of coverage costs by payroll deduction before federal income, Social Security, and, if applicable, state income taxes are calculated and deducted. This lowers your taxable pay and reduces your payroll taxes.

Beneficiary
A person whom you designate to receive your life insurance and/or AD&D benefits when you die. You may also designate a beneficiary to your health savings account (HSA) to ensure that your assets are properly assigned in the event of your death. You are automatically the beneficiary for dependent life insurance and dependent AD&D insurance.

Claims Administrator
A company that reviews, processes, and/or pays health care claims.

Coinsurance
The percentage you are responsible for once the plan pays the covered amount for the services received. For example, if the plan pays 80% for a covered service, the remaining 20% is your coinsurance.

Copayment
The amount you are responsible for paying the provider at the time you receive certain health care services.

Cosmetic Surgery or Treatment (Medical, Prescription, and Disability Plans)
Procedures or treatment to alter appearance but not to restore or improve impaired physical function.

Covered Health Services
Those health services, including services, supplies, or pharmaceutical products, which are provided for the purpose of preventing, diagnosing, or treating sickness, injury, mental illness, substance abuse, or their symptoms; not provided for the convenience of the covered person, physician, facility, or any other person; included in the schedule of benefits; provided to a covered person who meets the plan's eligibility requirements; and not identified as an exclusion.

Custodial Care
Care that the plan administrator or claims administrator determines is provided mainly to help you with personal hygiene or the activities of daily living.

Deductible
When required by a plan, the amount you are required to pay each year before the plan begins to pay benefits.

Dentally Necessary
The most appropriate and necessary service or supplies for the direct care and treatment of a dental condition in terms of generally accepted dental standards, as determined by the plan administrator or claims administrator.

Dentist
A dentist or other physician furnishing dental services within the scope of his or her license.

Doctor or Physician
A person who is legally licensed to practice medicine. A licensed practitioner will be considered a doctor if the service he or she performs is within the scope of his or her training and license.

Eligible Class
A full-time associate who is regularly scheduled to work 30 hours, on average, or more per week.

Emergency
An injury or the sudden onset of a medical condition of sufficient severity that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect to result in serious bodily impairment or dysfunction, or serious jeopardy to their health.

Evidence of Insurability (EOI)
A statement of your medical history or, in some cases, a medical exam.

Experimental or Investigational
A drug, device, procedure, or treatment is considered to be experimental or investigational if it has not been approved by the FDA or if a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes.

Explanation of Benefits (EOB)
A statement from the claims administrator that shows what the plan paid—and what you owe—for a covered service.

Flexible Spending Account (FSA)
Allows you to set aside before-tax money through payroll deductions to pay for eligible health care or dependent care expenses. Deadlines to incur expenses and submit claims for reimbursement apply annually.

Forfeiture
Any contributions that remain unused in a flexible spending account after the claim deadline. IRS rules require unused amounts to be forfeited. Forfeitures are used to pay the expenses of administering the plan.

Generic Drug
A drug that includes the same ingredients as its brand-name equivalent. Most health care professionals believe that generic drugs are as safe and effective as brand-name drugs. Generic drugs are less expensive than brand-name drugs. The plan automatically fills your prescription with a generic drug unless your doctor specifically requests the brand name.

Health Savings Account (HSA)
Allows you to set aside before-tax money through payroll deductions to pay for eligible health care expenses. Funds in the HSA roll over year to year with no forfeiture of unused funds.

Hospital
A legally operated, accredited facility that has 24-hour nursing services and that provides general or specialized medical care through medical, diagnostic (including x-ray and laboratory), and major surgical facilities that are on the premises or under its control. A hospital is not a nursing home or a school or facility for nursing, convalescence, rest, or the aged.

Hospital Confinement
A hospital confinement occurs when you incur room and board charges for partial or full days spent in a hospital.

In-Network Services
Services or supplies provided by a doctor, hospital, or other health care provider who is part of the network for a medical plan option you select.

Insurance Carrier
An insurance company that provides benefits under an insurance contract.

Legal Custody
Custody of a child granted and documented by the courts through appropriate legal processes, appointing an adult to exercise parental duties, rights, and responsibilities.

Lifetime Maximum
The maximum benefit that a plan will provide during the lifetime of a covered person. Examples may include medical lifetime maximums and the lifetime maximum for orthodontic treatment under the dental plan.

