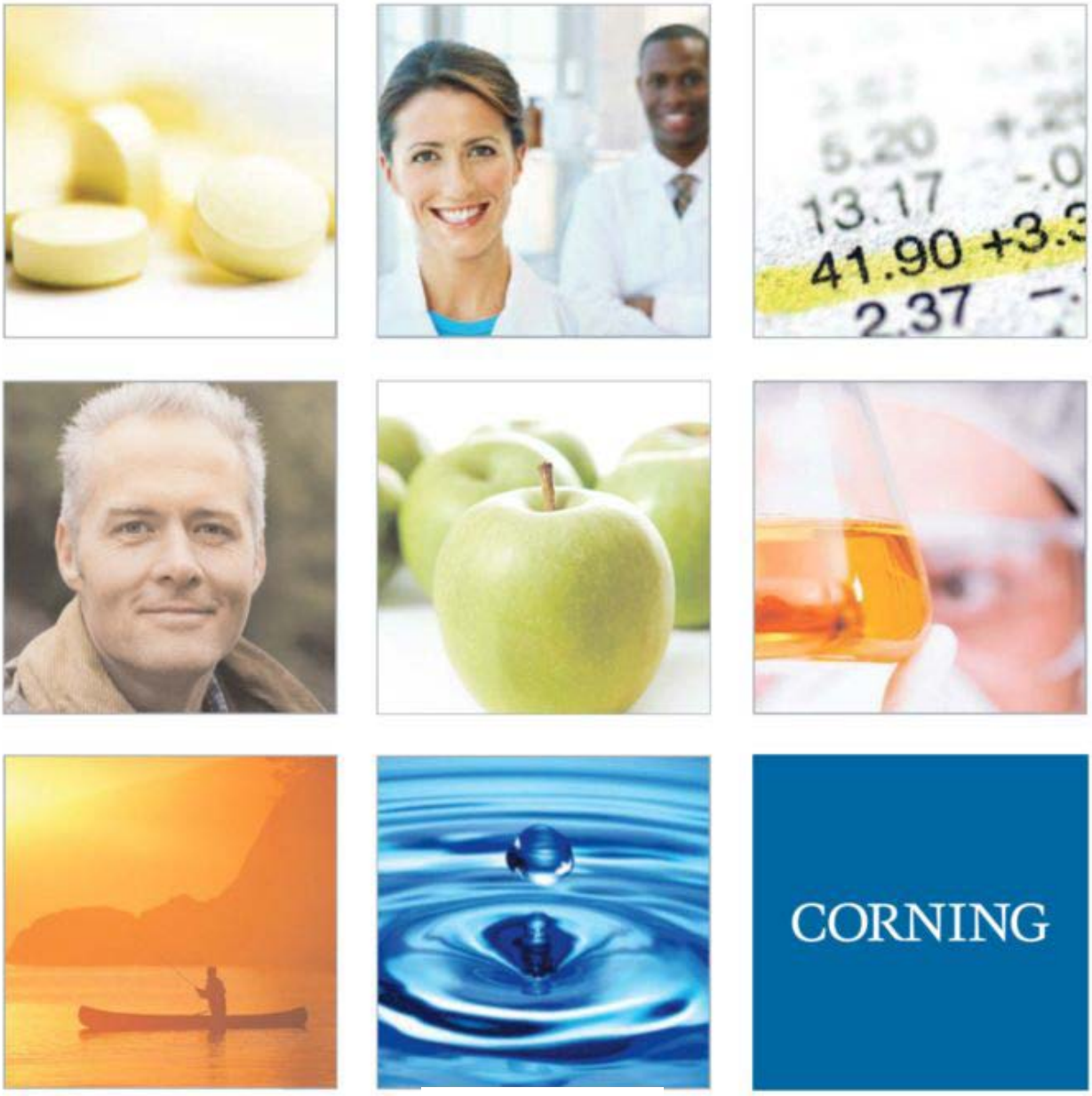
Corning Retiree Medical Plan

Summary Plan Description

For Corning Salaried and Union-free Hourly Retirees

January 2024



This Summary Plan Description (SPD) is intended to provide easy-to-understand general explanations about your benefits with Corning Incorporated ("Corning" or "Company"). This SPD summarizes only the major features of your benefits. In the event of any contradiction between the information contained in this SPD and the Plan documents, the Plan documents will govern in all cases.

Corning has the right to amend or terminate any plan for active or former employees in any way at any time, for any reason. If a change is made, you will be notified. Employee benefit plans must comply with applicable government regulations.

The Plan Administrator has the sole and absolute authority to interpret the terms of the Plan, determine benefit eligibility, and resolve any and all ambiguities or inconsistencies in the Plan.

You have certain rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA). A statement of ERISA rights and information about the Plan's claims and appeals procedures are provided automatically without charge in this SPD. See the "Your Rights as a Plan Member" and "Claims and Appeals Procedures" sections of this SPD for more information.

This SPD applies to salaried and union-free hourly retirees. Separate SPDs apply for union retirees.

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The Corning Retiree Medical Plan

As a Corning retiree, you may be eligible for medical coverage under the Corning Retiree Medical Plan. This SPD describes how this retiree benefit program works for you and your eligible dependents. Be sure to read this information carefully and to contact the Corning Benefits Network at 800-858-3875 with any questions you may have. It is important that you have all the information you need to take advantage of your Corning retiree benefits.

Retiree Medical Coverage Overview

Your medical coverage in retirement differs, depending on whether you or your dependents are eligible for Medicare:

- Salaried and union-free hourly retirees and covered dependents who are younger than age 65 and not Medicare-eligible are eligible to enroll in the Corning Retiree Medical Plan.
  - **If you meet this eligibility criteria, this SPD describes the benefits available to you.** You can elect either the Corning Retiree Consumer Health Plan (Corning Retiree CHP) or the Corning Retiree Preferred Provider Organization (Corning Retiree PPO) which are described throughout this SPD.
- Salaried and union-free hourly retirees and covered dependents who are age 65 or older and Medicare-eligible are eligible to enroll in an individual medical plan through UnitedHealthcare Medicare Solutions.
  - **If you meet this eligibility criteria, the Corning Retiree Medical Plan benefits described in this SPD do not apply to you.** See the "If Age 65 or Older" section of this SPD for a brief overview of the Medicare benefits for which you are eligible when you turn age 65. You may contact UnitedHealthcare Medicare Solutions at 866-658-9432 or go to www.myuhcplans.com/corning regarding your coverage options.

If you become eligible for Medicare due to a disability and you are an active Corning employee (or covered dependent of an active Corning employee) of any age or a salaried or union-free hourly retiree (or covered dependent of such retiree) younger than age 65, you will be covered under the Corning Medicare Supplemental Plan, which is described in a separate SPD.

Eligibility

You are eligible for the Corning Retiree Medical Plan (Corning Retiree Consumer Health Plan (CHP) or Corning Retiree PPO) if you:

- Are at least 55 years old when you leave Corning, but have not yet attained age 65,
- Have completed at least five years of service, as defined by the Corning Incorporated Pension Plan ("Pension Plan"),
- Were eligible for medical and Pension Plan benefits as an active employee at the time of your retirement, and
- Are not Medicare-eligible due to a disability.

You are not eligible for retiree medical benefits if you leave Corning before age 55, regardless of your years of service.

If you are age 65 or older and otherwise eligible for retiree medical benefits, you are no longer eligible for medical benefits under the Corning Retiree CHP or PPO medical option. Instead, you may select a retiree medical plan through UnitedHealthcare Medicare Solutions. For more information, call UnitedHealthcare Medicare Solutions at 866-658-9432. You can also view these plan options available where you live at www.myuhcplans.com/corning.

Eligible Dependents

The following chart shows the conditions under which you may cover your eligible dependents. Please note that the Corning Retiree Medical Plan is not subject to many of the rules under the Patient Protection and Affordable Care Act enacted in March 2010. The age limit for child eligibility is different under the Corning Retiree Medical Plan compared to the Corning Medical Plan for active employees.

Dependent Category	Details
Spouse	Your spouse is eligible for coverage if: ▪ They are legally married to you. ▪ You are not divorced and you are not legally separated from the person you are covering as a spouse.

Dependent Category	Details
Domestic Partner	You and your domestic partner must: ▪ Reside together in the same residence, ▪ Not be married to or legally separated from anyone else, ▪ Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside, ▪ Not have had a different domestic partner within the last 12 months from the date of enrollment (this condition does not apply if you had a domestic partner who died), and ▪ At least two of the following are true: ▫ You have lived together continuously for 12 months, ▫ You have executed a domestic partner relationship agreement in a jurisdiction that authorizes such agreements, ▫ You have named your domestic partner as a beneficiary under your Will or your domestic partner has named you as a beneficiary under their Will, ▫ You have granted your domestic partner powers under a durable power of attorney or your domestic partner has granted you powers under a durable power of attorney, ▫ You have named your domestic partner as a beneficiary on your life insurance policy or your domestic partner has named you as beneficiary on their life insurance policy, ▫ You have a joint bank account, ▫ You are co-signers of a lease or deed, and/or ▫ You are named on the same car insurance policy.
Child The term "child" includes your natural children, legally adopted children, children officially placed in your home for adoption, stepchildren, and any other children (including children of a spouse/domestic partner or children of your unmarried dependent children). Every child you elect to cover must be: ▪ Primarily supported by you, ▪ Claimed by you as a tax dependent for federal income tax purposes, ▪ Unmarried, and ▪ Living with you (not applicable to students under the "Child Age 19 or over, Student" category at right, living separately to attend school). Children of divorced or separated parents and those who are subjects of official guardianship orders, such as Qualified Medical Child Support Orders, may be eligible for coverage under special rules and exceptions to the above. For more information, contact the Corning Benefits Network.	Child *under Age 19* Your child is eligible for coverage if they are under age 19 (or will attain age 19 during the current year). *Child Age 19 or over, Non-student* Your child is eligible for coverage if they are: ▪ Age 19 or over until Dec. 31 of the year in which they reach age 23 (children become ineligible for coverage as of the first day of the month following their 23rd birthday), and ▪ Not employed full-time (i.e., not scheduled to work 30 or more hours per week). *Child Age 19 or over, Student* Your child is eligible for coverage if they are: ▪ Age 19 up to age 25, and ▪ Enrolled as a full-time student in an accredited post-secondary educational institution. Children become ineligible for coverage as of the first day of the month following their 25th birthday. **Note:** Seriously ill or injured students who are covered dependents may be eligible to continue their coverage for up to one year while on medically necessary leaves of absence. *Child with a Disability* Your child with a disability of any age is eligible for coverage as a dependent if they have been certified as disabled and is fully dependent on you for support.

Proof of Eligible Dependents

Corning reserves the right to verify dependents at any time and may require documentation supporting the eligibility of any covered dependent. If it is determined that a retiree fraudulently elected or maintained coverage for an ineligible dependent, the retiree may be required to reimburse claims or expenses paid under the Plan for the ineligible dependent. To continue coverage for a child with a disability, you must submit proof of disability within 31 days of the end of the month in which the child reaches age 25. You may periodically be required to submit proof of disability to continue coverage for that child.

Dependent Verification – Required for New Dependents

If you are adding a new dependent to your coverage, you will need to provide documentation to verify they meet Corning's eligibility requirements within 60 days of enrollment. The Corning Benefits Network will send you information about how to supply the required verification documentation after you make your enrollment elections.

If you do not complete this process, your dependent will not be covered.

You can complete the verification process online or by sending copies of documents by mail or by fax. We encourage you to submit all documentation together at one time by the *Documentation Due Date*. Read through the information provided online and review the *Acceptable Documentation* list to determine which documents are required to verify each dependent.

Qualified Medical Child Support Order (QMCSO)

Your benefits may be subject to a court or agency order extending health care coverage to a child or children named in the order. The Plan Administrator is responsible for determining if the order is a QMCSO. For this purpose, properly completed National Medical Support Notices (NMSNs) are considered to be QMCSOs. In the event a determination is made that the order satisfies all legal requirements, you will be notified by the Plan Administrator that you must provide health care benefits for children as part of your obligation to provide support in accordance with a state's domestic relations law.

You may request a copy of the procedures governing the court orders, free of charge, by contacting the Corning Benefits Network.

The Plan Administrators for the Corning benefit plans have the complete authority, in their sole and absolute discretion, to construe the terms of the procedures for enforcing court orders and to decide the eligibility for, and the extent of, benefits under the Plans with respect to these orders. All such decisions will be final and binding upon all parties affected. The Plan Administrators also reserve the right to amend any (or all) of the QMCSO procedures at their sole discretion, at any time.

Ineligible Dependents

The following dependents are not eligible for coverage:

- Dependents who are in active military service for any country or jurisdiction. If you have a dependent in active military service, call the Corning Benefits Network to remove them from your coverage.
- A former spouse/domestic partner, even if you are required to provide medical coverage under a court decree. (**Note:** A former spouse/domestic partner may be eligible to continue coverage under COBRA. Generally, a domestic partner is not a tax dependent and therefore is not entitled to COBRA coverage; however, Corning provides "COBRA-like coverage" for domestic partners. See the "Continuing Coverage through COBRA" section for more details.)

If you are found to have an ineligible dependent, you may be required to reimburse claims or expenses paid for that dependent.

Cost

The amount of your premium contributions for coverage under the Corning Retiree Medical Plan depends on when you were hired, the number of dependents you cover, and which medical plan option you choose. You can call the Corning Benefits Network to find out what the cost of retiree medical coverage would be for you and your dependents. The cost of coverage will be shown on your *Retiree Confirmation Statement*, which is mailed to your home each fall. Premium contribution amounts are subject to change and are reviewed and updated annually.

Retiree Medical Premium Contribution Payment Options

Retiree medical premium contributions are typically deducted from your Corning pension payment each month. However, if your premium contribution is larger than 70 percent of your pension payment amount or if you do not receive a pension payment, you are billed directly each month.

Direct billing is administered through Willis Towers Watson. If you do not make timely direct-bill payments to Willis Towers Watson, your coverage will be discontinued, and you may not reenroll until the next annual enrollment period unless you experience a qualifying status change. If you are direct billed, you can avoid the risk of missing a monthly payment by having your premium contributions debited directly from your bank account. The Corning Benefits Network can help you set up either Pension Plan trust deductions or direct-debit payments. If you would like to set up Pension Plan trust deductions to pay for your medical coverage, contact the Corning Benefits Network. Otherwise, the default payment method is through direct billing.

If you pay your medical premium contributions through pension check deductions and would prefer to pay through a direct billing arrangement, please call the Corning Benefits Network to request a change.

Access-only Premium Contributions—If You Were Hired or Rehired on or After Jan. 1, 2007

If you were hired or rehired on or after Jan. 1, 2007, or if you were employed at certain acquired companies or subsidiaries, you will pay 100% of the cost. This “access-only” coverage means you can take advantage of the group plan that Corning offers, but you will pay the full cost of your coverage.

Exception: *If you were rehired after Jan. 1, 2007, but you were eligible for the cost sharing employees hired before Jan. 1, 2007 when you first separated from service with Corning, you will continue to be eligible for the cost sharing based on your total service when you retire.*

If You Were Employed at Certain Acquired Companies or Subsidiaries

Employees from certain acquired companies or subsidiaries may be eligible for Corning Retiree Medical Plan coverage. See the chart below to determine when employees from your integrated organization became eligible to participate in the Corning Retiree Medical Plan.

Integrated Organization	Participation Eligibility Date for Corning Retiree Medical Plan Coverage	Counting Your Service
Costar Corporation	Jan.1, 1998	For service based contributions, service is counted from the later of Jan. 1, 1994, or date of hire with Costar Corporation.
Optical Corporation of America	Jan. 1, 1999	For service based contributions, service is counted from the later of April 27, 1997, or date of hire with Optical Corporation of America.
NZ Applied Technologies Corporation	July 1, 2000	All service is counted from date of hire at NZ Applied Technologies Corporation.
Lasertron Inc.	July 1, 2000	All service is counted from date of hire at Lasertron Inc.
NetOptix Corporation	July 1, 2000	All service is counted from date of hire at NetOptix Corporation or Optical Filter Corporation.
IntelliSense Corporation	Jan. 1, 2001	All service is counted from date of hire with IntelliSense Corporation.
Rochester Photonics Corporation	Jan. 1, 2001	All service is counted from date of hire with Rochester Photonics Corporation.
Tropel Corporation	Jan. 1, 2006	Service based on Jan. 1, 2002, or hire date, if later
Optimum Manufacturing Company	Jan. 1, 2009	Not applicable—access only
Corning Gilbert	Jan. 1, 2009	Not applicable—access only
MobileAccess	Jan. 1, 2012	Not applicable—access only
Discovery Labware	Nov. 1, 2012	Service based if hired before Jan. 1, 2007 Access only if hired on or after Jan. 1, 2007, or if retirement benefit eligible at date of sale
ITS (NovaSol)	Jan. 20, 2015	Not applicable—access only, except HI
Corning Pharmaceutical Technologies	Nov. 2, 2015	Service based if hired before Jan. 1, 2001 Access only if hired on or after Jan. 1, 2001
Mediatech, Inc.	Jan. 1, 2016	Not applicable—access only
Sorenson Bioscience, Inc.	Jan. 1, 2016	Not applicable—access only
Alliance Fiber Optic Products	June 3, 2016	Not applicable—access only
VACCA Biologics	Aug. 1, 2017	Not applicable—access only
3M	June 1, 2018	Service based if hired before Jan. 1, 2007 Access only if hired on or after Jan. 1, 2007, or if retirement benefit eligible at date of sale
J R Scientific, Inc.	Sep. 17, 2018	Not applicable—access only
SpiderCloud Wireless, Inc.	Apr. 1, 2019	Not applicable—access only
TR Manufacturing, Inc.	Jan. 1, 2020	Not applicable—access only

In the Event of Your Death as a Retiree—Survivor Medical Coverage

If Your Dependent is Under Age 65 at Time of Your Death

Your covered dependent may continue coverage under the Corning Retiree Medical Plan, provided they were covered at the time of your death. Your dependent must continue to pay their share of the cost of coverage.

If Your Dependent is Age 65 or Older at Time of Your Death

Your covered spouse/domestic partner may continue coverage through UnitedHealthcare Medicare Solutions and their Retiree Reimbursement Account, provided they were covered at the time of your death. Your dependent must continue to pay their share of the cost.

If covered at the time of your death, your children may also continue coverage (along with your surviving spouse/domestic partner) until they are no longer eligible dependents. However, if you have no surviving spouse/domestic partner, or if your spouse/domestic partner later dies, the dependent child's coverage ends at the end of the month in which the event occurs. The child may then continue coverage under COBRA by paying 100% of Corning's cost for providing coverage, plus an additional 2% of that amount to cover the cost of administration. See the "Continuing Coverage through COBRA" section for more details.

Enrolling and Changing Coverage

Access Your "Retirement How To Guide" on My Total Rewards

This guide shows you the steps you need to take to initiate your Corning Pension Plan benefit and enroll in a Corning Retiree Medical Plan.

My Total Rewards >> Access Employee Self-Service Homepage >> Resource Library >> Resource Library >> Benefits Documents >> Forms & Documents >> Retirement How-To Guide

If You Are Under Age 65 at Retirement

The information in this section relates to individuals who are younger than age 65 at retirement. If you are age 65 or older, you will make your Medicare elections through UnitedHealthcare Medicare Solutions. See the "If Age 65 or Older" section of this SPD for an overview of the medical benefits available to you and/or your eligible dependents when you become eligible for Medicare.

You may enroll in either the Corning Retiree Consumer Health Plan or the Corning Retiree PPO Plan if you are younger than age 65 at retirement. Elections can be made through the My Total Rewards Employee Self-Service website or by speaking with a Benefit Services Representative at the Corning Benefits Network. You may begin this process within 90 days before your planned retirement date.

You must complete these elections within 30 days of your separation date for your retiree medical coverage to be effective on your retirement date. If you enroll within 31 days after your retirement date, your coverage will be retroactive to your official retirement date. Otherwise, you may not enroll until the next annual enrollment period unless you experience a qualifying status change.

You, your covered spouse/domestic partner, and eligible children are also eligible for COBRA if enrolled in active medical coverage at the time of your retirement. **Note:** A domestic partner is typically not a tax dependent and therefore is not entitled to COBRA coverage. However, Corning provides "COBRA-like coverage" for domestic partners. See the "Continuing Coverage through COBRA" section for more details.

Coverage Categories

You or your eligible dependents may elect one of the following when enrolling for medical coverage:

Who Is Covered	Coverage Category
Just yourself	Retiree-only
Yourself and your spouse/domestic partner	Retiree+Spouse/Domestic Partner
Yourself and your child(ren)	Retiree+Child(ren)
Yourself, your spouse/domestic partner, and your child(ren)	Retiree+Family
No coverage	Waive

For a Retiree or Dependent Turning Age 65

When you or a covered spouse/domestic partner reaches age 65, you become eligible to enroll for Medicare through UnitedHealthcare Medicare Solutions. About 90 days before you or your eligible dependent attains age 65, UnitedHealthcare will send an information kit that describes the UnitedHealthcare Medicare Solutions individual plans that are available in your area.

Your benefits after age 65 are coordinated with Medicare; you must be enrolled in Medicare Parts A and B before you may enroll in a UnitedHealthcare Medicare Solutions individual plan. You should start this process 60 to 90 days before turning age 65. See the "If Age 65 or Older" section for more information.

You and your spouse/domestic partner have a one-time opportunity to select one of the Medicare plans available through UnitedHealthcare Medicare Solutions. If you do not enroll during your one-time opportunity, you, your spouse/domestic partner, and any dependent(s) will become ineligible for Corning retiree medical coverage, regardless of your age. You will also lose eligibility for the Retiree Reimbursement Account (see the "Retiree Reimbursement Account" section).

Coordinating Coverage with the Corning Retiree Medical Plan If You Are Younger than Age 65

Before you make your Corning Retiree Medical Plan election, consider whether you have any other source of coverage. For example, if you are eligible for coverage under your spouse's/domestic partner's plan, compare the benefits and costs of all plans to determine which plan best meets your family's needs.

If you have access to other health coverage, you have the following options:

- You may enroll yourself, your spouse/domestic partner, and/or your eligible children in Corning coverage.
- You may waive coverage at Corning and enroll as a dependent in a plan offered by your spouse's/domestic partner's employer, if eligible.
- You and your spouse/domestic partner (and your eligible dependent children) may enroll for coverage under both of your respective employers, if eligible. In this case, benefits would be paid as explained in the "Coordination of Benefits" section. You will want to consider whether it is cost effective for you and your spouse/domestic partner to both pay for plan coverage.

If Your Spouse/Domestic Partner Works at or Retired from Corning

You cannot be covered as a retiree and as a dependent of another Corning employee or retiree. If you have children, they may be enrolled either as your dependents or as your spouse's/domestic partner's dependents. You and your spouse/domestic partner cannot both cover the same children as dependents under any Corning medical plan option.

No Pre-existing Condition Limitations

There are no pre-existing condition limitations under any of the plans. If you have a medical condition that existed before your medical coverage began, your plan will pay for covered services related to that condition under the standard terms of the plan, subject to the plan's copayments, deductibles, and/or coinsurance.

Privacy of Your Health Information

The Health Insurance Portability and Accountability Act (HIPAA) protects the use and disclosure of individual health information. A notice describing your rights under HIPAA is available in the My Total Rewards Resource Library (Go to: Resource Library >> Benefits Documents >> "Required Notices") or call the Corning Benefits Network at 800-858-3875.

Women's Health and Cancer Rights Notice

All Corning Retiree Medical Plan options cover expenses for reconstructive surgery following a mastectomy. In addition to covering the medical and surgical benefits related to a mastectomy, the Corning Retiree Medical Plan options cover:

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

These services are subject to any applicable Plan deductibles, coinsurance, and copayments.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

A Note About the Affordable Care Act

Please note that the Corning Retiree Medical Plan is not subject to many of the rules related to the Affordable Care Act (ACA). Changes to the Corning Retiree Medical Plan are not based on this health care law.

Corning Retiree Medical Plan for Non-Medicare-eligible Retirees

Corning Retiree Consumer Health Plan (CHP) and Corning Retiree Preferred Provider Organization (PPO)

Corning offers the choice of the Corning Retiree Consumer Health Plan (CHP) or the Corning Retiree PPO administered by UnitedHealthcare for you and your family members who are younger than age 65. You may also choose to waive coverage.

Network Providers

The Corning Retiree CHP and Corning Retiree PPO plan options both offer the same network of providers that includes doctors, hospitals, laboratories, and other health care professionals and facilities. Before becoming part of the network, health care providers undergo a screening process to ensure that they meet the Plan Administrator's quality standards. This process involves a review of the provider's licensing, malpractice history, and other records. The Plan Administrator routinely monitors health care providers after they are in the network to ensure that they continue to deliver high-quality care to participants. This credentialing process confirms public information about providers' licenses and other credentials but does not assure the quality of the service provided.

The Plan Administrator's provider directory is available at no cost to you. To access UnitedHealthcare's directory:

- Call 877-644-4334, or
- Visit www.myuhc.com and select "Search for a Provider."

You may also request a paper copy of the directory by calling UnitedHealthcare at 877-644-4334. Keep in mind that the network changes occasionally, as new providers join the network and other providers leave the network. This means that a printed provider directory will not always be up to date. For this reason, it is a good idea to call the Plan Administrator or go to its website to be sure that the providers you want to use are still in the network.

In addition, Corning has partnered with Cleveland Clinic for cardiac conditions and Memorial Sloan Kettering Cancer Center (MSK) for cancer conditions. These partnerships provide you with high care in situations where a local provider may not be able to provide the most appropriate level of care. See the "Corning Preferred Provider Partners" section for more information.

Before obtaining services, you should always verify the network status of your provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. If you receive a covered health service from a non-network provider and were informed incorrectly before receipt of the covered health service that the provider was a network provider, either through a database, provider directory, or in a response to your request for the information (via telephone, electronic, web-based or internet-based means), you may be eligible for network benefits.

It is possible that you might not be able to obtain services from a particular network provider. The network of providers is subject to change. Or you might find that a particular network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another network provider to receive network benefits. However, if you are currently receiving treatment for covered health services from a provider whose network status changes from network to non-network during the treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the network benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help finding out if you are eligible for continuity of care benefits, call the number on your ID card.

Incentives to Providers

UnitedHealthcare may provide financial incentives to network providers to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation, which is a practice where a group of network providers receives a monthly payment from UnitedHealthcare for each covered person who selects a network provider within the group to perform or coordinate certain health services. The network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment.
- Bundled payments, which is a practice where certain network providers receive a bundled payment for a group of covered health services for a particular procedure or medical condition. The applicable copayment and/or coinsurance is calculated based on the provider type that received the bundled payment. The network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional copayment and/or coinsurance may not be required if the follow-up services are included in the bundled payment. You may receive some covered health services that are not considered part of the inclusive bundled payment and those covered health services would be subject to the applicable copayment and/or coinsurance, as described in this SPD.

The Claims Administrator uses various payment methods to pay specific network providers. From time to time, the payment method may change. If you have questions about whether your network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the number on your ID card.

Continuity of Care

If your provider leaves the network and you have medical reasons preventing an immediate transfer of your care to a network provider, you may request that coverage relating to the medical reasons be covered at the in-network level for a defined period. Contact UHC for more information on when continuity of care is available and how long the extended coverage for that care may continue.

Corning Health Connection

You can get health and benefit answers and support with just one call to a Corning Health Connection Advocate. The Corning Health Connection is a team of registered nurses and dedicated advocates for medical and mental health/substance use disorder benefits that are specially trained to understand how your Corning health benefits work. Corning Health Connection Advocates are available to help make navigating healthcare a little easier for you and your family by providing the following:

Answers	Information	Support
▪ Understand your benefits coverage ▪ Learn how your HSA works ▪ Resolve claims issues	▪ Get connected to the most advanced methods of diagnosis and treatment from world-renown specialists ▪ Save money comparing costs for services ▪ Find out how to use your telemedicine and virtual services benefits	▪ Stay up to date on preventive care screenings ▪ Learn about Corning Preferred Provider Partners for help in managing a new or existing health condition ▪ Set up an appointment with a doctor or specialist

If you have a concern that cannot be taken care of on a single call, an Advocate will continue to help you until you get the answers and resources you need. The Advocate will even provide you with their direct phone number and call you back if needed.

You can reach a Corning Health Connection Advocate at 877-644-4334, Monday through Friday from 8 a.m. to 11 p.m. Eastern time. Add the Corning Benefits Directory (corningmtr.com) to your smartphone, so you have this and other important phone numbers when you need them.

Important: Corning Health Connection should not be used for emergency or urgent health needs. In an emergency, call 911 or go to the nearest hospital emergency room or urgent care center.

Corning Preferred Provider Partners

Corning provides you with access to Preferred Provider Partners to receive the most advanced methods of diagnosis and treatment for certain specialty care. You have access to:

- Cleveland Clinic for cardiac care if you are facing a heart condition, or
- Memorial Sloan Kettering (MSK) Cancer Center if you have a cancer diagnosis.

Corning's Preferred Provider Partners were selected based on their subject matter expertise and ability to provide high quality patient care. Using a Corning Preferred Provider Partner allows you to remove barriers to get the highest level of care by providing:

- Direct access to concierge service (expedited appointment scheduling)
- Enhanced travel and lodging benefits, and
- No copayments, coinsurance, or deductible (**Note:** Per IRS regulations, if you are a Consumer Health Plan member, you must satisfy your deductible before the Corning Retiree Plan begins to pay benefits).

To take advantage of Corning's Preferred Provider Partners and receive the most advanced methods of diagnosis and treatment from clinical experts:

Preferred Provider Partner	Contact When	Contact
Cleveland Clinic (Cleveland, OH)	You or a covered dependent are diagnosed with a condition requiring a non-urgent/non-emergency heart procedure, like valve repair or replacement	▪ WebTPA at 877-563-7490 Hours of Operation: Monday through Friday, 9 a.m. to 6 p.m. Eastern time ▪ CorningPPP@webtpa.com
Memorial Sloan Kettering Cancer Center (six facilities in New York and New Jersey plus virtual care nationwide)	You or a covered dependent: ▪ Are newly diagnosed or have a suspicion of cancer ▪ Have been diagnosed with cancer ▪ Are receiving or in need of cancer treatment and want a second opinion or are looking to transfer care to MSK ▪ Have a history of cancer and have a proven recurrence or suspicion of recurrence for which treatment is indicated	▪ MSK Direct at 877-449-1505 Hours of Operation: Monday through Friday, 8 a.m. to 6 p.m. Eastern time (Messages left outside of normal hours of operation will be returned the next business day)

MSK Direct Cancer Program

A cancer diagnosis can be overwhelming. You need to make decisions about treatment, where to go for care, and how to balance treatment with a busy schedule. Corning has partnered with Memorial Sloan Kettering Cancer Center to offer MSK *Direct* — a program that facilitates prompt access to care. MSK is the world's oldest and largest private cancer center, devoting more than 130 years to top patient care and innovative research for cancer treatment and adult and pediatric transplants. In addition, MSK Kids also offers the largest pediatric program in the country whose sole focus is caring for children, teenagers, and young adults with cancer, immune deficiencies, and blood disorders.

In addition to using one of MSK's premier facilities, the other advantage is that benefits will be covered at:

- 100% under the Corning Retiree PPO plan option, or
- 100% after the deductible under the Corning Retiree CHP plan option.

Contact MSK *Direct* if you or a family member:

- Is told you have cancer, and would like to explore options for treatment at MSK,
- Get results from a medical test or exam that may signal that you have cancer,
- Are told by your doctor to schedule an appointment with an oncologist,
- Would like a second opinion on a cancer diagnosis received from another doctor or hospital, or
- Are currently in cancer treatment at MSK or elsewhere and would like to know your options.

The MSK *Direct* team will:

- Make an appointment for you at MSK, usually within two business days,
- Help you gather your medical records for your first appointment, and
- Meet you at your first appointment to introduce you to the facility and your care team.

For second opinions, if you choose to seek treatment through another facility, Corning offers MSK *Remote*, which is a program that covers a second opinion provided by an MSK provider, which is covered at:

- 100% under the Corning Retiree PPO plan option, or
- 100% after the deductible under the Corning Retiree CHP plan option.

You can schedule an in-person or remote second opinion for patients who have already received a diagnosis or recommendation for treatment elsewhere.

Telemedicine

You have access to health care providers from the comfort of your home through digital audio-visual technologies, such as FaceTime, Skype, Zoom, and many other dedicated telemedicine applications. This kind of virtual visits are ideal for avoiding a trip to the hospital or urgent care center for illnesses, like the seasonal flu, allergies, pink eye, and more.

- **Virtual Visits with UnitedHealthcare Network Providers:** Many medical providers are available for telehealth visits. Telehealth visits with your health care provider can be used for both COVID-19 and other health needs, keeping you in your home while still receiving the care you need.
- **24/7 Virtual Visits through Teladoc:** Teladoc is a telemedicine service that provides virtual services to leverage state-of-the-art technologies including e-prescribing, Electronic Health Records (EHR), and video and telephonic conferencing to bring you and your family instant access to a board-certified physician who is able to evaluate, diagnose, and treat your condition.

You and your dependents covered under a Corning Retiree Medical Plan option administered by UnitedHealthcare will be eligible to use Teladoc. You can use Teladoc not only for yourself and covered family members, but also for extended family members for whom you are a caregiver—even if they are not covered by your Corning Retiree Medical plan option. Easily connect with a licensed doctor, dermatologist, behavioral health clinician, or Global Care by web, phone, or mobile app. Or get a prescription and have it sent to your local pharmacy, when medically necessary. Copayments for telemedicine through Teladoc varies, depending on who is covered and what type of provider you see, as follows:

Teladoc Provider	CHP	PPO
General Medicine	Before your deductible is met, you pay a $52 consultation fee per visit After your deductible is met, you pay 25% coinsurance Caregivers: You pay $49	You pay $10 copay per visit Caregivers: You pay $49
Dermatology	Before your deductible is met, you pay a $80 consultation fee per visit After your deductible is met, you pay 25% coinsurance	You pay $10 copay per visit
Behavioral Health	Before your deductible is met, you pay: ▪ Psychiatrist: $190 consultation fee for first visit, then $95 consultation for each additional visit ▪ Other Provider: $85 consultation fee per visit After your deductible is met, you pay 25% coinsurance	You pay $20 copay per visit

You will receive more information about Teladoc in the mail after you enroll in a medical plan option or go to www.teladoc.com.

Virta Health Diabetes Treatment Program

Corning has partnered with Virta Health to provide additional resources for participants with Type 2 diabetes and pre-diabetes. Virta provides a research-backed treatment to safely and sustainably manage Type 2 diabetes and pre-diabetes without medications or surgery.

The Virta Health Diabetes Treatment Program returns blood sugar to sub-diabetic levels while safely reducing and even eliminating diabetes medications. Reversal is possible through individualized nutrition therapy focused on carbohydrate restriction, personalized nutrition, daily biomarker monitoring, and an advanced telehealth model by a physician-led care team.

The Virta Health Diabetes Treatment Program includes:

- Medical supervision,
- Personal one-on-one health coach,
- Tools for biomarker feedback,
- Mobile and desktop apps,
- On-demand resources, and
- Private Virta community.

You are eligible to participate if you or a covered dependent is:

- Between ages 18 and 69,
- Enrolled in a Corning medical plan option administered by UnitedHealthcare, and
- Currently diagnosed with Type 2 diabetes or pre-diabetes.

Note: There are some serious medical conditions that could exclude patients from the Virta Health Diabetes Treatment Program. You should apply to learn if you qualify for the Virta Health Diabetes Treatment Program.

For more information, contact Virta Health:

- By calling 844-847-8216,
- Online at www.virtahealth.com/corning, or
- By email at support@virtahealth.com.

What You Can Do to Lower Your Health Costs

Corning provides a number of programs to control rising health care costs. When you use these programs, you are doing your part in controlling Corning's overall cost for providing medical care. Using these programs today may mean lower out-of-pocket expenses for you now and they also help Corning control health care costs. And, since you and Corning share the cost of medical coverage, helping Corning to reduce these costs today can help to control your contributions in the future.

Additional Resources At a Glance

To make the most of your medical benefits, when you enroll in a Corning Retiree Medical Plan option, you have access to the following resources:

Provider	Purpose	Phone Number
UnitedHealthcare Resources		
Health Connection Advocate	UHC offers a variety of programs to meet your and your covered dependents needs. Some program available through UHC include: ▪ UHC Able to Program, which is a program that works behind the scenes to review claims and reaches out to individuals to provide virtual counseling and coping tools if needed ▪ UHC Special Me Program, which is a program for participants who have a child age 0-17 with special needs and who needs advocacy services ▪ Diagnostic Odyssey Program, which is a program that allows participants to take advantage of UHC relationships with special facilities, such as the Mayo Clinic, to connect you with special centers of excellence and possible travel and lodging benefits	▪ Health Connection Advocate: 877-644-4334 ▪ www.myuhc.com
Optum Health, a subsidiary of UnitedHealthcare	Optum Health provides care directly through specialized networks, including the following: ▪ Behavioral Health network (for mental health and substance use disorder providers) ▪ Bariatric Resource Services (BRS)	▪ www.myuhc.com ▪ 877-683-8546 ▪ 888-936-7246
Additional Resources		
Adoption and Surrogacy Benefit	Corning offers a reimbursement benefit for expenses related to adoption and/or surrogacy through Maven Wallet	▪ mavenclinic.com/join/corning1
Cleveland Clinic (Cleveland, OH)	Cleveland Clinic offers you and your covered dependents assistance when you are diagnosed with a condition requiring a non-urgent/non-emergency heart procedures	▪ WebTPA: 877-563-7490 ▪ CorningPPP@webtpa.com
Family Building Support Programs	Maven and Fertility Solutions Plus provide comprehensive, 24/7 education and counseling support for your family building and family health journeys	▪ mavenclinic.com/join/corning1
Memorial Sloan Kettering Cancer Center (MSK Direct)	Through MSK Direct, you and your covered dependent can receive assistance when you: ▪ Are newly diagnosed or have a suspicion of cancer ▪ Have been diagnosed with cancer ▪ Are receiving or in need of cancer treatment and want a second opinion or are looking to transfer care to MSK ▪ Have a history of cancer and a proven recurrence or suspicion of recurrence for which treatment is indicated	▪ 877-449-1505
My Medical Ally, Alight (formerly ConsumerMedical)	Alight offers My Medical Ally Services and Surgery Decision Support, which provides you with guidance to help you and your family make informed decisions about your medical care and treatment	▪ 888-644-1640 ▪ mymedicalally.alight.com

Provider	Purpose	Phone Number
Pelago (formerly Quit Genius)	Pelago offers various addiction treatment programs (for example, alcohol, opioid, tobacco)	▪ 877-349-7755 ▪ my.pelagohealth.com/corning
RethinkCare	RethinkCare provides research-based resources to inspire and empower people with developmental disabilities and those who support them; equipping you with tools, resources, and private consultations, at no cost	▪ 800-714-9285 ▪ connect.rethinkcare.com/sponsor/corning Access Code: Corning
Teladoc	Telemedicine services, which may include services such as general medical, dermatology, and behavioral health counseling	▪ 800-835-2362 ▪ www.teladoc.com
Virta Health	Type 2 diabetes and pre-diabetes program that provides additional resources to help safely and sustainably manage Type 2 diabetes without medications or surgery; treatment is designed to help control blood sugar and reduce A1C levels while safely eliminating diabetes medications and losing weight	▪ 844-847-8216 ▪ www.virtahealth.com/corning support@virtahealth.com

Additional information about these services may be available in this SPD, as well as online in the Benefits Directory at corningmtr.com. If you need assistance with the resources available to you, contact Corning Health Connection at 877-644-4334.

Corning Retiree CHP

The Corning Retiree Consumer Health Plan (CHP) option is a high deductible health plan that may be linked to a Health Savings Account (HSA). You take on most of the cost for claims until you meet the deductible. In exchange for a higher deductible and out-of-pocket maximum, your premium contributions are lower.

You can use the money in your HSA to save on taxes and pay for medical expenses.

The Corning Retiree CHP covers the same medical, mental health/substance use disorder, and prescription drug services as the Corning Retiree PPO. It also provides access to the same UnitedHealthcare provider network. Some advantages of the Corning Retiree CHP include:

- **A focus on prevention.** Preventive care—including routine physicals—is covered at 100% if you see an in-network provider.
- **No claim forms for in-network care.** Network providers submit your medical expenses directly to the Plan. You may have to submit claim forms to be reimbursed for out-of-network care under the Corning Retiree CHP.
- **No MNRP for in-network care.** Because network providers agree to accept rates set by the Plan, you do not have to pay expenses above their charges. If you seek out-of-network care under the Corning Retiree CHP, you may be charged for expenses above MNRP.
- **Eligible for a Health Savings Account (HSA).** You may set up an HSA when you enroll in the Corning Retiree CHP, if you did not already have one while an active employee. If you already have an HSA with Optum Financial that was established as an active employee, you may continue to contribute to it directly or you may establish an account at any financial institution that offers HSAs. You fund this account; Corning does not contribute to it. The account is portable; meaning that you can take your account with you and continue to use your funds to pay for eligible expenses even if you end your retiree health coverage with Corning.

About Maximum Non-Network Reimbursement Program (MNRP)

"Maximum non-network reimbursement program" (MNRP) is a term used in descriptions for non-participating (out-of-network) providers. The allowed charge is determined based on the following (MNRP) rate in the order set forth below:

110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare service codes for the same or similar service within the geographic market if the covered health services are provided by a non-participating provider who has not negotiated a discount in fees with UnitedHealthcare.

You get the most out of the Corning Retiree CHP when you use providers who are in the Plan's network. However, with the Corning Retiree CHP, you may choose to receive your care from a network provider or you may choose to see any licensed provider who is not part of the network.

- **In-network.** You have the lowest out-of-pocket costs when you use participating providers in the UnitedHealthcare network. Most other services are covered at 75% after you pay the annual deductible ($1,800 if you have individual coverage or $3,600 if you cover dependents). Because network providers agree to negotiated rates, you do not have to pay expenses above their charges.

  With the Corning Retiree CHP, you do not have to choose a primary care doctor or obtain a referral to see a network specialist. You simply go to the network provider and receive the in-network level of benefits.

- **Out-of-network.** If you use out-of-network providers, you pay a larger share of the cost. In this case, you will be reimbursed 55% of MNRP after you pay an annual deductible ($3,900 if you have individual coverage or $7,600 if you cover dependents). To be reimbursed for out-of-network care, you must submit a claim form to the Plan Administrator. You will be responsible for paying expenses above MNRP. Depending upon the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-network providers who have agreed to discounts negotiated from their charges on certain claims or covered health services. The Shared Savings Program is a program in which UnitedHealthcare may obtain a discount to a non-network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network provider. When this happens, you may experience lower out-of-pocket amounts. Corning Retiree CHP coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If that happens you should call the number on your medical ID card. Shared Savings Program providers are not network providers and are not credentialed by UnitedHealthcare. (See the "Your Rights and Protections Against Surprise Medical Bills" section for additional information.)