Medically Necessary
The most appropriate and necessary service, treatment, or supplies for the direct care and treatment of a medical condition as generally accepted by medical standards and known to be effective in improving health outcomes, all as determined by the plan administrator or the claims administrator.

Mental Health Facility
A facility licensed in the jurisdiction in which it is located to provide care and treatment for a mental or nervous disorder or disease. Such facility must provide care on a 24-hour-a-day basis under the supervision of a staff of physicians and must provide a broad range of nursing care on a 24-hour-a-day basis by or under the direction of a registered professional nurse.

Network
A select group of doctors, hospitals, and other health care providers that contract with a plan's claims administrator to offer discounted rates to participants. If you use an in-network provider, you'll never be charged more than the network's discounted rate for a service.

Non-Preferred Brand-Name Drug
A brand-name drug that is not on the preferred drug list. Generally, non-preferred brand-name drugs are more expensive for you and the plan than the preferred brand-name drugs.

Ophthalmologist
A physician who is licensed by a State Board of Medical Examiners and who specializes in ophthalmology.

Optometrist
An optometrist, a doctor of optometry, or a therapeutic optometrist.

Out-of-Network Services
Services or supplies provided by a doctor, hospital, or other health care provider who is not part of the network for a plan in which you participate.

Out-of-Pocket Costs
Your share of health care expenses, which might include annual deductibles, coinsurance, and copayments.

Out-of-Pocket Maximum
The maximum amount of money you pay in addition to premium payments. The out-of-pocket maximum is usually the sum of the deductible and coinsurance payments. Once you reach this maximum, the plan pays 100% of the remaining eligible charges. For specific details of payments included in the out-of-pocket maximum, refer to the applicable benefit section of this SPD or contact your plan's claims administrator.

Outpatient Services
Services for treatment of an injury or illness when room and board charges are not incurred for a hospital confinement.

Payroll Deductions
The amount deducted for you from each paycheck to pay for the benefits you elect.

Plan Year
The calendar year of January 1 through December 31.

Pre-existing Condition
Any disease, illness, sickness, or other condition that was diagnosed or treated by a health care provider within a specified period before health care or disability coverage begins and that will not be covered for a specified period under that plan. Pregnancy is generally excluded.

Preferred Brand-Name Drug
A drug selected under your prescription drug plan for its safety, effectiveness, and cost. You pay less for a preferred brand-name drug than for a non-preferred brand-name drug.

Preferred Provider Organization (PPO)
A health care benefit plan design that allows you and your dependents to direct your own care and decide at the time you need care whether to use in-network providers or out-of-network providers. You are not required to coordinate your care through a primary care physician (PCP).

Prescription Drug
A drug that can be obtained only through a doctor's order, and that, under federal and state law, only a licensed pharmacist can dispense.

Preventive Care
Covered services and diagnostic tests that are not related to an existing illness or injury but are meant to prevent illnesses or to diagnose them in their early stages.

Primary Care Physician (PCP)
The principal personal or family doctor who is designated in the records of the administrator as the doctor who is responsible for providing or arranging in-network care for you and/or your dependents.

Principal Sum
The full benefit payable by the life insurance plan.

Prior Authorization (PA)
The process of obtaining certification of coverage for certain medically necessary prescription drug products, prior to their dispensing, using approved plan guidelines.

Qualified Child Care Provider
Child care that is provided by either a dependent care facility that maintains all required licensure under relevant state and local laws, regulations, rules, and ordinances applicable to those facilities, or an individual or facility not required to maintain licensure under relevant laws, regulations, rules, and ordinances to provide care for individuals.

Reasonable Occupation
Any gainful activity for which you are, or may reasonably become, fitted by education, training, or experience, and which results in, or can be expected to result in, an income of more than 80% of your pre-disability earnings.

Retro Deductions
Deductions owed as a result of a retroactive election or change to coverage. Retro premiums are deducted on the first possible paycheck after the retroactive election has been made. If the full retro premium balance cannot be taken in full on the first possible paycheck after the election, your balance due will be converted to an arrears balance.

Skilled Nursing Care Facility
A licensed facility that provides skilled nursing care and treatment for you if you are recovering from an illness or injury.

Treatment Plan (for the dental plan)
A treatment schedule for orthodontia services that outlines the orthodontia services to be provided, how long the services will take, and how much they will cost.