Notes:

- Emergency health services provided by a non-network provider will be reimbursed as eligible expenses, as described in this SPD.
- Covered services provided at certain network facilities by a non-network physician, when not emergency health services, will be reimbursed as eligible expenses, as described by this SPD. For these covered health services, certain network facility is limited to a hospital (as defined in *1861(e) of the Social Security Act*), hospital outpatient department, critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), ambulatory surgical center (as described in section *1833(i)(1)(A) of the Social Security Act)*, or any other facility specified by the Secretary.

- Air ambulance transport provided by a non-network provider will be reimbursed as an eligible expense, as described in this SPD.

Out-of-Area Care: If you do not have access to a network provider who is within a 30-mile radius of your home, the Corning Retiree CHP may offer an exception to the out-of-network coverage. In this case, you can receive care from a closer provider who is not part of the network and that care will be covered as if the provider was in-network. Be sure to call the member services number listed on your medical ID card to receive approval before you start services with a provider that may warrant coverage through a "gap exception."

In the "Corning Retiree CHP Summary" section, you will find a detailed description of the benefits available under the Corning Retiree CHP. Also, see the "Mental Health/Substance Use Disorder Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section and the "Prescription Drug Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section for more information about these benefits.

Deductibles

The annual deductible is the amount of eligible expenses, or the recognized amount when applicable, you must pay each calendar year for covered health services before you are eligible to begin receiving benefits. The amounts you pay toward your annual deductible accumulate over the course of the calendar year.

The Corning Retiree CHP has separate deductibles for in-network and out-of-network care.

Unlike the Corning Retiree PPO, if you cover any dependents under the Corning Retiree CHP, you must meet the **entire family deductible** before the Plan begins to pay benefits for covered services.

Family Deductible Example

The following example shows how the $3,600 family in-network deductible works for five covered family members who have in-network medical expenses:

How Eligible In-Network Expenses Are Paid	
Family Deductible	$3,600
Retiree (You pay $1,500 in expenses toward deductible)	- $1,500
Spouse/Domestic Partner (You pay $1,100 in expenses toward deductible)	- $1,100
Child #1 (You pay $800 in expenses toward deductible)	- $800
Child #2 ($500 in expenses. You pay $200 toward deductible; remaining $300 paid through coinsurance as shown below)	- $200
Family Deductible Remaining to Be Met	$0
Subsequent Claims Subject to Coinsurance	Plan pays 75% coinsurance = $225
Child #2 ($300 in remaining expenses paid through coinsurance after deductible)	You pay 25% coinsurance = $75
Child #3 ($200 in expenses paid through coinsurance)	Plan pays 75% coinsurance = $150 You pay 25% coinsurance = $50

Corning Retiree CHP Deductibles

	In-Network	Out-of-Network
Individual	$1,800	$3,900
Family	$3,600	$7,600

Coinsurance

Coinsurance is the percentage of MNRP charges for covered expenses that the Plan pays, after any deductibles are met. The coinsurance is 75% in-network and 55% out-of-network.

Services that are subject to coinsurance include X-rays, inpatient and outpatient services, equipment and prosthetics, and others.

Out-of-pocket Maximums

The out-of-pocket maximum is the maximum amount you will have to pay for covered services each year. Medical deductibles and coinsurance, mental health/substance use disorder deductibles and coinsurance, and prescription copayments and coinsurance count toward the out-of-pocket maximum. Once your out-of-pocket expenses reach the limit (not including amounts for non-covered services and amounts above MNRP charges that you have paid), the Corning Retiree CHP will pay 100% of MNRP charges for all additional covered expenses.

If you cover dependents, your maximum annual out-of-pocket is $8,200 for the entire family before benefits are paid at 100%. You meet the family out-of-pocket maximum once covered family members have paid the combined total toward their individual out-of-pocket maximum. Once you have met the family out-of-pocket maximum, no further copayments or coinsurance will be charged that year, no matter how many dependents you have enrolled.

Combined Corning Retiree CHP Out-of-pocket Maximums (Medical, Mental Health/Substance Use Disorder, and Prescription Drugs)

	In-Network	Out-of-Network
Individual	$4,200	$7,300
Family	$8,200	$14,200

Lifetime Maximum

There is no lifetime maximum for in-network benefits under the Corning Retiree CHP. The out-of-network lifetime benefit maximum is $1 million. This means that each covered person is eligible to receive a maximum of $1 million of out-of-network covered services in their lifetime under the Corning Retiree Medical Plan.

Corning Retiree CHP Summary

This section provides an overview of covered medical services under the Corning Retiree CHP. Refer to the "Services That Require Prior Authorization" section for the list of services and supplies that require prior authorization. See the "Mental Health/Substance Use Disorder Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section and the "Prescription Drug Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section for a summary of these benefits.

Covered Services	In-Network	Out-of-Network
Plan Features		
Provider Choice	Use any network provider; no referral required	Use any licensed provider; no referral required
Deductible	$1,800 individual $3,600 family	$3,900 individual $7,600 family
Coinsurance	Plan pays 75% after the deductible for most covered services; you pay 25% of the contracted rate	Plan pays 55% of MNRP after the deductible for most covered services; you pay 45%, plus charges above MNRP
Out-of-pocket Maximum	$4,200 individual only $8,200 family coverage Includes deductible, copayments for medical, mental health, substance abuse, and prescription drugs, and coinsurance; excludes non-covered services and amounts that exceed the contracted rate	$7,300 individual only $14,200 family coverage Includes deductible, copayments for medical, mental health, substance abuse, and prescription drugs, and coinsurance; excludes non-covered services and amounts that exceed MNRP
Lifetime Maximum Benefit	None	$1 million per person
Outpatient Services		
Office Visit for Illness or Injury	75% after the deductible	55% of MNRP after the deductible
Preventive Care Office Visits	Covered at 100% (frequency depends on age; see "Preventive Care Services" section)	55% of MNRP after the deductible for gynecological and immunizations only (frequency depends on age; see "Preventive Care Services" section for more information) Physicals and well-child care are not covered
Laboratory Tests and X-rays	75% after the deductible 100% after the deductible for preventive at independent labs and X-rays in an office setting	55% of MNRP after the deductible
Outpatient Surgery	75% after the deductible	55% of MNRP after the deductible
Chemotherapy (Drugs and Administration)	75% after the deductible	55% of MNRP after the deductible
Radiation Therapy	75% after the deductible	55% of MNRP after the deductible
Kidney Dialysis	75% after the deductible	55% of MNRP after the deductible
Allergy Tests	75% after the deductible	55% of MNRP after the deductible
Allergy Injections	75% after the deductible	55% of MNRP after the deductible
Maternity Care (prenatal/delivery/postnatal)	Childbirth/Delivery Professional Services: 75% after the deductible Prenatal and Postnatal Care: 100%, no deductible	55% of MNRP after the deductible

Covered Services	In-Network	Out-of-Network
Hospital Inpatient Services (Subject to Notification Requirements, see "Services That Require Prior Authorization" section)		
Semi-private Room and Board, Nursing and Doctor Services, Surgery, Diagnostic X-rays, and Lab Tests	75% after the deductible Mammography and/or Colonoscopy: ***Preventive:*** 100%, no deductible ***Diagnostic:*** 100% after the deductible	55% of MNRP after the deductible
Anesthesia	75% after the deductible	55% of MNRP after the deductible
Inpatient Physical Rehabilitation	75% after the deductible; up to 60 days per admission (in- and out-of-network combined)	55% of MNRP after the deductible; up to 60 days per admission (in- and out-of-network combined)
Hospital Outpatient Services		
Surgical Care	75% after the deductible Covered health services provided by a non-network physician in certain network facilities will apply the same cost sharing (deductible, coinsurance, and/or copayment) as if those services were provided by a network provider; however, eligible expenses will be determined as described in this SPD	55% of MNRP after the deductible Covered health services provided by a non-network physician in certain network facilities will apply the same cost sharing (deductible, coinsurance, and/or copayment) as if those services were provided by a network provider; however, eligible expenses will be determined as described in this SPD
Pre-admission Testing	75% after the deductible	55% of MNRP after the deductible
Emergency Services		
Emergency	75% after the deductible **Emergency Services:** If you are admitted as an inpatient to a hospital directly from the emergency room, you will not have to pay this cost sharing; you will pay the hospital inpatient services cost sharing amount instead. This does not apply to services provided to stabilize an emergency after admission to a hospital; eligible expenses for emergency health services provided by a non-network provider will be determined as described in this SPD.	75% after the deductible **Emergency Services:** If you are admitted as an inpatient to a hospital directly from the emergency room, you will not have to pay this cost sharing; you will pay the hospital inpatient services cost sharing amount instead. This does not apply to services provided to stabilize an emergency after admission to a hospital; eligible expenses for emergency health services provided by a non-network provider will be determined as described in this SPD.
Non-emergencies	55% of MNRP after the out-of-network deductible if not a true emergency	55% of MNRP after the out-of-network deductible if not a true emergency
Freestanding Urgent Care	75% after the deductible	55% of MNRP after the deductible
Ambulance - True Emergencies	75% after the deductible	75% after the deductible
Ambulance Non-emergencies	75% after the deductible	75% after the deductible
Inpatient and Outpatient Services		
Skilled Nursing Facility	75% after the deductible (semi-private room accommodations and all medically necessary services); up to 210 days per admission (in- and out-of-network combined)	55% of MNRP after the deductible (semi-private room accommodations and all medically necessary services); up to 210 days per admission (in- and out-of-network combined)

Covered Services	In-Network	Out-of-Network
Home Health Care and Private Duty Nursing	75% after the deductible when ordered by your doctor There is a combined limit of 120 visits per person per calendar year (in- and out-of-network combined) and a combined limit of $20,000 per person per lifetime (in- and out-of-network combined)	55% of MNRP after the deductible when ordered by your doctor There is a limit of 120 visits per person per calendar year (in- and out-of-network combined) and a combined limit of $20,000 per person per lifetime (in- and out-of-network combined)
Hospice	100% after the deductible; up to 210 days per member per lifetime (in- and out-of-network combined) Includes six bereavement counseling visits completed within six months after the patient is deceased for covered members (in- and out-of-network combined)	100% after the deductible; up to 210 days per member per lifetime (in- and out-of-network combined) Includes six bereavement counseling visits completed within six months after the patient is deceased for covered members (in- and out-of-network combined)
Vision Therapy	75% after the deductible; up to 20 visits per year; additional visits subject to medical necessity review	55% of MNRP after the deductible; up to 20 visits per year; additional visits subject to medical necessity review
Speech, Occupational, Physical Therapy - Maximum	75% after the deductible; up to 40 visits per therapy per year (in- and out-of-network combined); additional visits subject to medical necessity review	55% of MNRP after the deductible; up to 40 visits per therapy per year (in- and out-of-network combined); additional visits subject to medical necessity review
Respiratory Therapy	75% after the deductible, based on medical necessity review	55% of MNRP after the deductible, based on medical necessity review
Cardiac Rehabilitation	75% after the deductible, based on medical necessity review	55% of MNRP after the deductible, based on medical necessity review
Chiropractic Services (inclusive of Osteopathic Therapy)	75% after the deductible; up to 30 visits per year	55% of MNRP after the deductible; up to 30 visits per year
Hearing Aid Appliances	$750 allowance after the deductible; limited to one device per ear once every three years (in- and out-of-network combined)	55% of MNRP after the deductible; limited to one device per ear once every three years (in- and out-of-network combined)
Hearing Aid Evaluation	75% after the deductible; up to one hearing aid evaluation every three years (in- and out-of-network combined)	55% of MNRP after the deductible; up to one hearing aid evaluation every three years (in- and out-of-network combined)
Diagnostic Hearing Evaluation	75% after the deductible	55% of MNRP after the deductible
Cochlear Implants	75% after the deductible	55% of MNRP after the deductible
Second Surgical Opinion	75% after the deductible	55% of MNRP after the deductible
Durable Medical Equipment (standard equipment)	75% after the deductible	55% of MNRP after the deductible
Internal Prosthetics	75% after the deductible	55% of MNRP after the deductible
External Prosthetics	75% after the deductible	55% of MNRP after the deductible
Elective Sterilization	75% after the deductible	55% of MNRP after the deductible

Covered Services	In-Network	Out-of-Network
Fertility Services	Must use Center of Excellence 75% after the deductible during diagnosis and testing, plus: **Office Visits:** 75% after the deductible Lab/Radiology Testing Associated with Fertility Treatment: 75% after the deductible **Fertility Drugs:** May be covered under the pharmacy benefit Lifetime maximum on medical fertility services $25,000 and pharmacy related medications $10,000 Services will not be covered if member is not enrolled in the Fertility Solutions program	Must use a UnitedHealthcare Center of Excellence unless there is an approved exception to use an in-network provider; no out-of-network coverage provided
Dental Services	75% after the deductible for services related to accidental injury to sound and natural teeth performed within 12 months of the accident Routine dental care not covered	55% of MNRP after the deductible for services related to accidental injury to sound and natural teeth performed within 12 months of the accident Routine dental care not covered
Eye Exams	75% after the deductible for exams, including refraction tests, associated with disease or injury Routine eye exams not covered	55% of MNRP after the deductible for exams associated with disease or injury Routine eye exams not covered
Eyeglasses and Contacts	75% after the deductible; up to one pair of corrective lenses or contact lenses after cataract surgery	55% of MNRP after the deductible; up to one pair of corrective lenses or contact lenses after cataract surgery

Corning Retiree PPO

The Corning Retiree PPO works with a network of health care providers who agree to accept negotiated rates. Under the Corning Retiree PPO, you have the flexibility to see providers who are not in the Plan's network, but you pay a larger share of the cost.

Some advantages of the Corning Retiree PPO option include:

- **Low out-of-pocket cost.** When you use network providers for covered services, you pay a copayment for office visits.
- **A focus on prevention.** Preventive care—including routine physicals—is covered at 100% if you see a network provider.
- **No claim forms for in-network care.** Network providers submit your medical expenses directly to the Plan. You may need to submit claim forms to be reimbursed for out-of-network care under the Corning Retiree PPO.
- **No MNRP for in-network care.** Because network providers agree to accept rates set by the Plan, you do not have to pay expenses above their charges. If you seek out-of-network care under the Corning Retiree PPO, however, you may be charged for expenses above MNRP.

About Maximum Non-Network Reimbursement Program (MNRP)

"Maximum non-network reimbursement program" (MNRP) is a term used in descriptions for non-participating (out-of-network) providers. The allowed charge is determined based on the following (MNRP) rate in the order set forth below:

110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare service codes for the same or similar service within the geographic market if the covered health services are provided by a non-participating provider who has not negotiated a discount in fees with UnitedHealthcare.

The "Corning Retiree PPO Summary" chart highlights some of the key features of the Corning Retiree PPO. Be sure to read the rest of this section for more detailed information about the benefits the Plan provides.

You get the most out of the Plan when you use providers who are in the Plan's network. However, with the Corning Retiree PPO, you may choose to receive your care from a network provider or you may choose to see any licensed provider who is not part of the network.

- **In-network.** You have the lowest out-of-pocket costs when you use participating providers in the Corning Retiree PPO network. You pay a fixed copayment for office visits, urgent care, and emergency room visits. Most other services are covered at 80% after you pay an annual deductible ($600 per person; $1,200 if you cover dependents). Because in-network providers agree to negotiated rates, you do not have to pay expenses above their charges.

  With a PPO, you do not have to choose a primary care doctor or obtain a referral to see a network specialist. You simply go to any network provider and receive the in-network level of benefits.

- **Out-of-network.** If you use out-of-network providers, you pay a larger share of the cost. In this case, you will be reimbursed 50% of MNRP after you pay an annual deductible ($1,200 per person; $2,400 if you cover dependents). To be reimbursed for out-of-network care, you must submit a claim form to the Plan Administrator. You will be responsible for paying expenses above MNRP. Depending upon the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-network providers who have agreed to discounts negotiated from their charges on certain claims or covered health services. The Shared Savings Program is a program in which UnitedHealthcare may obtain a discount to a non-network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If that happens you should call the number on your medical ID card. Shared Savings Program providers are not network providers and are not credentialed by UnitedHealthcare. (See the "Your Rights and Protections Against Surprise Medical Bills" section for additional information.)
- **Out-of-area care.** If you do not have access to a network provider who is within a 30-mile radius of your home, you may be able to receive an exception to the out-of-network coverage requirement. In this case, you can receive care from a closer provider who is not part of the network and that care will be covered as if the provider were in-network. Be sure to call the member services number listed on your medical ID card to receive approval before you start services with a provider that may warrant coverage through a "gap exception."

Notes:

- Emergency health services provided by a non-network provider will be reimbursed as eligible expenses, as described in this SPD.
- Covered services provided at certain network facilities by a non-network physician, when not emergency health services, will be reimbursed as eligible expenses, as described by this SPD. For these covered health services, certain network facility is limited to a hospital (as defined in *1861(e) of the Social Security Act*), hospital outpatient department, critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), ambulatory surgical center (as described in section *1833(i)(1)(A) of the Social Security Act)*, or any other facility specified by the Secretary.
- Air ambulance transport provided by a non-network provider will be reimbursed as an eligible expense, as described in this SPD.

In the "Corning Retiree PPO Summary" section, you will find a detailed description of the benefits available under the Corning Retiree PPO. Also, see the "Mental Health/Substance Use Disorder Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section and the "Prescription Drug Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section for additional information about covered health services.

Copayments

Office Visit Copayment

Your copayment for office visits under the Corning Retiree PPO will depend on the type of doctor you see. When you seek in-network primary care, urgent care, or speech, occupational, and/or physical therapy, you will pay $35. If you choose to see a specialist, you will pay a higher copayment of $55 for in-network services.

Out-of-network visits for primary care, specialists visits, urgent care, or speech, occupational, and/or physical therapy are covered at 50% of MNRP after you pay the annual out-of-network deductible.

Preventive Care Visits

The Corning Retiree PPO covers preventive care services without charging a deductible, copayment, or coinsurance when these services are provided by a network provider. Refer to the "Preventive Care Services" section for more details on covered services.

Emergency Room Visit Copayment

Your copayment for an emergency room visit under the Corning Retiree PPO is $150. This copayment is waived if you are admitted for an emergency condition within 24 hours.

Urgent Care Visit Copayment

Your copayment for an urgent care visit under the Corning Retiree PPO is $35.

Deductibles

The annual deductible is the amount of eligible expenses, or the recognized amount when applicable, you must pay each calendar year for covered health services before you are eligible to begin receiving benefits. The amounts you pay toward your annual deductible accumulate over the course of the calendar year.

For in-network office visits, you do not have to satisfy the deductible, and copays do not apply to the deductible. The Corning Retiree PPO has separate deductibles for in-network and out-of-network care.

Corning Retiree PPO Deductibles

	In-Network	Out-of-Network
Individual	$600	$1,200
Family	$1,200	$2,400

Under the Corning Retiree PPO, you meet the individual deductible once you have paid the deductible amount for yourself or another covered individual, even if you cover other dependents. You meet the family deductible once covered family members have paid the combined total toward their individual deductibles. Once you have met the family deductible, no further deductible will be charged that year, no matter how many dependents you have enrolled.

Coinsurance

Coinsurance is the percentage of covered expenses that the Plan pays, after deductibles are met. The coinsurance is 80% of negotiated rates for in-network and 50% of MNRP for out-of-network.

Services that are subject to coinsurance typically include inpatient and outpatient services, equipment and prosthetics, and others.

Out-of-pocket Maximums

The out-of-pocket maximum is the maximum amount you will have to pay for covered services each year. Medical deductibles and coinsurance, mental health/substance use disorder copayments and coinsurance, and prescription drug copayments and coinsurance all count toward the out-of-pocket maximum. Once your out-of-pocket expenses reach the limit (not including amounts for non-covered services or amounts above MNRP that you have paid for out-of-network expenses), the Corning Retiree PPO will pay 100% of charges for all additional covered expenses. There are separate out-of-pocket maximums for in-network and out-of-network benefits.

You meet the family out-of-pocket maximum once covered family members have paid the combined total toward their individual out-of-pocket maximum. Once you have met the family out-of-pocket maximum, no further copayments or coinsurance will be charged that year, no matter how many dependents you have enrolled.

Combined Corning Retiree PPO Out-of-pocket Maximums (Medical, Mental Health/Substance Use Disorder, and Prescription Drugs)

	In-Network	Out-of-Network
Individual	$3,600	$7,000
Family	$7,000	$13,400

Lifetime Maximum

There is no lifetime maximum for in-network benefits under the Corning Retiree PPO. The out-of-network lifetime benefit maximum is $1 million. This means that each covered person is eligible to receive a maximum of $1 million of out-of-network covered services in their lifetime under the Corning Retiree Medical Plan.

Corning Retiree PPO Summary

This section provides an overview of covered medical services under the Corning Retiree PPO. Refer to the "Services That Require Prior Authorization" section for the list of services and supplies that require prior authorization. See the "Mental Health/Substance Use Disorder Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section and the "Prescription Drug Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)" section for a summary of these benefits.

Covered Services	In-Network	Out-of-Network
Plan Features		
Provider Choice	Use any network provider; no referral required	Use any licensed provider; no referral required
Deductible	$600 individual $1,200 family	$1,200 individual $2,400 family
Copayment	$35 primary care provider office visits (includes OB/GYN, physical, occupational, and speech therapy visits) $55 specialist office visits $35 urgent care center visits $150 emergency room visits	N/A

Covered Services	In-Network	Out-of-Network
Coinsurance	Plan pays 80% after the deductible for most covered services; you pay 20% of the contracted rate	Plan pays 50% of MNRP after the deductible for most covered services; you pay 50%, plus charges above MNRP
Out-of-pocket Maximum	$3,600 individual $7,000 family coverage Includes deductible, copayments for medical, mental health, substance abuse, and prescription drugs, and coinsurance; excludes non-covered services and amounts that exceed the contracted rate	$7,000 individual $13,400 family coverage Includes deductible, copayments for medical, mental health, substance abuse, and prescription drugs, and coinsurance; excludes non-covered services and amounts that exceed MNRP
Lifetime Maximum Benefit	None	$1 million per person
Outpatient Services		
Office Visit for Illness or Injury	$35 copayment for primary care providers (includes OB/GYN, physical, occupational, and speech therapy visits) $55 copayment for specialists	50% of MNRP after the deductible
Preventive Care Office Visits	Covered at 100% (frequency depends on age; see the “Preventive Care Services” section)	50% of MNRP after the deductible for gynecological and immunizations only (frequency depends on age; see the “Preventive Care Services” section) Physicals and well-child care are not covered
Laboratory Tests and X-rays	80%, no deductible 100% at independent labs or in an office setting	50% of MNRP after the deductible
Outpatient Surgery	80% after the deductible	50% of MNRP after the deductible
Chemotherapy (Drugs and Administration)	80% after the deductible	50% of MNRP after the deductible
Radiation Therapy	80% after the deductible	50% of MNRP after the deductible
Kidney Dialysis	80% after the deductible	50% of MNRP after the deductible
Allergy Tests	$35 copayment for primary care providers $55 copayment for specialists	50% of MNRP after the deductible
Allergy Injections	80% after the deductible	50% of MNRP after the deductible
Maternity Care (prenatal/delivery/postnatal)	Childbirth/Delivery Professional Services: 80% after the deductible Prenatal and Postnatal Care: 100%, no deductible	50% of MNRP after the deductible
Hospital Inpatient Services (Subject to Notification Requirements, see “Services That Require Prior Authorization” section)		
Semi-private Room and Board, Nursing and Doctor Services, Surgery, Diagnostic X-rays, and Lab Tests	80% after the deductible Mammography and/or Colonoscopy: ***Preventive:*** 100%, no deductible ***Diagnostic:*** 100%, no deductible	50% of MNRP after the deductible
Anesthesia	80% after the deductible	50% of MNRP after the deductible

Covered Services	In-Network	Out-of-Network
Inpatient Physical Rehabilitation	80% after the deductible; up to 60 days per admission (in- and out-of-network combined)	50% of MNRP after the deductible; up to 60 days per admission (in- and out-of-network combined)
Hospital Outpatient Services		
Surgical Care	**Office Visit Setting:** $35 copayment for primary care providers; $55 copayment for specialists **Facility:** 80% after the deductible Covered health services provided by a non-network physician in certain network facilities will apply the same cost sharing (deductible, coinsurance, and/or copayment) as if those services were provided by a network provider; however, eligible expenses will be determined as described in this SPD	50% of MNRP after the deductible Covered health services provided by a non-network physician in certain network facilities will apply the same cost sharing (deductible, coinsurance, and/or copayment) as if those services were provided by a network provider; however, eligible expenses will be determined as described in this SPD
Pre-admission Testing	80% after the deductible	50% of MNRP after the deductible
Emergency Services		
Emergency	$150 copayment per visit; waived if admitted within 24 hours **Emergency Services:** If you are admitted as an inpatient to a hospital directly from the emergency room, you will not have to pay this copayment; you will pay the hospital inpatient services cost sharing amount instead. This does not apply to services provided to stabilize an emergency after admission to a hospital; eligible expenses for emergency health services provided by a non-network provider will be determined as described in this SPD.	$150 copayment per visit; waived if admitted within 24 hours **Emergency Services:** If you are admitted as an inpatient to a hospital directly from the emergency room, you will not have to pay this copayment; you will pay the hospital inpatient services cost sharing amount instead. This does not apply to services provided to stabilize an emergency after admission to a hospital; eligible expenses for emergency health services provided by a non-network provider will be determined as described in this SPD.
Non-emergencies	50% of MNRP after the out-of-network deductible if not a true emergency	50% of MNRP after the out-of-network deductible if not a true emergency
Freestanding Urgent Care	$35 copayment per visit	50% of MNRP after the deductible
Ambulance - True Emergencies	80% after the deductible	80% after the deductible
Ambulance Non-emergencies	80% after the deductible	80% after the deductible
Inpatient and Outpatient Services		
Skilled Nursing Facility	80% after the deductible (semi-private room accommodations and all medically necessary services); up to 210 days per admission (in- and out-of-network combined)	50% of MNRP after the deductible (semi-private room accommodations and all medically necessary services); up to 210 days per admission (in- and out-of-network combined)

Covered Services	In-Network	Out-of-Network
Home Health Care and Private Duty Nursing	80% after the deductible when ordered by your doctor There is a combined limit of 120 visits per person per calendar year (in- and out-of-network combined) and a combined limit of $20,000 per person per lifetime (in- and out-of-network combined)	50% of MNRP after the deductible when ordered by your doctor There is a combined limit of 120 visits per person per calendar year (in- and out-of-network combined) and a combined limit of $20,000 per person per lifetime (in- and out-of-network combined)
Hospice	100%, no deductible; up to 210 days per member per lifetime (in- and out-of-network combined) Includes six bereavement counseling visits completed within six months after the patient is deceased for covered members (in- and out-of-network combined)	100%, no deductible; up to 210 days per member per lifetime (in- and out-of-network combined) Includes six bereavement counseling visits completed within six months after the patient is deceased for covered members (in and out-of-network combined)
Vision Therapy	$55 copayment per visit; up to 20 visits per year, additional visits subject to medical necessity review	50% of MNRP after the deductible; up to 20 visits per year, additional visits subject to medical necessity review
Speech, Occupational, Physical Therapy - Maximum	$35 copayment per visit; up to 40 visits per therapy per year (in- and out-of-network combined); additional visits subject to medical necessity review; deductible and coinsurance apply if therapy conducted in hospital or outpatient facility vs. office	50% of MNRP after the deductible; up to 40 visits per therapy per year (in- and out-of-network combined); additional visits subject to medical necessity review
Respiratory Therapy	$55 copayment per visit, based on medical necessity review; deductible and coinsurance apply if therapy conducted in hospital or outpatient facility vs. office	50% of MNRP after the deductible, based on medical necessity review
Cardiac Rehabilitation	**Office Setting:** $55 copayment per visit, based on medical necessity review; deductible and coinsurance apply if therapy conducted in hospital or outpatient facility vs. office **Outside an Office Setting:** 80% after the deductible, based on medical necessity review	50% of MNRP after the deductible, based on medical necessity review
Chiropractic Services (inclusive of Osteopathic Therapy)	$55 copayment per visit; up to 30 visits per year	50% of MNRP after the deductible; up to 30 visits per year
Hearing Aid Appliances	$750 allowance after the deductible; limited to one device per ear once every three years	50% of MNRP after the deductible; limited to one device per ear once every three years
Hearing Aid Evaluation	Office visit copayment; up to one hearing aid evaluation every three years (in- and out-of-network combined)	50% of MNRP after the deductible; up to one hearing aid evaluation every three years (in- and out-of-network combined)
Diagnostic Hearing Evaluation	80% after the deductible	50% of MNRP after the deductible
Cochlear Implants	80% after the deductible	50% of MNRP after the deductible
Second Surgical Opinion	$35 copayment for primary care providers $55 copayment for specialists	50% of MNRP after the deductible

Covered Services	In-Network	Out-of-Network
Durable Medical Equipment (standard equipment)	80% after the deductible	50% of MNRP after the deductible
Internal Prosthetics	80% after the deductible	50% of MNRP after the deductible
External Prosthetics	80% after the deductible	50% of MNRP after the deductible
Elective Sterilization	80% after the deductible	50% of MNRP after the deductible
Fertility Services	Must use Center of Excellence 80% after the deductible during diagnosis and testing, plus: **Office Visits:** 80% after the deductible Lab/Radiology Testing Associated with Fertility Treatment: 80% after the deductible **Fertility Drugs:** May be covered under the pharmacy benefit Lifetime maximum on medical fertility services $25,000 and pharmacy related medications $10,000 Services will not be covered if member is not enrolled in the Fertility Solutions program	Must use a UnitedHealthcare Center of Excellence unless there is an approved exception to use an in-network provider; no out-of-network coverage provided
Dental Services	$55 copayment per visit for services related to accidental injury to sound and natural teeth performed within 12 months of the accident Routine dental care not covered	50% of MNRP after the deductible for services related to accidental injury to sound and natural teeth performed within 12 months of the accident Routine dental care not covered
Eye Exams	$55 copayment per exam for exams, including refraction tests, associated with disease or injury Routine eye exams not covered	50% of MNRP after the deductible for exams associated with disease or injury Routine eye exams not covered
Eyeglasses and Contacts	80% after the deductible; up to one pair of corrective lenses or contact lenses after cataract surgery	50% of MNRP after the deductible; up to one pair of corrective lenses or contact lenses after cataract surgery

What Is Covered (Applies to Corning Retiree CHP and Corning Retiree PPO)

Preventive Care Services

The Corning Retiree Medical Plan covers preventive care services provided on an outpatient basis at a physician's office, an alternate facility, or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force,
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,

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

Preventive care services include certain medical care services received and items purchased, including prescription drugs, for certain conditions for individuals with that condition. Covered preventive care services may change each year; for the most up-to-date information about how and what preventive care services are covered under medical plan options administered by UHC, go to www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/preventive-care-services.pdf.

Preventive care services under the:

- Corning CHP are covered at 100% ***before*** meeting the annual in-network deductible.
- Corning PPO are covered at 100% ***before*** meeting the annual in-network deductible.

Diagnostic procedure services under the:

- Corning CHP are covered at 100% ***after*** meeting the annual in-network deductible.
- Corning PPO are covered at 100% ***before*** meeting the annual in-network deductible.

For questions about the Plan's preventive care benefits call the number on the back of your medical ID card.

Services That Require Prior Authorization

UnitedHealthcare encourages an efficient system of care by identifying and addressing possible covered health care needs. This may include admission counseling, inpatient care advocacy, health education, discharge planning and disease management activities.

Before receiving certain covered health services from network or out-of-network providers, you must call UnitedHealthcare at 877-644-4334.

It is always up to you and your doctor to determine what care, if any, you receive, regardless of what UnitedHealthcare recommends or what the Plan will pay; the Plan does not provide medical advice. Any expenses that you pay because you do not follow the UnitedHealthcare program do not count toward your out-of-pocket maximum. Ultimately, decisions on medical care must be made between you and your doctor. UnitedHealthcare determines only if the service or supply will be considered a covered health service under the terms of the Corning Retiree Medical Plan.

Obtaining prior authorization from UnitedHealthcare does not guarantee that benefits will be payable. Benefits will be based on:

- The services or supplies performed or given,
- Your (or your dependent's) eligibility on the date the services or supplies are performed or given, and
- Copayments, deductibles, coinsurance, maximum limits, and all other terms of the Corning Retiree Medical Plan.

When to Obtain Prior Authorization from UnitedHealthcare	
Inpatient admissions (non-emergency) **Including skilled nursing facilities and rehabilitation facilities**	At least five business days before the start of a scheduled admission
Inpatient admissions (emergency)	Within two business days of the admission
Pregnancy **Inpatient admission for delivery of child**	Recommended if the stay will last more than 48 hours following a vaginal delivery or more than 96 hours following a cesarean section. If inpatient care is recommended beyond these limits, prior authorization must be obtained from UnitedHealthcare before the end of these time periods
Radiology (excluding X-ray) ▪ MRI ▪ CT Scan ▪ Bone Scan ▪ PET Scan	You must obtain prior authorization from UnitedHealthcare for services performed at an out-of-network facility
Other services ▪ Applied Behavioral Analysis ▪ Chemotherapy ▪ Home health care services ▪ Bariatric surgery* ▪ Fertility services* (Lifetime maximum Medical $25,000; Pharmacy $10,000) ▪ Gender Dysphoria services ▪ Durable medical equipment (over $1,000) ▪ Prosthetic devices (over $1,000) ▪ Reconstructive procedures including breast reconstruction surgery following mastectomy and breast reduction surgery ▪ Congenital heart disease surgeries ▪ Clinical trials ▪ Genetic testing including BRCA ▪ Surgery (sleep apnea and orthognathic surgeries) ▪ Outpatient sleep studies ▪ All outpatient therapeutic services ▪ Hospice care	At least five business days before the service or supply is provided * Must be enrolled in the applicable UnitedHealthcare Center of Excellence program
Organ/tissue transplants	At least seven business days before the evaluation, donor search, organ procurement/tissue harvest, or transplant, or as soon as reasonably possible

Note: For out-of-network benefits, the Plan's payment will be reduced by a $500 penalty if you fail to obtain prior authorization from UnitedHealthcare as outlined in this section. If your stay is going to extend beyond approved limits, additional authorization is required.

My Medical Ally Surgery Decision Support (SDS)

In addition to UnitedHealthcare's services, Corning offers My Medical Ally, Alight to help you learn about medical treatment options, make informed surgical decisions, find physicians, and more.

If you are age 18 or older and covered under the plan, you are required to complete the My Medical Ally SDS program before surgery if your doctor recommends any of the following non-emergency surgeries:

- Weight loss (bariatric surgery),
- Hysterectomy,
- Knee replacement,

- Hip replacement, or
- Lower back.

If you do not complete the program before one of these surgeries, you will be subject to a $750 penalty.

My Medical Ally offers free, confidential, one-on-one expert guidance to help you and your family make informed decisions about any medical care and treatment; the program can help you understand risks, benefits, and alternatives to surgery. And, if you complete the program, you can receive a $400 prepaid card.

Through the program, you receive:

- Support from a team of nurses, doctors, and other healthcare practitioners over the phone, via secure email or by text,
- Education resources about your medical condition and treatment options,
- Help getting a second opinion when needed,
- Recommendations for the best in-network doctors and hospitals to treat your condition, and
- Guidance on the right questions to ask your doctor.

Eligible Expenses

Corning has delegated to the Claims Administrator the discretion and authority to decide if a treatment or supply is a covered health service and how the eligible expense will be determined and otherwise covered under the Plan.

Eligible expenses are the amount the Claims Administrator determines that the Plan will pay for benefits as follows:

- ***For designated network benefits and network benefits for covered health services provided by a network provider,*** except for your cost sharing obligation, you are not responsible for any difference between the eligible expense and the amount the provider bills.
- ***For non-network benefits,*** except as described below, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for the eligible expense.
- ***For covered health services that are ancillary services received at certain network facilities on a non-emergency basis from non-network physicians,*** you are not responsible, and the non-network provider may not bill you, for amounts in excess of your copayment, coinsurance, and/or deductible; amounts that are based on the recognized amount as defined by the Claims Administrator.
- ***For covered health services that are non-ancillary services received at certain network facilities on a non-emergency basis from non-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied as described below,*** you are not responsible, and the non-network provider may not bill you, for amounts in excess of your copayment, coinsurance, and/or or deductible; amounts that are based on the recognized amount, as defined by the Claims Administrator.
- ***For covered health services that are emergency health services provided by a non-network provider,*** you are **not** responsible, and the non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance, and/or deductible; amounts that are based on the recognized amount, as defined by the Claims Administrator.

- ***For covered health services that are air ambulance services provided by a non-network provider,*** you are not responsible, and the non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance, and/or deductible; amounts that are based on the rates that would apply if the service was provided by a network provider and that are based on the recognized amount, as defined by the Claims Administrator.

Eligible expenses are determined according to the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible expenses are based on the following:

- ***When covered health services are received from a designated network and network provider,*** eligible expenses are our contracted fee(s) with that provider, or
- ***When covered health services are received from a non-network provider as arranged by the Claims Administrator,*** eligible expenses are an amount negotiated by the Claims Administrator or an amount permitted by law.

Contact the Claims Administrator if you are billed for amounts in excess of your applicable coinsurance, copayment, or deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When covered health services are received from a non-network provider (as described below), eligible expenses are determined as follows:

- For non-emergency covered health services received at certain network facilities from non-network physicians when such services are either ancillary services or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the eligible expense is based on the first of the following, as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*,
  - The reimbursement rate as determined by state law,
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator, or
  - The amount determined by Independent Dispute Resolution (IDR).
- For this provision, certain network facilities are limited to a hospital (as defined in 1861(e) of the Social Security Act), hospital outpatient department, critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary.

  Important: *For ancillary services, non-ancillary services provided without notice and consent, and non-ancillary services for unforeseen or urgent medical needs that arise at the time a service, you are not responsible, and a non-network physician may not bill you, for amounts in excess of your applicable copayment, coinsurance, and/or deductible; amounts that are based on the recognized amount, as defined by the Claims Administrator.*

- ***For emergency health services provided by a non-network provider,*** the eligible expense is based on the first of the following, as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*,
  - The reimbursement rate as determined by state law,
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator, or
  - The amount determined by Independent Dispute Resolution (IDR).

  Important: *You are not responsible, and a non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance, and/or deductible; amounts that are based on the recognized amount, as defined by the Claims Administrator.*
- ***For air ambulance transportation provided by a non-network provider,*** the eligible expense is based on the first of the following, as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*,
  - The reimbursement rate as determined by state law,
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator, or
  - The amount determined by Independent Dispute Resolution (IDR).

  Important: *You are not responsible, and a non-network provider may not bill you, for amounts in excess of your copayment, coinsurance, and/or deductible; amounts that are based on the rates that would apply if the service was provided by a network provider and that are based on the recognized amount, as defined by the Claims Administrator.*

When covered health services are received from a non-network provider, except as described above, eligible expenses are determined, based on one of the following:

- Negotiated rates agreed to by the non-network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates, or subcontractors, at the Claims Administrator's discretion,
- If rates have not been negotiated, then one of the following amounts applies based on the claim type:
  - Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 110% of CMS for the same or similar freestanding laboratory service, or
    - 110% of CMS for the same or similar durable medical equipment from a freestanding supplier, or CMS competitive bid rates,

- When a rate is not published by CMS for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:
  - For services other than pharmaceutical products, the Claims Administrator uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information,
  - For pharmaceutical products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource,
- When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar network providers for the same or similar service.
- When a rate for all other services is not published by CMS for the service and a gap methodology does not apply to the service, the eligible expense is based on 50% of the provider's billed charge.

The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

Important: Non-network providers may bill you for any difference between the provider's billed charges and the eligible expense, as defined by the Claims Administrator; this includes non-ancillary services when notice and consent is satisfied as described under section 2799B-2(d) of the Public Service Act.

If the billed charge exceeds the MNRP rate, you are responsible for paying the non-participating (out-of-network) provider the difference between the non-participating provider's billed charge and what was not covered by the Plan. Such excess amounts will not count toward the deductible or maximum out-of-pocket expense.

If you go to an out-of-network provider whose charges exceed the MNRP, you usually have to pay the excess charges out of your own pocket. These excess charges may be reimbursable through a health care FSA or Health Savings Account. You may also choose to appeal the decision by contacting UnitedHealthcare. To do so, ask your provider to send an appeal to UnitedHealthcare including an explanation of the service performed, the CPT (procedure) code, the diagnosis, and the amount of the charge. UnitedHealthcare will review your appeal and notify you and the provider of its decision. If your appeal is approved, the claim will be adjusted.

Covered Health Services

UnitedHealthcare pays for medically necessary covered health services that are considered to be:

- Medically appropriate,
- Necessary to meet your or your dependent's basic health needs,
- Provided in the most cost-efficient manner and setting appropriate for the delivery of the service,

- Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of UnitedHealthcare-recognized national medical, research, health care organizations, or government agencies,
- Consistent with the diagnosis of the condition,
- Required for reasons other than the comfort or convenience of you, your dependent, or your health care provider, and
- Of demonstrated medical value.

The fact that a doctor has performed or prescribed a procedure or treatment, or the fact that this may be the only treatment for a particular illness, injury, or mental illness, does not mean that it is medically necessary.

When covered health services are received from a non-network provider as a result of an emergency or as arranged by UnitedHealthcare, eligible expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance or any deductible. The Plan will not pay charges or amounts you are not legally obligated to pay.

Definition of Medically Necessary ─ health care services provided for the purpose of preventing, evaluating, diagnosing, or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease, or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance-related and addictive disorders, disease, or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease, or symptoms.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *generally accepted standards of medical practice* scientific evidence, prevailing medical standards, and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to covered persons on www.myuhc.com or by calling the number on your medical ID card.

Laboratory Tests

The cost of routine laboratory testing can vary up to five times higher when performed in different settings. For instance, under the Retiree CHP and Retiree PPO:

Lab Service	When you go to an in-network independent lab or have lab work performed at the office of a participating doctor:	When your lab work is performed by an in-network hospital lab:	When your lab work is performed by an out-of-network provider (physician or facility):
Preventive Care Lab Services	Covered at 100% of the eligible expense not subject to the deductible	Covered at 100% of the eligible expense not subject to the deductible	Not covered
Non-Preventive Care Lab Services	You may be required to pay a deductible/coinsurance (CHP) or copay (PPO) when an office visit is billed with the lab tests in the following scenarios: ▪ In-network doctor draws blood and performs lab work at their office ▪ In-network doctor draws blood and sends to an in-network independent lab ▪ Out-of-network doctor draws blood and sends to an in-network independent lab ▪ Any doctor provides a prescription and the patient goes to an independent lab/ patient service center	If you are in the Corning Retiree CHP, you may be required to pay a deductible first, then you pay 25% of the contracted rate for lab tests. If you are in the Corning Retiree PPO, you do not have a deductible, you only pay 20% of the contracted rate for lab tests in the following scenarios: ▪ Any doctor draws blood and sends to an in-network hospital lab ▪ Any doctor provides a prescription and the patient goes to an in-network hospital lab	You pay the deductible first, then you pay 45% (CHP) or 50% (PPO) of the allowed amount for the lab service. The out-of-network lab can also bill you for the difference between their charge and the allowed amount* in the following scenarios: ▪ Out-of-network doctor draws blood and performs lab work ▪ Any doctor draws blood and sends to an out-of-network independent lab ▪ Any doctor draws blood and sends to an out-of-network hospital lab ▪ Any doctor provides a prescription and the patient goes to an out-of-network hospital lab

* See the "Your Rights and Protections Against Surprise Medical Bills" section for additional information.

Emergency Room Care

In an emergency, go directly to the nearest health care facility. You pay 75% after the deductible for the Corning Retiree CHP or a $150 copayment for emergency room visits for the Corning Retiree PPO (if you are admitted to the hospital within 24 hours, the $150 emergency room copayment is waived).

If you are admitted to the hospital – in-network or out-of-network – you (or a family member, friend, or hospital representative) must notify the Plan within two business days. If you are admitted to an out-of-network hospital and do not notify UnitedHealthcare, your benefits will be reduced by a $500 penalty. For more information, see "Services That Require Prior Authorization" earlier in this section.

Definition of an Emergency

An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Mental health crisis.

Urgent Care

An urgent care facility provides medical care to treat minor illnesses or injuries when immediate care is needed. If you need urgent but not true emergency treatment, you will receive in-network benefits only if the urgent care facility is in the network. If you are enrolled in Corning Retiree CHP, you pay the full cost of urgent care until you meet the deductible. Once you meet the deductible, in-network urgent care is covered at 75% and out-of-network urgent care is covered at 55%. If you are enrolled in the Corning Retiree PPO, you pay a $35 copayment at in-network urgent care centers. If the urgent care facility is not in the network, you receive out-of-network benefits (50% of MNRP after the out-of-network deductible).

Out-of-Area Care

Because UnitedHealthcare has a national network, you can find network providers in most areas of the United States. If you or a dependent needs non-emergency out-of-area care, call your Plan Administrator to see if there is a network provider in the area. If you do not use a network provider when one is available, the Plan will cover your care at the out-of-network level.

Treatment of Gender Dysphoria

Benefits for the treatment of Gender Dysphoria (GD) are limited to:

- Psychotherapy for GD and associated co-morbid psychiatric diagnoses, as described under the Plan's mental health benefits,
- Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided, as described under the Plan's pharmaceutical products – outpatient benefits,
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting,
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy,
- Surgery for the treatment for GD, including the following surgeries:
  - Bilateral mastectomy or breast reduction,
  - Clitoroplasty (creation of clitoris),
  - Hysterectomy (removal of uterus),
  - Labiaplasty (creation of labia),
  - Metoidioplasty (creation of penis, using clitoris),
  - Orchiectomy (removal of testicles),
  - Penectomy (removal of penis),

- Penile prosthesis,
- Phalloplasty (creation of penis),
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries),
- Scrotoplasty (creation of scrotum),
- Testicular prosthesis,
- Urethroplasty (reconstruction of urethra),
- Vaginectomy (removal of vagina),
- Vaginoplasty (creation of vagina),
- Vulvectomy (removal of vulva),
- Thyroid chondroplasty (removal of reduction of the Adam's Apple),
- Augmentation mammoplasty (including breast prosthesis if necessary) if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role, and
- Facial feminization (facial surgical procedures that will result in MtF with a more feminized facial appearance).

Documentation Requirements

For breast surgery, you must provide a written psychological assessment from at least one qualified behavioral health provider experienced in treating GD. The assessment must document that the following criteria are met:

- The GD is persistent and well-documented,
- The individual has the capacity to make a fully informed decision and to consent to treatment,
- The individual is age 18 or older, and
- If significant medical or mental health concerns are present, they are reasonably well controlled.

For genital surgery, you must provide a written psychological assessment from at least two qualified behavioral health providers experienced in treating GD, who have independently assessed the individual. The assessment must document that the following criteria are met:

- The GD is persistent and well-documented,
- The individual has the capacity to make a fully informed decision and to consent to treatment,
- The individual is 18 years or older, and
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

In addition, for GD treatment, an individual must:

- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender, and
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The Plan will pay for certain benefits for the treatment of GD that conform to the World Professional Association for Transgender Health Association (WPATH) Standards of Care for Gender Identity Disorders. Whether the Plan covers GD treatment will depend on the nature of the treatment and the stage of the covered person's GD. A covered person may be required to submit documentation to the Plan Administrator for GD treatments to be covered under the Plan. For more information on the various stages of GD, the treatments covered under each stage, and the documentation required for treatment coverage at each stage, call the Claims Administrator's number on your medical ID card.

Cranial Orthotic Devices

Cranial orthotic devices that are reconstructive for treatment of craniofacial asymmetry with severe non-sysnostotic positional palgiocephaly or craniosynostosis are covered.

Fertility Solutions Plus

Fertility Solutions Plus is an inclusive, comprehensive fertility and family-building support solution designed to help employees navigate various paths to parenthood. By combining UnitedHealthcare's fertility support services with Maven's digital family health platform, Fertility Solutions Plus provides personalized support to help improve outcomes and employee satisfaction while advancing diversity, health equity, and inclusion.

To provide support throughout the process, Fertility Solutions Plus offers:

- Personalized engagement through 24/7 digital content, access to a dedicated fertility nurse, and care advocate and support finding quality providers,
- Clinical and virtual support resources for help navigating coverage and getting referrals for in-person and virtual specialists,
- Company-funded reimbursement may be available through Maven Wallet for expenses not covered by the medical plan, including adoption or surrogacy, and
- For those seeking medical treatment related to fertility, UnitedHealthcare provides education and counseling through individualized case management, utilization management, and access to a high-quality fertility Centers of Excellence (COE) network.

Coverage includes therapeutic services for the treatment of infertility when provided by or under the direction of a physician. Benefits are limited to:

- Assisted Reproductive Technologies (ART), including, but not limited:
  - In Vitro Fertilization (IVF),
  - Egg/oocyte retrieval,
  - Fresh or frozen embryo transfer,
  - Intracytoplasmic Sperm Injection (ICSI),
  - Assisted hatching,
  - Cryopreservation and storage of embryos for five years, and
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD),
- Frozen embryo transfer cycle, including the associated cryopreservation and storage of embryos,
- Artificial Insemination (AI) and Intrauterine Insemination (IUI),
- Ovulation induction (or controlled ovarian stimulation),

- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) (male factor associated surgical procedures for retrieval of sperm),
- Surgical procedures, including, but not limited to laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, and ovarian cystectomy,
- Electroejaculation,
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo,
- Embryo biopsy for Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer to increase the chance for conception, and
- Fertility preservation for medical reasons when planned cancer or other medical treatment is likely to produce infertility/sterility. Coverage is limited to the collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than five years are not covered.

Enhanced Benefit Coverage

- Embryo biopsy for Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer to increase the chance for conception,
- Donor coverage, which includes costs associated with donor medical expenses, including collection and preparation of oocyte and/or sperm; the Plan does not cover donor charges associated with medications associated with the collection and preparation of oocyte and/or sperm, compensation, or administrative services,
- Fertility preservation for non-medical reasons when you would like to delay pregnancy for non-medical reasons; coverage is limited to collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, embryo cryopreservation, and long-term storage costs for up to five years,
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation),
- Infertility treatment following unsuccessful reversal of voluntary sterilization, and
- Infertility treatment following the reversal of voluntary sterilization provided the reversal meets criteria to be eligible for coverage (tubal reversal, reanastomosis, vasectomy reversal, vasovasostomy, or vasoepididymostomy).

You do not need to have a diagnosis of infertility to be eligible to receive the enhanced benefit coverage described above. To be eligible, you must be a female younger than age:

- 44 if using your own oocytes (eggs), or
- 55 if using donor oocytes (eggs).

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

Child dependents are eligible for fertility benefits until the last day of the month the Dependent turns age 26.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility, such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures when provided by or under the care or supervision of a physician:

- Collection of sperm,
- Cryo-preservation of sperm,
- Ovarian stimulation, retrieval of eggs, and fertilization,
- Oocyte cryo-preservation, and
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are covered under other Plan benefits.

Benefits are not available for long-term storage costs (long-term is considered five years or more).

Benefit limits are included as part of the Plan's fertility benefits limit. This limit also includes Preimplantation Genetic Testing (PGT-M and PGT-SR) and related services benefits. Benefits are further limited to one cycle of fertility preservation for Iatrogenic infertility per person during the entire period they are enrolled for Plan coverage.

Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services

The Plan covers Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible, the following criteria must be met:

- The PGT must be ordered by a physician after genetic counseling, and
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).

Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a physician:

- Ovulation induction (or controlled ovarian stimulation),
- Egg retrieval, fertilization, and embryo culture,
- Embryo biopsy,
- Embryo transfer, and
- Cryo-preservation and short-term embryo storage.

Benefits are not available for long-term storage costs (long-term is consider five years or more).

Benefit limits are included as part of the Plan's fertility benefits limit; however, this limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit does include fertility preservation for Iatrogenic infertility benefits.

Benefits for ART for related services, included as part of the Plan's fertility services, do not include preimplantation genetic testing for a specific genetic disorder.

Maven Wallet

Corning also provides the Maven Wallet Program for adoption and surrogacy. This comprehensive program provides critical support for fertility, pregnancy, adoption, parenting, and pediatrics. Working with Fertility Solutions benefits, Maven Wallet provides financial support up to a $25,000 lifetime maximum reimbursement. To enroll in the Maven Wallet Program, go to mavenclinic.com/join/corning1Corning Retiree.

Obesity Surgery – Bariatric Solutions

The Plan covers surgical treatment of obesity provided by or under the direction of a physician, provided the following is true:

- Patient has a minimum Body Mass Index (BMI) of 40
- Patient has a BMI > 35, with at least one complicating comorbidity, directly related to, or exacerbated by morbid obesity, for example:
  - Type 2 diabetes,
  - Cardiovascular disease (e.g., stroke, myocardial infarction, poorly controlled hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy)),
  - History of coronary artery disease with a surgical intervention such as cardiopulmonary bypass or percutaneous transluminal coronary angioplasty,
  - Cardiopulmonary problems (e.g., documented Obstructive Sleep Apnea (OSA) confirmed on polysomnography with an AHI or RDI of >= 30 (as defined by AASM Task Force. Sleep.1999;22:667-89), or
  - History of cardiomyopathy.
- Patient must be 18 years of age or older, or for adolescents, they have achieved greater than 95% of estimated adult height **and** a minimum Tanner Stage of 4,
- Patient must have documentation of a motivated attempt of weight loss through a structured diet program, before bariatric surgery, which includes physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program within the last two years required before approval, and
- Patient must complete a pre-surgical psychological evaluation.

You are required to use the Bariatric Resource Services (BRS), which is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. The program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information, and education in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence.

All authorization information and enrollment for bariatric surgery must be initiated through Optum's BRS program. Covered participants seeking coverage for bariatric surgery must notify Optum as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling Optum at 888-936-7246 to enroll in the program.

You are encouraged, but not required, to use a BRS Center of Excellence Center (COE). **Note:** Travel and lodging services are covered health services only in connection with obesity-related services received at a BRS COE (see the "Travel and Lodging Services" section).

Excess Skin Removal Surgery following Obesity Surgery

Surgery for excess skin removal is covered when a member has had weight loss (surgical and/or non-surgical) using the following criteria:

- Member can have either a panniculectomy or abdominoplasty; if both procedures are performed the one of lesser cost will be covered.
- No other additional procedures are covered under this benefit. Examples would be procedures such as body sculpting or skin removal from the face or arms.
- For members who have not had a bariatric procedure, they must submit copies of their physician's clinical office notes from at least 18 months before the request for coverage documenting their base weight. They must also submit documentation of achieving their body weight goal over a minimum of 12 months and maintaining that loss for at least six additional months.
- Coverage for these procedures will be limited to one procedure per individual's lifetime.

Note: These services are considered to be reconstructive services and are not handled through the BRS Program. Prior authorization is required for reconstructive procedures.

Unlimited non-preventive nutritional counseling services are covered when rendered by a network provider, so long as you have contacted and are working with Bariatric Resource Services.

Travel and Lodging Services

United Resource Networks will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD),
- Kidney Solutions services,
- Transplantation services,
- Fertility services,
- Elective termination of pregnancy (when not available in your state of residence),
- Bariatric services,
- Cancer-related treatments,
- Gender dysphoria treatments (when not available in your state of residence), and
- Substance use disorder treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated United Resource Networks Facility (Center of Excellence). UnitedHealthcare makes the determination on what is an eligible expense.

The Claims Administrator will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the patient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site for the purposes of an evaluation, procedure, or necessary post-discharge follow-up.
- Eligible expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Facility.
- If the patient is an Enrolled Dependent minor child, travel expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum benefit of $10,000 per covered person for all travel and lodging expenses incurred by the patient and companion(s) and reimbursed under this Plan in connection with all transplant procedures, cancer-related services, bariatric services, kidney services, fertility services, or CHD procedures.

Examples of travel expenses may include:

- Airfare at coach rate,
- Taxi or ground transportation, or
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated United Resource Networks Facility.

Preferred Provider Partner Program – Enhanced Travel and Lodging Benefits

If you or a covered dependent will be traveling more than 50 miles to a Preferred Provider Partner, the Plan provides enhanced travel and lodging benefits, which cover the travel and lodging expenses for the covered member and a travel companion.

You will receive more information when you engage with a Preferred Provider Partner (Cleveland Clinic or Memorial Sloan Kettering (MSK) Cancer Center). For information on who to contact and when, see the "Corning Preferred Provider Partners" section.

There is a combined overall lifetime maximum of $10,000 per covered person for all travel and lodging expenses incurred by the patient and companion(s) and reimbursed under this Plan in connection with services received at a Preferred Provider Partner.

Travel and Lodging Assistance Program

The Plan provides you with travel and lodging assistance. Travel and lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a designated provider and the distance from your home address to the facility. Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have questions about the Travel and Lodging Assistance Program, call the Travel and Lodging office at 800-842-0843.

Plan coverage for travel and lodging for the patient, provided they are not covered by Medicare, and a companion, are as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a designated provider for an evaluation, the procedure, or necessary post-discharge follow-up,
- Eligible expenses for lodging for the patient (while not a hospital inpatient) and one companion, and
- If the patient is a dependent minor child, transportation expenses of two companions.

Travel and lodging expenses are only available if the patient resides more than 50 miles from the designated provider.

Reimbursement for certain lodging expenses for the patient and their companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

The transplant program offers a $10,000 per person per transplant maximum for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

A separate maximum of $10,000 per person applies for travel and lodging services related to bariatric treatment during the entire period that a person is covered under this Plan.

The Claims Administrator must receive valid receipts for charges before you will be reimbursed for the following expenses:

- Lodging:
  - A per diem rate, up to $50 per day, for the patient (when not in the hospital) or the caregiver,
  - A per diem rate, up to $100 per day, for the patient and one caregiver when a child is the patient; two persons may accompany the child.
- Examples of items that are not covered:
  - Groceries,
  - Alcoholic beverages,
  - Personal or cleaning supplies,
  - Meals,
  - Over-the-counter dressings or medical supplies,
  - Deposits,
  - Utilities and furniture rental, when billed separate from the rent payment, and
  - Phone calls, newspapers, or movie rentals.
- Transportation, including:
  - Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient’s home and the designated provider,
  - Taxi fares (not including limos or car services),
  - Economy or coach airfare,
  - Parking,
  - Trains,

- Boat,
- Bus, and
- Tolls.

Mental Health/Substance Use Disorder Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)

Corning provides mental health/substance use disorder benefits through UnitedHealthcare. This program is designed to provide flexible and consistent mental health and substance use disorder benefits.

The Mental Health Parity and Addiction Equity Act requires group health plans like the Corning Retiree Medical Plan to ensure that the financial requirements (such as copayments and deductibles) and treatment limitations (such as visit limits) for mental health or substance use disorders are equivalent to all other medical/surgical benefits.

Some of the advantages of the mental health/substance use disorder benefits include:

- Round-the-clock access to knowledgeable mental health/substance use disorder professionals to help you get the confidential care you need,
- State-of-the-art treatment approaches, and
- Your ability to choose in-network or out-of-network providers.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health therapy and coaching is available and provided by AbleTo, Inc. if you have certain co-occurring behavioral and medical conditions.

AbleTo provides behavioral covered health services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

For the Corning Retiree CHP option, except for the initial consultation, you must meet your annual deductible before you are eligible to these services; there are no deductibles, copayments, or coinsurance for the initial consultation.

For the Corning Retiree PPO option, you do not need to pay any deductibles, copayments, or coinsurance before you are eligible for these services.

For more information about these services, contact the Claims Administrator at the number on your ID card.

Enhanced Substance Use Disorder Coverage Through Optum Network Providers

When you use an Optum network provider for inpatient, residential, partial hospitalization, and/or intensive outpatient substance use disorder services, the Plan pays:

- 100% under the Corning Retiree PPO, or
- 100% after the deductible under the Corning Retiree CHP.

For help finding an Optum network provider, call 877-644-4334 or go online to www.lliveandworkwell.com (access code: Corning).

Summary of Mental Health/Substance Use Disorder Benefits

Covered mental health/substance use disorder services include those received on an inpatient basis in a hospital or an alternate facility, and those received on an outpatient basis in a provider's office or at an alternate facility.

Corning Retiree CHP Summary of Mental Health and Substance Use Disorder Benefits

Plan Features	In-Network	Out-of-Network
Annual Deductible	Shared with the medical plan	Shared with the medical plan
Annual Out-of-Pocket Maximum	Shared with the medical plan	Shared with the medical plan
Annual Limits	None	None
Outpatient	**Mental Health:** Plan pays 75% after the deductible **Substance Use Disorder:** Plan pays 100% after the deductible Notification required for non-routine services*	Plan pays 55% of MNRP after the deductible; notification required for non-routine services*
Inpatient	**Mental Health:** Plan pays 75% after the deductible **Substance Use Disorder:** Plan pays 100% after the deductible Notification required	Plan pays 55% of MNRP after the deductible; notification required*

* Prior authorization is required for certain services; see the "Services That Require Prior Authorization" section for the list of services and supplies that require prior authorization as well as what happens if you do not obtain prior authorization when required.

Corning Retiree PPO Summary of Mental Health/Substance Use Disorder Benefits

Plan Features	In-Network	Out-of-Network
Annual Deductible	Shared with the medical plan	Shared with the medical plan
Annual Out-of-Pocket Maximum	Shared with the medical plan	Shared with the medical plan
Annual Limits	None	None
Outpatient	**Mental Health:** You pay a $35 or $55 copayment per visit in the office setting (depending on the type of provider); Billed as an outpatient setting, Plan pays 80% after the deductible **Substance Use Disorder:** Plan pays 100% after the deductible Notification required for non-routine services*	Plan pays 50% of MNRP after the deductible; notification required for non-routine services*
Inpatient	**Mental Health:** Plan pays 80%, no deductible **Substance Use Disorder:** Plan pays 100%, no deductible Notification required	Plan pays 50% of MNRP after the deductible; notification required*

* Prior authorization is required for certain services; see the "Services That Require Prior Authorization" section for the list of services and supplies that require prior authorization as well as what happens if you do not obtain prior authorization when required.

How the Mental Health/Substance Use Disorder Benefits Work

When you need to access Corning's mental health/substance use disorder benefits, call UnitedHealthcare at 877-683-8546 (TTY/TDD 800-842-9489). UnitedHealthcare representatives are available 24 hours a day, 7 days a week. You will speak with a trained behavioral health professional who will assess your situation, determine your clinical needs, and refer you to appropriate treatment.

Under mental health/substance use disorder benefits, you may choose to use either a network or out-of-network provider, but you will receive higher benefits if you use a network provider.

Enhanced Coverage for Substance Use Disorder (SUD) Treatment

When you use an Optum® network provider for inpatient, residential, partial hospitalization, or intensive outpatient SUD services, the Corning Retiree Medical Plan will pay 100% of eligible expenses for the Corning Retiree PPO, and 100% of eligible expenses after the deductible is met for the Corning Retiree CHP.

Optum's SUD providers offer high-quality clinical experience, handle insurance paperwork and claims, and provide concierge support.

To find a mental health provider or treatment program, contact a Corning Health Connection Advocate at 877-644-4334 or visit liveandworkwell.com, access code: Corning. After you log on to the site, click "Find a Provider."

Remember, you must obtain prior authorization from UnitedHealthcare for an inpatient admission within two business days.

Claims information will be available on myuhc.com.

What Is Covered

The following services are provided for both mental health-related and substance use disorder-related diagnoses when provided by a licensed mental health provider:

- Diagnostic evaluations and assessment,
- Treatment planning,
- Referral services,
- Medication management,
- Detoxification,
- Inpatient/24-hour supervisory care,
- Partial hospitalization/day treatment,
- Intensive outpatient treatment,
- Services at a residential treatment facility,
- Individual, family, therapeutic group, and provider-based case management services,
- Psychotherapy, consultation and training sessions for parents, and paraprofessional and resource support to family,
- Crisis intervention,

- Transitional care, and
- Telephone consultations. Benefits are provided for telemedicine/telehealth services from network and non-network providers. Benefits for telemedicine services are provide to the same extent provided for applicable in-person services.

Autism Spectrum Disorder

Autism Spectrum Disorder is a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests, or activities. Treatment includes Intensive Behavioral Therapy (IBT), which is outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorder. An example of this type of treatment includes Applied Behavior Analysis (ABA), which is an evidence-based science in which behavior modifications are systematically applied to improve socially significant behavior to a meaningful degree, and which is considered to be the most effective treatment for children who have autism.

The Plan pays benefits for behavioral services for Autism Spectrum Disorder, including IBT, such as ABA, that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder,
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under appropriate supervision, and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, and property, and impairment in daily functioning.

These benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a covered health service for which benefits are available as described under the applicable medical covered health service category in this section.

Benefits include the following levels of care:

- Inpatient treatment,
- Residential treatment,
- Partial hospitalization/day treatment,
- Intensive outpatient treatment, and
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment, and treatment planning,
- Treatment and/or procedures,
- Medication management and other associated treatments,
- Individual, family, and group therapy,
- Crisis intervention, and
- Provider-based case management services.

The Plan Administrator for mental health/substance-related and addictive disorders provides administrative services for all levels of care. You are encouraged to contact the Plan Administrator for mental health/substance-related and addictive disorders for referrals to providers and coordination of care.

What Is Not Covered (Applies to Corning Retiree CHP and Corning Retiree PPO)

While the Corning Retiree Medical Plan covers many services, not all services are covered. To confirm whether a service is covered, contact UnitedHealthcare at 877-644-4334.

Note: *In describing services or providing examples, when the SPD says, "this includes" or "including, but not limited to," it is not the Plan's intent to limit the description to the specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."*

- Alternative Treatments:
  - Acupressure.
  - Aromatherapy.
  - Hypnotism.
  - Massage therapy (except as otherwise described as covered).
  - Rolfing (holistic tissue massage).
  - Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

  This exclusion does not apply to manipulative treatment and non-manipulative osteopathic care for which benefits are provided.
- Dental:
  - Dental care, which includes dental X-rays, supplies and appliances, and all associated expenses, including hospitalizations and anesthesia, limited to:
    - Transplant preparation,
    - Before the initiation of immunosuppressive drugs,
    - The direct treatment of acute traumatic injury, cancer, or cleft palate,
    - Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition (examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication), and
    - Endodontics, periodontal surgery, and restorative treatment.

    This exclusion does not apply to:
    - Accident-related dental services, or
    - Dental care (oral examination, X-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Plan.
  - Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums. Examples include:
    - Extractions (including wisdom teeth),
    - Restoration and replacement of teeth,
    - Medical or surgical treatments of dental conditions, and
    - Services to improve dental clinical outcomes,

This exclusion does not apply to:

- Preventive care for which benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement, or
- Accident-related dental services.

- Dental implants, bone grafts, and other implant-related procedures.

  This exclusion does not apply to accident-related dental services for which benefits are provided.

- Dental braces (orthodontics).
- Dental X-rays, supplies and appliances, and all associated expenses, including hospitalizations and anesthesia.

  This exclusion does not apply to dental care (oral examination, X-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Plan.

- Treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly, such as cleft lip or cleft palate.

- Devices, Appliances and Prosthetics:
  - Devices used specifically as safety items or to affect performance in sports-related activities.
  - Orthotic appliances and devices that straighten or re-shape a body part.

    This exclusion does not apply to:

    - Cranial molding helmets and cranial banding, or
    - Diabetic footwear, which may be covered for diabetic foot disease.

  - Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the-counter.
  - The following items , even if prescribed by a physician:
    - Blood pressure cuff/monitor,
    - Enuresis alarm,
    - Non-wearable external defibrillator,
    - Trusses, and
    - Ultrasonic nebulizers,
  - Repairs to prosthetic devices due to misuse, malicious damage, or gross neglect.
  - Replacement of prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.
  - Devices and computers to assist in communication and speech, except for dedicated speech generating devices and tracheo-esophageal voice devices for which benefits are provided.
  - Oral appliances for snoring.
  - Powered and non-powered exoskeleton devices.

- Drugs: These exclusions apply to the Plan's medical benefits only (prescription drug coverage is a separate and coverage may be available under the Plan's prescription drug benefits):
  - Prescription drugs for outpatient use that are filled by a prescription order or refill.
  - Self-administered or self-infused medications.

    This exclusion does not apply to:

    - Medications that, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting, or
    - Hemophilia treatment centers contracted to dispense hemophilia factor medications directly for self-infusion.
  - Growth hormone therapy unless prescribed by a health care professional for gender dysphoria.
  - Non-injectable medications given in a physician's office.

    This exclusion does not apply to non-injectable medications that are required in an emergency and consumed in the physician's office.
  - Over-the-counter drugs and treatments.
  - Certain new pharmaceutical products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31 of the following calendar year.

    This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment); if you have a life-threatening sickness or condition, under these circumstances, benefits may be available for the new pharmaceutical product to the extent provided.
  - A pharmaceutical product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product; the determinations may be made up to six times during a calendar year.
  - A pharmaceutical product that contains (an) active ingredient(s) that is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product; the determinations may be made up to six times during a calendar year.
  - A pharmaceutical product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. For this exclusion, a biosimilar is a biological pharmaceutical product approved based on showing that it is highly similar to a reference product (a biological pharmaceutical product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations n may be made up to six times per calendar year.
  - Benefits for pharmaceutical products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.
  - Certain pharmaceutical products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator; the determinations may be made up to six times during a calendar year.

- Compounded drugs that contain certain bulk chemicals.
- Compounded drugs that are available as a similar commercially available pharmaceutical product.

- Experimental, Investigational, or Unproven Services: Experimental, investigational, and unproven services, and all services related to experimental, investigational, and unproven services are excluded. The fact that an experimental, investigational, or unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition.

  This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided.

- Foot Care:
  - Routine foot care. Examples include the cutting or removal of corns and calluses.

    This exclusion does not apply to preventive foot care for individuals with diabetes for which benefits are provided.
  - Nail trimming, cutting, or debriding (removal of dead skin or underlying tissue),
  - Hygienic and preventive maintenance foot care. Examples include cleaning and soaking the feet and applying skin creams to maintain skin tone.

    This exclusion does not apply to preventive foot care for individuals who are at risk of neurological or vascular disease arising from diseases, such as diabetes.
  - Treatment of flat feet.
  - Treatment of subluxation of the foot.
  - Shoes.

    This exclusion does not include diabetic footwear, which may be covered for individuals with diabetic foot disease.
  - Shoes orthotics.

    This exclusion does not include diabetic footwear, which may be covered for individuals with diabetic foot disease.
  - Shoe inserts.

    This exclusion does not include diabetic footwear, which may be covered for individuals with diabetic foot disease.
  - Arch supports.

    This exclusion does not include diabetic footwear, which may be covered for individuals with diabetic foot disease.

- Medical Supplies and Equipment:
  - Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
    - Compression stockings,
    - Ace bandages,

- Gauze and dressings, and
- Diabetic strips, and syringes.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of durable medical equipment for which benefits are provided,
- Diabetic supplies for which benefits are provided,
- Ostomy supplies for which benefits are provided, or
- Urinary catheters for which benefits are provided.

- Tubings and masks, except when used with durable medical equipment.

- Mental Health, Neurobiological Disorders, Autism Spectrum Disorder (ASD), and Substance Use Disorder Services: In addition to all other exclusions listed in this section, the following exclusions apply to services for mental health, neurobiological disorders, ASD, and/or substance use disorder services:
  - Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
  - Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
  - Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control, and conduct disorders, gambling disorder, and paraphilic disorders.
  - Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
  - Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
  - Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale, as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
  - Transitional living services.
  - Non-medical 24-hour withdrawal management.
  - High intensity residential care including American Society of Addiction Medicine (ASAM) criteria for individuals with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
- Nutrition:
  - Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals, or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).
  - Food of any kind, infant formula, standard milk-based formula, and donor breast milk.

This exclusion does not apply to enteral formula and other modified food products for which benefits are provided.

- Health education classes, unless offered by UnitedHealthcare or its affiliates, including, but not limited to, asthma, smoking cessation, and weight control classes.

- Personal Care, Comfort, or Convenience:
  - Television.
  - Telephone.
  - Beauty/barber service.
  - Guest service.
  - Supplies, equipment, and similar incidentals for personal comfort. Examples include:
    - Air conditioners,
    - Air purifiers and filters,
    - Batteries and battery chargers,
    - Dehumidifiers and humidifiers,
    - Ergonomically correct chairs,
    - Non-hospital beds, comfort beds, motorized beds, and mattresses,
    - Breast pumps,

      This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.
    - Car seats,
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, and recliners,
    - Exercise equipment and treadmills,
    - Hot tubs, Jacuzzis, saunas, and whirlpools,
    - Medical alert systems,
    - Music devices,
    - Personal computers,
    - Pillows,
    - Power-operated vehicles,
    - Radios,
    - Strollers,
    - Safety equipment,
    - Vehicle modifications, such as van lifts,
    - Video players, and
    - Home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

- Physical Appearance:
  - Cosmetic procedures, as defined by the Claims Administrator. Examples include:
    - Abdominoplasty,
    - Breast enlargement, including augmentation mammoplasty and breast implants,
    - Body contouring, such as lipoplasty,
    - Calf implants,
    - Injection of fillers or neurotoxins,
    - Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of Gender Dysphoria.,
    - Hair transplantation,
    - Liposuction,
    - Mastopexy,
    - Pectoral implants for chest masculinization,
    - Skin resurfacing,
    - Voice modification surgery, and
    - Voice lessons and voice therapy.
  - Physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation.
  - Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.
  - Wigs regardless of the reason for the hair loss, except for cancer treatment, alopecia areata, or accidental injury.
  - Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Procedures and Treatments:
  - Biofeedback (other than for treatment of hyperhidrosis).
  - Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).
  - Rehabilitation services and manipulative treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
  - Speech therapy to treat stuttering, stammering, or other articulation disorders.
  - Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, congenital anomaly, or ASD.
  - A procedure or surgery to remove fatty tissue, such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.
  - Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

- Psychosurgery (lobotomy).
- Chelation therapy, except to treat heavy metal poisoning.
- Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain, and improve function, such as asthma or allergies.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Non-surgical obesity treatment, even for morbid obesity.
- Surgical treatment of hyperhidrosis (excessive sweating); non-surgical treatment using Botox, biofeedback, hypnotherapy, or iontophoresis may be covered if determined to be medically necessary.
- Services for the evaluation and treatment of Temporomandibular Joint (TMJ) syndrome, when the services are considered medical or dental in nature.
- Breast reduction surgery that is determined to be a cosmetic procedure.

  This exclusion does not apply to breast reduction surgery that the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which benefits are provided.
- Habilitative services or therapies for general well-being or a condition in the absence of a disabling condition.
- Intracellular micronutrient testing.

- Provider Services:
  - Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child.
  - A provider may perform on himself or herself.
  - Performed by a provider with your same legal residence.
  - Ordered or delivered by a Christian Science practitioner.
  - Performed by an unlicensed provider or a provider who is operating outside of the scope of their license.
  - Provided at a diagnostic facility (hospital or free-standing) without a written order from a provider.
  - When self-directed to a free-standing or hospital-based diagnostic facility.
  - Ordered by a provider affiliated with a diagnostic facility (hospital or free-standing) when that provider is not actively involved in the medical care before ordering the service or after the services is received.

    This exclusion does not apply to mammography testing.
- Reproduction:
  - The following fertility treatment-related services:
    - Cryopreservation and other forms of preservation of reproductive materials except as described in the "Fertility Solutions Plus" section. This exclusion does not apply to storage (up to five years) and retrieval of reproductive materials for which coverage is provided by the Plan.
    - Donor services and non-medical costs of oocyte or sperm donation, such as donor agency fees.

- Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
- Ovulation predictor kits.

- The following services related to a gestational carrier or surrogate:
  - Fees for the use of a gestational carrier or surrogate.
  - Insemination or in vitro fertilization procedures for surrogate or transfer of an embryo to gestational carrier.
  - Pregnancy services for a gestational carrier or surrogate who is not covered under the Plan.
  - Donor, gestational carrier or surrogate administration, agency fees, or compensation.
- The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
  - Purchased egg donor (i.e., clinic or egg bank), which includes the cost of donor eggs and medical costs related to donor stimulation and egg retrieval (this refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database).
  - Purchased donor sperm (i.e., clinic or sperm bank), which includes the cost of procurement and storage of donor sperm (this refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database).
- The reversal of voluntary sterilization.
- Fertility services not received from a designated provider.
- Assisted reproductive technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

- Services Provided under Another Plan: This includes services for which coverage is available:
  - Under another plan, except for eligible expenses payable due to coordination of benefits.
  - Under workers' compensation, no-fault automobile coverage, or similar legislation if you could elect it, or could have it elected for you.
  - While on active military duty.
  - For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.
- Transplants:
  - Health services for organ and tissue transplants, unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
  - Health services for transplants involving animal organs.
  - Donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's plan).
  - Transplants that are not performed at a designated provider or network facility that is not a designated provider.

    This exclusion does not apply to corneal transplants.

- Travel:
  - Health services provided in a foreign country, unless required as emergency health services.
  - Travel or transportation expenses, even if ordered by a physician, except as covered under the Plan's travel and lodging benefits; in which case additional travel expenses related to covered health services received from a designated provider may be reimbursed at the Plan's discretion.

    This exclusion does not apply to ambulance transportation for which benefits are provided.
- Types of Care:
  - Custodial care, as defined by the Claims Administrator, or maintenance care.
  - Domiciliary care, as defined by the Claims Administrator.
  - Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
  - Private duty nursing received on an inpatient basis.
  - Respite care.

    This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which benefits are provided.
  - Rest cures.
  - Services of personal care attendants.
  - Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
- Vision and Hearing:
  - Routine vision examinations, including refractive examinations to determine the need for vision correction.
  - Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
  - Purchase cost and associated fitting charges for eyeglasses or contact lenses.
  - Bone anchored hearing aids, except for a covered individual with:
    - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid, or
    - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
  - The Plan will not pay for more than one bone anchored hearing aid per person who meets the above coverage criteria during the entire period the individual is covered under this Plan. Repairs and/or replacement for a bone anchored hearing aid for these individuals are not covered, other than for malfunctions.
  - Eye exercise or vision therapy.
  - Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

- All Other Exclusions:
  - Autopsies and other coroner services and transportation services for a corpse.
  - Charges for:
    - Missed appointments,
    - Room or facility reservations,
    - Completion of claim forms, or
    - Record processing.
  - Charges prohibited by federal anti-kickback or self-referral statutes.
  - Diagnostic tests that are:
    - Delivered in other than a physician's office or health care facility, and
    - Self-administered home diagnostic tests, including, but not limited to, HIV and pregnancy tests.
  - Expenses for health services and supplies:
    - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country,

      This exclusion does not apply to covered individuals who are civilians injured or otherwise affected by war, any act of war, or terrorism in a non-war zone.
    - That are received after the date your coverage under this Plan ends, including health services for medical conditions that began before the date your coverage under the Plan ends,
    - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan,
    - That exceed eligible expenses or any specified Plan limitation,
    - For which a non-network provider waives the copayment, deductible, or coinsurance amount.
  - Foreign language and sign language services.
  - Long term (more than 30 days) storage of blood, umbilical cord, or other material. Examples include cryopreservation of tissue, blood, and blood products.
  - Health services and supplies that do not meet the definition of a covered health services as defined by the Claims Administrator; covered health services are those health services including services, supplies, or prescription drugs that the Claims Administrator determines to be all of the following:
    - Medically necessary,
    - Described as a covered health service by the Plan, and
    - Not otherwise excluded by the Plan.
  - Health services related to a non-covered health service. When a service is not a covered health service, all services related to that non-covered health service are also excluded.

    This exclusion does not apply to services the Plan would otherwise determine to be covered health services if they are to treat complications that arise from the non-covered health service.
  - For this exclusion, a complication is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a complication are bleeding or infections following a cosmetic procedure that require hospitalization.

- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:
  - Required solely for education, sports or camp, travel, career or employment, insurance, marriage, or adoption, or as a result of incarceration,
  - Conducted for medical research,

    This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided.
  - Related to judicial or administrative proceedings or orders, or
  - Required to obtain or maintain a license of any type.

Prescription Drug Benefits (Applies to Corning Retiree CHP and Corning Retiree PPO)

Corning provides a pharmacy benefit program through CVS Caremark to help you purchase prescription drugs at reduced costs when you use a participating pharmacy in the CVS Caremark retail pharmacy network or CVS Caremark's mail service program. You are eligible to participate in the CVS Caremark pharmacy program if you are enrolled in a Corning Retiree Medical Plan option.

Cost

The CVS Caremark pharmacy program encourages you to make the most out of your prescription benefit. Generics are generally the most cost-effective choice. You can also save by choosing to use CVS Caremark mail service for your long-term (i.e., maintenance) medications.

If you are enrolled in the Corning Retiree CHP, you must meet the deductible before copayments or coinsurance for prescription drugs. However, the deductible, copayments, and coinsurance do not apply to certain preventive medications. See the "Preventive Care Medications" section for more information.

See the chart that outlines your prescription drug costs.

Prescription Drug Copayments

Flat dollar copayments apply to:

- Generic (Tier I) drugs,
- All drugs purchased through the CVS Caremark mail service program, and
- All 90-day supply drugs purchased through the CVS retail pharmacy.

Prescription Drug Coinsurance

Coinsurance applies to all Tier II and Tier III drugs for up to a 30-day supply when filled at a participating retail pharmacy. Minimum and maximum amounts apply to the coinsurance costs. Coinsurance will count towards your medical plan option's annual out-of-pocket maximum. Coinsurance does not count toward your medical plan option's annual deductible (for the Corning Retiree PPO only).

Corning Retiree CHP Prescription Drug Costs

Drug Type	Retail Pharmacy Costs	CVS Caremark Mail Service Costs
Supply per prescription	Up to a 30-day supply	Up to a 90-day supply
Tier I (generic)	$15 copayment*	$35 copayment*
Tier II (preferred brand-name)	25% coinsurance ($35 minimum; $75 maximum)*	$75 copayment*
Tier III (non-preferred brand-name)	45% coinsurance ($65 minimum; $130 maximum)*	$160 copayment*

* Subject to deductible, except IRS preventive medicines. Counts toward out-of-pocket maximum.

Note: CVS Caremark's Tier II drug list is available online at www.caremark.com or by calling CVS Caremark at 800-826-7122.

Corning Retiree PPO Prescription Drug Costs

Drug Type	Retail Pharmacy Costs	CVS Caremark Mail Service Costs
Supply per prescription	Up to a 30-day supply	Up to a 90-day supply
Tier I (generic)	$15 copayment*	$35 copayment*
Tier II (preferred brand-name)	25% coinsurance ($35 minimum; $75 maximum)*	$75 copayment*
Tier III (non-preferred brand-name)	45% coinsurance ($65 minimum; $130 maximum)*	$160 copayment*

* Prescription drug costs will count towards your medical plan's annual out-of-pocket maximum.

Note: CVS Caremark's Tier II drug list is available online at www.caremark.com or by calling CVS Caremark at 800-826-7122.

Preventive Care Medications

The CVS Caremark pharmacy program covers preventive care medications as required by the Patient Protection and Affordable Care Act (PPACA), without charging copayment, deductible, or coinsurance when these medications are prescribed by a physician based on your age and gender. Contact the CVS Caremark customer care team for a complete list of these medications at 800-826-7122 or go to www.caremark.com.

Mandatory Generic

If a brand-name drug is dispensed when a generic is available (regardless of whether you or your doctor indicates that the pharmacy is to "dispense as written"), for the Corning Retiree CHP, you pay the full cost of the prescription drug until you meet the deductible. The mandatory generic rule applies once you meet the deductible. For the Corning Retiree PPO, you pay the generic copayment, ***plus*** the difference in cost between the brand-name drug and the generic drug, up to a maximum amount of $300 (this $300 maximum does not apply to retail coinsurance). This is called "mandatory generic." The difference in cost between brand-name drugs and their generic equivalents continues to widen. When speaking with your doctor, find out whether a generic equivalent is available for any of your prescribed drugs. Choosing the generic could mean hundreds of dollars in savings for you and your family.

Example: Buying Brand-Name Drugs When Generics Are Available

Let's look at an example of someone who purchases a brand-name drug through the mail service when a generic drug equivalent is available to treat the condition.

Assume your doctor writes a prescription for a 90-day supply of a brand-name drug. The price of the brand-name drug is $200. The copayment for the generic equivalent is $35.

You would pay $200 to purchase the brand-name drug. The generic equivalent would cost you only $35.

Generic = Savings for You and for Corning

Brand-Name Drug	You Pay
The difference in cost between the brand-name and generic drugs ($200-$35)	$165
Plus the generic copayment	+ $35
	= $200
Generic Equivalent	**You Pay**
The generic copayment	$35

Note: These prices are for illustrative purposes only. Your actual costs may vary.

Maintenance Choice Program

Long-term maintenance drugs must be filled either through CVS Caremark's mail service or a CVS Maintenance Choice retail pharmacy. If using a participating pharmacy other than CVS, you may only get two 30-day fills before having to select either the CVS Caremark mail service or the CVS retail pharmacy for any future prescriptions. Maintenance drugs are long-term (90 days or more) medications that you take on a regular, ongoing basis. To confirm which prescriptions are considered maintenance drugs, call CVS Caremark at 800-826-7122 or log on to www.caremark.com.

Types of Prescription Drugs

Tier I Drugs

These are generic drugs that have the same chemical composition as brand-name drugs but are available at a lower cost. Generic drugs have been shown to have the same effect on your body as brand-name drugs.

Tier II Drugs

These are brand-name drugs that are on the CVS Caremark Primary/Preferred Drug List. The drug list consists of preferred, proven, and cost-effective brand-name drugs that have been carefully reviewed and selected by an expert team of medical professionals. The purpose of this list is to provide complete therapeutic coverage while controlling prescription drug costs.

The Primary/Preferred Drug List is generally updated quarterly. Access www.caremark.com or call your customer care team at 800-826-7122 for the most current list.

Tier III Drugs

These are brand-name drugs that are not on CVS Caremark's Primary/Preferred Drug List. Tier III drugs are the most expensive—for you and for Corning. In addition, if a particular prescription drug becomes available without a prescription (that is, over-the-counter), other brand-name drugs that fall into the same classification—regardless of tier—may be subject to the Tier III copayment.

How Prescription Drug Benefits Work

The prescription drug program is easy to use. Here is how it works:

Short-term Prescriptions (Up to a 30-Day Supply) at Participating Pharmacies

- Show your prescription drug ID card (which shows the group code: RX1379) to the pharmacist and provide the Subscriber ID number shown on your prescription drug ID card.
- For the Corning Retiree CHP, pay the full cost of your prescription until you meet the deductible. Once you meet the deductible, pay your copayment or coinsurance, and receive your prescription. For the Corning Retiree PPO, pay your copayment or coinsurance and receive your prescription.
- If you are enrolled in the Corning Retiree CHP, you may use your Health Savings Account to reimburse yourself for pharmacy claims.

The CVS Caremark retail pharmacy network includes most major drug store chains and many independent pharmacies. To see if your pharmacy is in the CVS Caremark retail pharmacy network, ask your pharmacist or call CVS Caremark at 800-826-7122. You can also log on to CVS Caremark's website—www.caremark.com.

Long-term Prescriptions (Up to a 90-Day Supply) Through CVS Caremark Mail Service or CVS Retail Pharmacy

Corning offers another way to save on prescription drugs—the CVS Caremark mail service program. Ordering prescriptions by mail is an easy way to obtain maintenance medications and you can manage your prescriptions at www.caremark.com. When you order by mail or use a CVS retail pharmacy, you save more too. You will receive up to a 90-day supply for just one copayment. When your doctor writes a prescription for a long-term medication, here is what you should do:

- ***Ask your doctor for two prescriptions.*** One should be for a short-term supply (30 days plus one refill) that you can fill immediately at a participating retail pharmacy. The other prescription should be for a 90-day supply, plus three refills, when appropriate.
- ***Send your Mail Service Order Form, payment, and prescription to CVS Caremark.*** Generally, your care provider will submit your prescription electronically. To request a *Mail Service Order* form, call CVS Caremark at 800-826-7122 or log on to www.caremark.com. This form is also available in the "Claim Forms" section of My Total Rewards Resource Library.
- ***Watch for your prescription in the mail or pick it up at a CVS retail pharmacy.*** Your prescription usually arrives within 7 to 10 calendar days after CVS Caremark receives your order.
- ***Contact CVS Caremark for refills.*** Whether you call CVS Caremark or log on to www.caremark.com, be prepared to provide your or your covered dependent's Subscriber ID (on your prescription drug ID card), Corning's group code (RX1379), the prescription number, your daytime phone number and a credit card number and expiration date. You may also set up your prescriptions for auto refill to help you with medication adherence.

Prescription Drug Resources

To make the most of your prescription drug benefits, when you enroll in a Corning Retiree Medical Plan option, you have access to the following resources:

Provider	Services Offered	Contact
CVS Caremark	Provides prescription drug benefits when you use a network retail pharmacy Provides a maintenance program where you can obtain a 90-day supply from a CVS Health retail pharmacy or through CVS Caremark mail order	▪ 800-826-7122 ▪ www.caremark.com ▪ "Caremark" app
CVS Caremark Fast Start Line	Provides assistance when you have a new prescription you need filled	▪ 800-875-0867
CVS Caremark Specialty Pharmacy Services	Provides specialized delivery of high-cost biotech pharmaceuticals and related therapeutic services for certain chronic or genetic conditions	▪ 800-237-2767 ▪ www.cvsspecialty.com
PrudentRx Copay Program	Provides certain specialty medications at no cost to you (after your deductible for the Corning Retiree CHP)	▪ 800-578-4403
Rx Savings Solutions	Provides you with free, confidential service and personalized guidance on how to spend less on prescriptions. Rx Savings Solutions will contact you directly if they find a savings opportunity and can assist you and your doctor in making the change.	▪ 800-268-4476 ▪ www.myrxss.com ▪ support@rxsavingssolutions.com

What Is Not Covered

While prescription drug benefits cover many services, not all services are covered. To confirm whether a service is covered, contact CVS Caremark at 800-826-7122.

Following are some of the services that are not covered:

- Respiratory therapy,
- Ostomy supplies,
- Glucose monitors,
- Allergy serums, and
- Over-the-counter medications (unless a prescription is written by your provider).

Quantity Limitations

Some medications will be limited to a certain quantity within a given time frame, according to clinical guidelines. The guidelines for use and quantity were developed by doctors and pharmacists based on accepted medical practices, U.S. FDA guidelines, the recommendations of the drug manufacturer, and the cost-effective use of medicines.

In some cases, the quantity of your medication may require approval of a doctor before it can be dispensed. If this is the case, your pharmacist can call CVS Caremark at a special toll-free number that will be provided to the pharmacy when it processes the prescription. Alternatively, you may ask your doctor to call CVS Caremark directly.

Diabetic Supplies

Diabetic supplies (including test strips, lancets and syringes and needles used to inject insulin) are subject to the same costs as prescription drugs. For example, if you are enrolled in the Corning Retiree CHP, once you meet the deductible you pay the Tier II cost when you buy a 90-day supply of preferred brand-name test strips through CVS Caremark's Maintenance Choice program. If you are enrolled in the Corning Retiree PPO, you pay the Tier II cost when you buy a 90-day supply of preferred brand-name test strips through CVS Caremark's Maintenance Choice program. Keep in mind that not all diabetic supplies are on the preferred list.

Diabetic supplies are subject to CVS Caremark's mandatory mail service program. This means you can buy up to a two-month supply at a retail pharmacy. After two months, these supplies are covered only through CVS Caremark's Maintenance Choice program.

When your doctor writes a prescription for insulin, they also need to write a prescription for any additional diabetic supplies that you might need.

If you have questions about coverage of insulin or diabetic supplies, call CVS Caremark at 800-826-7122.

Note: Corning has partnered with Virta Health to provide additional resources for participants with Type 2 diabetes. See the "Virta Health Diabetes Treatment Program" section for additional information.

If you are enrolled in the real-time Medicare Part B Program, you will need to get your future supplies from a Medicare approved Part B Pharmacy retail or mail service supplier for diabetic testing supplies.

Prescription Changes Approved by Your Doctor

In certain situations, CVS Caremark will contact your prescribing doctor to inquire about a possible change in the drug being prescribed, the dosage being prescribed, possible interactions with other prescriptions previously dispensed to you, etc. These interventions can help address concerns about safety, drug effectiveness, and cost. Your prescription will not be changed unless your prescribing doctor approves that a change be made for your benefit. If you have questions about a prescription that has been changed, contact your doctor or a CVS Caremark pharmacist at the telephone number included in your shipment.

New and Experimental Prescription Drugs

New and experimental prescription drugs will not be covered by CVS Caremark unless they have been approved by the FDA for a specific diagnosis. To determine whether a prescription drug is covered, call a customer service representative at 800-826-7122.

Get Your Refills Online!

Once you have processed a mail service prescription through CVS Caremark, you can obtain a refill through www.caremark.com. After logging in, click on "Prescriptions" at the top, then select "View/Refill All Prescriptions" from the drop-down menu. You can also sign up for automatic refills by selecting "Manage Automatic Refills" from the same drop-down menu.

CVS Caremark Specialty Pharmacy Services

For patients with certain chronic or genetic conditions, CVS Caremark offers specialized home or office delivery of high-cost biotech pharmaceuticals and related therapeutic services, including assistance with drug therapy compliance, emergency telephone counseling, education programs and, where necessary, coordination of in-home nursing services.

Selected benefits may be available for the following as medically necessary and when authorized and provided through CVS Caremark Specialty Pharmacy Services:

- Crohn's Disease,
- Cystic Fibrosis,
- Immune Disorder,
- Multiple Sclerosis,
- Growth Hormone Deficiency,
- Hemophilia,
- Rheumatoid Arthritis,
- Hepatitis C,
- Respiratory Syncytial Virus (RSV),
- Immunoglobulin IV (IVIG), and
- Genetic Emphysema.

CVS Caremark Specialty Pharmacy Services can answer your questions and help you obtain specialized medications for your condition. Through this program, you will be assigned a specific care team of CVS Caremark professionals who will effectively and efficiently manage your care.

The PrudentRx Program is also available for certain specialty medications. When your specialty medication qualifies for this program, you receive the specialty medication at no cost (after your deductible for the Corning Retiree CHP). If your specialty medication is part of this program, you are automatically enrolled. You may opt out of the program; however, if you opt out, you will pay 30% coinsurance for your specialty medication. You will be contacted if your specialty medication qualifies for this program.

Specialty medications are only covered under the pharmacy benefit and must be dispensed by CVS Caremark Specialty Pharmacy Services. Call 800-237-2767 or go to www.CVSspecialty.com for the most current list of specialty medications covered under the pharmacy benefit through the CVS Caremark Specialty Pharmacy Services.

Your order will be processed by mail through CVS Caremark Specialty Pharmacy Services. A patient care representative will work with you through the order and shipment process each time you order your medication.

Select specialty medications (self-injectables and oral oncology) are covered only under the pharmacy benefit through CVS Caremark Specialty Pharmacy Services. These specialty medications will be excluded as covered under *medical* coverage.

Prior authorization and specialty preferred drug plan design management may be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug.

Take Advantage of caremark.com

If you are enrolled in a Corning Retiree Medical Plan option, you have access to www.caremark.com, a robust resource for prescription drug information, with tools such as:

- **View prescription history.** Review all your CVS Caremark prescriptions. Print a record from the last two years, showing how much you and Corning have paid.
- **View true drug costs.** Do you know how much your drugs really cost and how much Corning pays? The "Check drug cost" tool shows the cost of your drug and similar drugs in the same medication class. This tool is especially useful for Tier II and Tier III prescription drugs, as these drugs are subject to coinsurance. Use the tool to estimate your share of these drugs' costs.
- **Order refills online.** Once you have mailed the paper prescription from your doctor, you can order refills online.
- **View the CVS Caremark Primary/Preferred Drug list.** The list is updated every three months. These drugs are subject to Tier II coverage under the Corning Retiree Medical Plan.
- **Check drug interactions.** Find out how certain drugs or foods might interact with medications you are taking.
- **Manage your CVS Caremark account.** Update your profile, give family members access to your account, set email alerts, and make other changes.

If you are visiting www.caremark.com for the first time, start by clicking "Not registered yet?" Provide the requested information, including the Corning Group Code: RX1379. Create a login and password for future visits.

Clinical Programs and Resources (Applies to Corning Retiree CHP and Corning Retiree PPO)

This section includes information on the health and wellbeing resources available to you, including:

- Consumer solutions and self-service tools,
- Disease management services, and
- Wellness programs for women's health and reproductive services.

Corning believes in giving you tools to help you be an educated health care consumer. To that end, Corning has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members,
- Manage chronic health conditions, and
- Navigate the complexities of the health care system.

Note: Information obtained through the services offered in the programs included in this section is based on current medical literature and on physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Hood Companies, Inc. are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care or your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-service Tools

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women,
- Pediatric and adolescent immunizations,
- Cervical cancer screenings for women,
- Comprehensive screenings for individuals with diabetes, and.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support

To help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information,
- Support by a nurse to help you make more informed decisions in your treatment and care,
- Expectations of treatment, and
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain,
- Knee and hip replacement,
- Prostate disease,
- Prostate cancer,
- Benign uterine conditions,
- Breast cancer, and
- Coronary disease.

www.myuhc.com

UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. www.myuhc.com opens the door to a wealth of health information and self-service tools.

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your physician,
- Search for network providers available in your Plan through the online provider directory,

- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques, and access health improvement resources,
- Use the treatment cost estimator to get an estimate of the costs of various procedures in your area, or.
- Use the hospital comparison tool to compare hospitals in your area on how they rate on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered, go to www.myuhc.com and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims,
- View eligibility and Plan benefit information, including copayments, deductibles, and coinsurance,
- View and print all of your Explanation of Benefits (EOBs), and
- Order a new or replacement ID card or print a temporary ID card.

To Learn More About a Condition or Treatment

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease Management Services

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

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition; this may include information on symptoms, warning signs, self-management techniques, recommended exams, and medications,
- Access to educational and self-management resources on a consumer website,
- An opportunity for the disease management nurse to work with your physician to ensure that you are receiving the appropriate care, and
- Access to and one-on-one support from a registered nurse who specializes in your condition; examples of support topics include:
    - Education about the specific disease and condition,
    - Medication management and compliance,
    - Reinforcement of on-line behavior modification program goals,
    - Preparation and support for upcoming physician visits,
    - Review of psychosocial services and community resources,

- Caregiver status and in-home safety, and
- Use of mail-order pharmacy and network providers.

Participation is completely voluntary and provided at no extra charge. If you think you may be eligible to participate or would like additional information regarding the program, contact the number on your ID card.

Bariatric Resource Services (BRS)

The Plan offers a Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to educate you on obesity treatment options, and
- Access to specialized network facilities and physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your ID card.

The Plan provides travel and lodging assistance; see the "Travel and Lodging Services" section.

Cancer Resource Services (CRS) Program

The Plan offers a Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS:

- Visit www.myoptumhealthcomplexmedical.com,
- Call the number on your ID card, or
- Call the program directly at 866-936-6002.

Coverage for oncology services and oncology-related services are based on the Plan's terms, exclusions, limitations, and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Comprehensive Kidney Solution (CKS) Program

If you are diagnosed with kidney disease, the Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

If the disease progresses to the point of needing dialysis, CKS provides access to top-performing dialysis centers. This means you will receive treatment based on a best practices approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on the Plan's terms, exclusions, limitations, and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, contact CKS.

Kidney Resource Services (KRS) Program and End-Stage Renal Disease (ESRD)

The Kidney Resource Services (KRS) program provides you with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you work with a nurse who provides you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. The nurse can also help you find doctors, specialists, and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information.

KRS nurse advocates are available, Monday through Friday toll-free at 866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on the Plan's terms, exclusions, limitations, and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports individuals who have Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program works with you and your physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD nurses, support from specialized social workers, assistance with choosing physicians and facilities, and access to designated providers.

To learn more about the CHD Resource Services program:

- Visit www.myoptumhealthcomplexmedical.com,
- Call UnitedHealthcare at the number on your ID card, or
- Call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on the Plan's terms, exclusions, limitations, and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries, you must contact CHD Resource Services before surgery to enroll in the program for the surgery to be considered a covered health service under the Plan.

Transplant Resource Services (TRS) Program

The Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a best practices approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on the Plan's terms, exclusions, limitations, and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

The Plan provides you with travel and lodging assistance; see the "Travel and Lodging Services" section.

Health Management Virtual Behavioral Health Therapy and Coaching Program

The Virtual Behavioral Health Therapy and Coaching program is provided through AbleTo, Inc. Participation is completely voluntary and provided at no extra charge. The program identifies individuals with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety, and stress that often accompany chronic medical health issues like diabetes, cancer, or cardiac conditions. If identified, you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for individuals enrolled in the program for monitoring your progress toward meeting the participation criteria.

You are encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensuring that your information is up-to-date. The site also includes links to other helpful tools and resources for behavioral health.

If you think you may be eligible to participate or would like additional information about the program, contact the number on your ID card.

Family Building Support Programs

Corning has partnered with Maven and Fertility Solutions Plus to provide comprehensive, 24/7 support for your family building and family health journeys.

Whether you are considering starting a family, actively pursuing parenthood, expecting a baby, have children under the age of 10, or going through menopause, these resources are designed to assist you at every stage.

Key program benefits:

- Enhanced family building support:
  - Maven's 24/7 virtual education and coaching support for those navigating preconception, egg freezing, IVF, IUI, adoption, and surrogacy, and
  - Access to experienced Optum fertility nurses for clinical support during preservation or fertility treatment
- 24/7 virtual education and coaching, with personalized resources for:
  - Pregnancy, childbirth, and newborn care, including lactation consultants, postpartum care, return-to-work support, and pregnancy loss support,
  - Parenting and pediatrics resources, and
  - Specialized menopause support.

Coordination of Benefits

This section applies if you are covered under the Retiree CHP or Retiree PPO; this section does *not* apply if you have health insurance through UnitedHealthcare Retiree Solutions.

When you have coverage under more than one plan, your benefits are coordinated. This section describes how benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Coordination of Benefits Applies

Coordination of Benefits (COB) provisions apply to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan,
- A medical component of a group long-term care plan, such as skilled nursing care,
- No-fault or traditional fault type medical payment benefits or personal injury protection benefits under an auto insurance policy,
- Medical payment benefits under any premises liability or other types of liability coverage, and/or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The primary plan pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense, as defined in this section.

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is primary or secondary when a person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all benefits paid do not exceed 100% of the total allowable expense.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

- **Primary Plan:** The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms, without regard to the possibility that another plan may cover some expenses.
- **Secondary Plan:** The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

The following rules determine the order of benefit payments when an individual is covered by two or more plans.

Medical Payment or Personal Injury Protection Coverage: This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

No COB Provision: When an individual has coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

This Plan determines its order of benefits using the first of the following rules that apply.

Non-Dependent or Dependent Rule: The plan that covers the person other than as a dependent (e.g., as an employee, former employee under COBRA, policyholder, subscriber, or retiree) is the primary plan and the plan that covers the person as a dependent is the secondary plan.

Exception: If the person is a Medicare beneficiary and, as due to federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.

COBRA or State Continuation Coverage Rule—this only applies if you are younger than age 65: If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the ***Non-Dependent or Dependent Rule*** can determine the order of benefits.

Longer or Shorter Length of Coverage Rule: The plan that covered the person for the longer period is the primary plan and the plan that covered the person the shorter period is the secondary plan.

If the preceding rules do not determine the order of benefits, allowable expenses are shared equally between the plans meeting the definition of plan for COB purposes. This Plan will not pay more than it would have paid had it been the primary plan.

How Benefits Are Paid When this Plan Is Secondary – Only Applies if You Are Younger than Age 65

When this Plan is secondary, the Plan determines the amount it will pay for a covered health service by following these steps:

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- If, based on the allowable expense, the Plan would have paid more if it were the only plan involved, the difference between the amount it would have paid and the amount it actually paid is recorded as a benefit reserve for the covered individual. This reserve can be used to pay any future allowable expenses not otherwise paid by the Plan during the calendar year.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

You are responsible for any applicable copayment, coinsurance, and/or deductible amounts as part of the COB payment. The maximum payment you may receive from all plans combined will not exceed 100% of the allowable expense.

Allowable Expense

For COB purposes, an allowable expense is a health care expense that meets the definition of a covered health services under this Plan.

When the provider is a:

- Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate.
- Network provider for the primary plan and a non-network provider for this Plan, the allowable expense is the primary plan's network rate.
- Non-network provider for the primary plan and a network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan.
- Non-network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges.

If this plan is secondary to Medicare, see the following sections for more information about the order of benefit determination and allowable expenses.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this Plan and other plans covering the individual claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Plan Right of Recovery

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that this Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If this Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. The Plan Sponsor reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If this Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider, as described in the following section.

Refund of Overpayments

If this Plan pays for benefits for expenses incurred for a covered individual, that covered individual or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you,
- All or some of the payment the Plan made exceeded Plan benefits, or
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits that are:

- Payable in connection with services provided to other individuals covered under the Plan, or
- Payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reallocated payment amount will either:

- Equal the amount of the required refund, or
- If less than the full amount of the required refund, be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to begin a legal action.

How to Collect Benefits

Your provider will submit claims for you. If you use an out-of-network provider, you must file a claim form to receive reimbursement for covered services.

Claim forms for out-of-network expenses are available by calling UnitedHealthcare. You may also obtain a UnitedHealthcare claim form at www.myuhc.com. Send your completed claim form, along with original itemized bills, to the address on the claim form. If you need assistance, call the Corning Health Connection at 877-644-4334. Claims must be filed within one year of the date of service.

For more information, contact UnitedHealthcare directly at the telephone number listed on your medical plan option ID card or in the "If You Have Questions" section.

Online Explanation of Benefits (EOB)

UnitedHealthcare offers Online EOBs though the myuhc.com website. Online EOB provides two features:

- View and print EOBs for medical claims, and
- Elect to stop the mailing of printed medical EOBs to your home for all family members.

Online EOB gives you fast access to your EOBs, the ability to organize and store EOBs electronically, and a reduced volume of paper mail. Here is how to access Online EOB:

- Select "Claims & Accounts" and then select "My Claims"
- Enter the appropriate search criteria on the Claims Summary page.
- Select a medical claim.
- Choose "View Details."
- Select "View Explanation of Benefits.:

Claims Submission for Medical Care Outside of the United States

Non-U.S. UnitedHealthcare claims are to be submitted to the following address:

UnitedHealth Group
International Claims
PO Box 740817
Atlanta, GA 30374
Or, by fax to 801-567-5498

The member will be required to submit claims using the *International Claim Transmittal* form, available from UnitedHealthcare. In addition, valid proof of payment is required:

- Credit card receipt or statement showing the payment made to the foreign provider.
- Bank statement showing a transaction amount matching the total billed charged (wire transfer, withdrawal, or other form of payment).

Covered Services:

- Services received in an emergency room of a hospital,
- An emergency inpatient admission to a hospital, and
- Emergency transportation services.

Excluded Services:

- All services rendered in a home health care setting, hospice, laboratory, outpatient facility, inpatient hospital or facility, rehabilitation center, skilled nursing facility, urgent care center, physician's office or other outpatient setting, all non-emergency travel, or transportation expenses.

If Your Claim Is Denied

If your claim is denied, you will receive a written notice. The notice will explain what additional information, if any, is necessary to process the claim. The notice will also tell you the process to follow if you want the decision to be reviewed. If your claim is denied because you or your dependent is not covered, contact the Corning Benefits Network at 800-858-3875.

For information about appealing a decision, see the "Claims and Appeals Procedures" section.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing ("surprise billing").

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a deductible, coinsurance, and/or copayment. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your network.

Out-of-network providers may bill you for the difference between what the Plan pays and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your out-of-pocket maximum.

You are protected from balance billing for:

- **Emergency Services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-share amount (i.e., coinsurance or copayment). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain Services at In-Network Hospitals or Ambulatory Surgical Centers:** When you get services at an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is the Plan's in-network cost-share amount (i.e., coinsurance or copayment). This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers cannot balance bill you unless you give written consent and give up your protections.
- **Certain Air Ambulance Transportation:** If you get certain transportation services from an air ambulance provider, the most these providers may bill you is the Plan's in-network cost-share amount (i.e., coinsurance or copayment). You cannot be balance billed for these transportation services.

You are never required to give up your protections from balance billing. In addition, you are not required to get care out-of-network. You can choose an in-network provider or facility.

When balance billing is not allowed, you have the following protections:

- You are only responsible for paying your share of the cost (i.e., your deductible, coinsurance, and/or copayment) that you would pay if the provider or facility was in-network. The Plan will pay out-of-network providers and facilities directly.
- The Plan will:
  - Cover emergency services without requiring you to get approval for services in advance,
  - Cover emergency services by out-of-network providers,
  - Base what you owe a provider or facility on what the Plan would pay an in-network provider or facility and show that amount in your explanation of benefits, and
  - Count any amount you pay for emergency services or out-of-network services toward your in-network out-of-pocket maximums.

The Plan will comply with any applicable state balance billing laws or requirements as appropriate. If you believe you have been wrongly billed or need any other assistance relating to balance billing, contact the Corning Benefits Network.

Claims and Appeals Procedures

Claims for benefits are reviewed according to procedures set forth in the Plan document. In some cases, a claim for benefits may be denied. On the following pages, you will find information about the claims review process and detailed procedures for appealing a denied claim.

ERISA provides certain rights and protections to participants under certain benefit plans. These include your right to have Claims Administrators respond to your claims within certain time frames and your right to appeal denied claims.

If a claim is denied, the Claims Administrator must provide information on why it was denied and how you can appeal the denial. You also have the right to request copies of documents and records relevant to your claim, to submit additional documents relating to your claim for consideration on appeal, and to file suit under ERISA after you exhaust other remedies provided under the Plan.

If the Plan fails to follow the required claims and appeals procedures described in this booklet or for rescissions of coverage (which is generally a retroactive cancellation of coverage, including any rescission of disability benefits that has a retroactive effect), you will be considered to have exhausted the Plan's administrative remedies and you may pursue any available remedies under ERISA Section 502(a).

Claims Procedures

This procedure applies only to claims submitted for benefits under this Plan. The following terms are defined for purposes of this subsection:

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim as defined below.

Pre-Service Claim means any claim for benefits whereby the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining care.

Urgent Care Claim means a claim for care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the claimant's life or health or the ability of the claimant to regain maximum function, or
- In the opinion of a doctor with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim involves Urgent Care will be made by an individual acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a claim will automatically be treated as an Urgent Care Claim if a doctor with knowledge of the claimant's condition determines that the claim involves Urgent Care.

Plan Administrator means the person or entity responsible for the relevant claims determination under a Plan.

Determination of Benefits

After the claimant or the claimant's representative files a claim for benefits, the Plan Administrator will respond within a certain period of time. The amount of time that the Plan Administrator has to respond will depend upon the type of claim for benefits being made as provided below:

- **Post-Service Claims.** The Plan Administrator will notify the claimant of the benefits determination within 30 days after receiving the claimant's claim. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Plan expects to decide the claimant's claim. If the initial 30-day period of time is extended due to the claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required from the claimant, and the claimant will have at least 45 days to provide the requested information.
- **Pre-Service Claims.** The Plan Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) within 15 days after receiving the claimant's claim. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the claimant with written notification prior to the expiration of the initial 15-day period of time explaining the reason for the additional extension and when the Plan expects to decide the claimant's claim. If the initial 15-day period of time is extended due to the claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required from the claimant, and the claimant will have at least 45 days to provide the requested information.

  In the event the claimant fails to follow proper Plan procedures in submitting their claim, the claimant will be notified within five days after the Plan initially receives the claimant's claim so that the claimant can make the proper adjustments.
- **Urgent Care Claims.** The Plan Administrator will notify the claimant of its benefit determination (whether adverse or not) as soon as reasonably possible, taking into consideration the medical circumstances involved. The Plan Administrator will always respond to an Urgent Care Claim within 72 hours unless the claimant fails to submit information necessary to decide a claim. In this situation, the claimant will be informed within 24 hours after submitting the claim of the specific information necessary to complete the form. Notification may be oral unless the claimant requests written notification. The claimant will be given at least 48 hours to provide the requested information. The Plan Administrator will notify the claimant of the benefits determination no later than 48 hours after the earlier of the Plan's receipt of the requested information or the end of the period the claimant was given to supply the additional information.

  In the event the claimant fails to follow proper Plan procedures in submitting their claim, the claimant will be notified within 24 hours after the Plan initially receives their claims so that the claimant can make the proper adjustments.
- **Concurrent Care Decisions.** In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this will constitute an adverse benefit determination. The Plan Administrator will notify the claimant of this adverse benefit determination within sufficient time to allow the claimant to appeal the decision and obtain a determination on review before the benefit is reduced or terminated.

If the claimant requests to extend the course of treatment and the claim involves an Urgent Care situation, the Plan Administrator will notify the claimant of the claim determination (whether adverse or not) within 24 hours after the claimant requests an extension, provided that the claimant submits such claim at least 24 hours prior to the expiration of the initial treatment period.

If a Claim Is Denied

If the claimant's claim for benefits is denied, in whole or in part, the claimant or the claimant's authorized representative will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the participant and will include:

- The specific reason(s) for the denial,
- References to the specific Plan provisions on which the benefit determination was based,
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such information is necessary,
- A description of the Plan's appeals procedures and applicable time limits,
- A statement of the claimant's right to bring a civil action under ERISA Section 502 following appeal,
- A statement regarding the claimant's rights to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or a statement that this will be provided free of charge upon request,
- In the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims,
- Information sufficient to identify the claim involved, including date of service, health care provider, and claim amounts,
- The codes for the denial, diagnosis, and treatment, and their corresponding meanings, will be provided free of charge upon request,
- A description of the external review process, if applicable, and
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance and ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review procedures.

In order to expedite the process in a situation involving an Urgent Care Claim, the claimant or the claimant's representative may initially be notified of an adverse claim determination orally, but a written notification providing the information set forth above will follow within three days.

Appealing a Denied Claim

If the claimant's claim for benefits is denied, the claimant or the claimant's representative may appeal their denied claim in writing to the Plan Administrator within 180 days after receiving the written notice of denial. The claimant may submit with their appeal any written comments, documents, records, and any other information relating to the claimant's claim. Upon the claimant's request, they will also have access to and the right to obtain copies of all documents, records, and information relevant to the claimant's claim free of charge.

If the situation involves an Urgent Care Claim, the claimant can request an expedited review process whereby the claimant may submit their appeal orally or in writing, and all necessary information, including the Plan's benefit determination on review, will be relayed to the claimant or the claimant's representative by telephone, fax, or other similarly expeditious method.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted. The claim determination will be made by the Plan Administrator. The Plan Administrator will not have been involved in the initial benefit determination and will not have been the subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Plan Administrator will consult a health care professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the health care professional who was consulted in the initial adverse benefit determination. If a health care professional is contacted in connection with the claimant's appeal, the claimant will have the right to learn the identity of such individual.

Before the Plan issues an adverse benefit determination on review, the Plan Administrator will provide the participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer, or such other person) in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the participant a reasonable opportunity to respond before that date.

Before the Plan issues an adverse benefit determination on review based on a new or additional rationale, the Plan Administrator will provide the participant, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the participant a reasonable opportunity to respond before that date.

Decision on Appeal

After an appeal is filed, the Plan Administrator will respond to the claimant within a certain period of time. The amount of time that the Plan Administrator has to respond is based on the claimant's underlying claim for benefits as set forth below:

- **Post-Service Claims:** 30 days after receiving claimant's appeal request.
- **Pre-Service Claims:** 15 days after receiving claimant's appeal request.
- **Urgent Care Claims:** 72 hours after receiving claimant's appeal request.

If the claim on appeal is denied, in whole or in part, the claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the participant and will include:

- The specific reason(s) for the denial,
- References to the specific Plan provisions on which the benefit determination was based,
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits,

- A description of the Plan's review procedures and applicable time limits,
- A statement of the claimant's right to bring a civil action under ERISA Section 502 following appeal,
- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or a statement that this will be provided free of charge upon request,
- Information sufficient to identify the claim involved, including date of service, health care provider, and claim amounts,
- The denial code and its corresponding meaning,
- A statement deciding the availability, upon request, of the diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning,
- A description of the external review process, if applicable, and
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance and ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review procedures.

Second Appeal

If the appeal of the claimant's benefit claim denial is denied, the claimant or the claimant's representative may make a second appeal of their denial in writing to the Appeals Review Unit within 180 days of the receipt of the written notice of denial. The claimant may submit with their second appeal any written comments, documents, records, and any other information relating to the claimant's claim. Upon the claimant's request, they will also have access to, and the right to obtain copies of, all documents, records, and information relevant to the claimant's claim free of charge.

Upon receipt of a second appeal, the Appeals Review Unit will conduct a full review of the claim file and any additional information submitted. The claim decision will be made by the Appeals Review Unit. The Appeals Review Unit would not have been involved in the initial benefit determination or in the first appeal and would not have been the subordinate of either the person making the initial benefit determination or the Plan Administrator.

If the first appeal was based in whole or in part on a medical judgment, the Appeals Review Unit will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, was not consulted in the initial adverse benefit determination nor in the first appeal, and is not a subordinate of the health care professional(s) consulted in the initial adverse benefit determination and first appeal.

Before the Plan issues an adverse benefit determination on review, the Plan Administrator will provide the participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer, or such other person) in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the participant a reasonable opportunity to respond before that date.

Before the Plan issues an adverse benefit determination on review based on a new or additional rationale, the Plan Administrator will provide the participant, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the participant a reasonable opportunity to respond before that date.

The time that the Appeals Review Unit has to respond to the claimant's second claim appeal will depend on the underlying claim for benefits as set forth below:

- **Post-Service Claims:** 30 days after receiving claimant's second appeal request.
- **Pre-Service Claims:** 15 days after receiving claimant's second appeal request.
- **Urgent Care Claims:** 72 hours after receiving claimant's second appeal request.

If the claim on appeal is denied, in whole or in part, for a second time, the claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the participant and will include the same information that was included in the first adverse determination letter and a statement of the claimant's right to bring an action under ERISA.

Where required by law, a claim also may be eligible for external review by an Independent Review Organization. Claimants must file a request for external review within four months of the Plan's final notification on internal appeal.

Legal Action

Unless otherwise provided by Department of Labor regulations, a claimant may not commence a judicial proceeding against any person or entity, including the Plan, a Plan fiduciary, the Designated Reviewer, the Appeals Review Unit, the Committee, the Plan Administrator, the Plan Sponsor, the Plan Trustee, or any other person or committee, with respect to a claim for benefits without first exhausting the claims procedures set forth in the preceding paragraphs.

No suit or legal action contesting in whole or in part any denial of benefits under the Plan will be commenced later than the earlier of:

- The first anniversary of:
  - The date of the notice of the Appeals Review Unit's final decision on appeals, or
  - If the claimant fails to request any level of administrative review within the time frame permitted under the Claims Review Procedure, the deadline for requesting the next level of administrative review, and
- The last date on which such legal action could be commenced under the applicable statute of limitations under ERISA (including, for this purpose, any applicable state statute of limitation that applies under ERISA to such legal action) or an applicable external review decision if later.

Right to Recovery

The Plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Made in error,
- Due to a mistake in fact,
- Advanced during the time period of meeting the calendar year deductible,

- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year, or
- Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested, or
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan, and
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

Payment of Benefits

Except as required by the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260), you may not assign, transfer, or in any way convey your benefits under the Plan or any cause of action related to your benefits under the Plan to a provider or to any other third party. Nothing in this Plan should be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for benefit payments.

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

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

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

Any such payment to a provider:

- Is **not** an assignment of your Plan benefits or of any legal or equitable right to institute any proceeding relating to your benefits,
- Is **not** a waiver of the prohibition on assignment of Plan benefits, and
- Will **not** estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Plan benefits is invalid and prohibited.

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

Right to Subrogation

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid benefits on your behalf for a sickness or injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is alleged to be responsible.

Subrogation Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

Reimbursement Example

Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages,
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury, or damages,
- The Plan Sponsor (for example Workers' Compensation cases),
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers, or third-party administrators, and
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable,
  - Providing any relevant information requested by the Plan,
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances,

- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses, and
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, will be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" will defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation will limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you will hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing, or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries, or any other person or party, will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to:
  - Construe and enforce the terms of the Plan's subrogation and reimbursement rights and
  - Make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Subrogation and Reimbursement—Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits. Under the Plan's reimbursement provisions, if you obtain any recovery against the driver or an insurance carrier, you are required to use that recovery to reimburse the Plan for the full amount of benefits it has paid, or the services it has provided on account of the accident up to the amount of the recovery without taking into account any attorneys' fees you may have paid to obtain the recovery.

When Coverage Ends

Your coverage will end at the end of the month in which any of the following events occur:

- The Plan is terminated,
- You fail to pay your premium contributions when due,
- You turn age 65 (see the "If Age 65 or Older" section of this SPD), or
- You die.

Your dependents' coverage will end when any of the following events occur:

- Your coverage ends,
- You cancel your dependent coverage,
- Your dependents are no longer eligible (see "Eligible Dependents" in the "Eligibility" section),
- Your spouse/domestic partner turns age 65 (see the "If Age 65 or Older" section of this SPD),
- Your spouse/domestic partner is no longer eligible because you and your spouse divorce or your domestic partnership ends, or
- Your dependent dies.

For information about continuing your or your dependents' coverage after it ends, see the "Continuing Coverage through COBRA" section.

Continuing Coverage through COBRA

Plans Covered under COBRA

Medical, Vision, and/or Dental Plans

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Corning provides you and your eligible dependents the opportunity to continue participation in an active Corning medical, vision, and/or dental plan for a limited period of time if certain circumstances would cause you to lose coverage. These circumstances are called qualifying events.

Eligibility for COBRA

When you retire, you may elect to continue your and your eligible dependents' active coverage through COBRA, or you can elect retiree coverage. COBRA coverage is only available to employees newly terminating from active employment; COBRA coverage does not apply to former employees currently enrolled in retiree coverage. However, if Corning declares Chapter 11 bankruptcy and you lose coverage during the two-year period beginning one year before the bankruptcy filing and ending one year after the bankruptcy filing, you are eligible to elect retiree COBRA coverage. In this case, your spouse/domestic partner, surviving spouse/domestic partner, and/or dependent children also become eligible coverage through COBRA.

If you and/or your dependents are eligible for retiree COBRA coverage due to a bankruptcy that results in the loss of coverage for retirees covered under the Plan, your coverage may continue until your death. Coverage for your dependents may continue until the earlier of their death or 36 months after the date of your death.

For Your Spouse/Domestic Partner

Your covered spouse/domestic partner may be eligible to continue coverage through COBRA if their coverage ends because:

- Your employment ends (including retirement),
- You become legally separated or divorced or end a domestic partnership, or
- You die.

For Your Dependent Children

Your covered dependent children may be eligible to continue coverage through COBRA if their coverage ends for any of the reasons listed under "For Your Spouse/Domestic Partner" above. Also, if your dependent children no longer meet the Plan's definition of an eligible dependent (for example, because of their age,), they may be eligible for COBRA continuation coverage.

How Long COBRA Coverage Lasts

Continuation for 18 Months

You have the right to continue medical coverage under COBRA for yourself and your covered dependents for up to 18 months immediately after you retire.

Continuation for 36 Months

If your dependents become eligible for COBRA coverage because of a qualifying event that occurs after you retire, their COBRA coverage generally lasts 36 months from the date of the qualifying event (for example, 36 months from the date of your divorce or death).

This section describes the COBRA coverage available to your covered dependents if they lose medical coverage as a result of the following qualifying events that occurs *after* you retire:

- You become legally separated or divorced or end a domestic partnership, or
- You die.

If applicable, your covered dependent children may also continue medical, vision, and dental coverage for up to a total of 36 months if they lose coverage because they no longer qualify as eligible dependents (for example, due to their age, student status, or marital status).

When COBRA Coverage Ends

COBRA coverage ends if any of the following occur:

- The COBRA participant fails to make a required premium contribution within 30 days of the date it is due,
- Corning stops offering medical, vision, and/or dental coverage to all employees or retirees,
- The COBRA participant elects coverage under another group medical, vision, and/or dental plan after the election of COBRA coverage (if the other plan limits coverage of a pre-existing condition, COBRA coverage may be continued in certain circumstances),
- The COBRA participant becomes entitled to Medicare after the election of COBRA medical coverage (applies to medical only), or
- For cause, such as submission of fraudulent claims.

If You Become Enrolled in Medicare

If you become enrolled in Medicare after you elect to continue medical coverage under COBRA, your continued coverage will end on the date of your Medicare enrollment. Your covered dependents, however, may be eligible to extend continued coverage, up to a maximum of 36 months from the date of the initial qualifying event.

Type of Coverage

The medical, vision, and/or dental plans available to you through COBRA are generally the same as the plans offered to Corning retirees. Any changes to the plans for retirees will automatically apply to your and your dependents' COBRA coverage.

How to Continue Coverage

Corning may not be aware of all qualifying events—such as divorce, dissolution of a domestic partnership legal separation, death, Medicare enrollment, or a child no longer qualifying as a dependent. It is your responsibility to notify the Corning Benefits Network at 800-858-3875 within 60 days of the qualifying event. The Corning Benefits Network will then notify the COBRA Administrator within 30 days. A COBRA notice will be sent to your covered family members within 14 days of the date when the COBRA Administrator receives notification of your qualifying event. This COBRA notice will explain their right to continue coverage.

Each covered family member will have an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse/domestic partner. Parents (or legal guardians) may elect COBRA coverage on behalf of their children.

Your covered family members have 60 days from the date of the qualifying event or the date they receive the COBRA notice, whichever is later, to elect to continue coverage. If they do not elect COBRA within 60 days, they will not be eligible to continue coverage through COBRA and their coverage will end according to the Plan's normal provisions.

If a dependent initially waives COBRA coverage and then decides to revoke the waiver, you or your dependent may elect COBRA coverage within the original 60-day period. In this case, the dependent's COBRA coverage will begin on the date the election is received by the COBRA Administrator (not retroactive to the date of the qualifying event).

You have 45 days to make your initial premium contribution. Coverage will not be reinstated until payment has been received and posted to their accounts.

Cost

Dependents will receive monthly bills for COBRA coverage from the COBRA Administrator. They must pay the bill in full no later than 30 days (grace period) from the due date; failure to pay on a timely basis will result in cancellation of coverage with no option for reinstatement. If the payment is received after the due date but before the end of the 30-day grace period, coverage may be interrupted.

Medical, Vision, and Dental Coverage

Your covered dependents are required to pay the full cost of medical, vision, and/or dental coverage, which includes Corning's full cost for providing coverage, plus an additional 2% of that amount to cover the cost of administrative services. If Corning's cost for providing coverage changes, their cost will also change.

Changing COBRA Coverage

While they are continuing coverage under COBRA, your covered dependents may change coverage during the annual enrollment period. If they did not elect COBRA during the 60-day election period (See the "How to Continue Coverage" section), they may not elect it during a subsequent annual enrollment period.

Your dependents may also make certain qualified status changes to your coverage while on COBRA, such as:

- Adding a new spouse/domestic partner or a newborn or newly adopted child (or a child who is placed in their home for adoption) to their coverage,
- Adding an eligible dependent who loses other coverage,
- Adding a dependent to their coverage if required by a Qualified Medical Child Support Order, and
- Changing their medical plan option if they are covered by a managed care plan and move out of its coverage area.

Your dependents must notify the COBRA Administrator within 60 days of the event that caused the status change in order to change coverage under COBRA. If they notify the COBRA Administrator within 30 days of the date of the status change, their change in coverage will be effective as follows:

- Coverage is effective as of the date of birth, adoption, or placement for adoption for new children.
- Coverage is effective as of the date after active coverage is lost for adding a dependent who loses their own coverage.
- Coverage is effective on the date required by a Qualified Medical Child Support Order for dependents who are added as a result of that order.
- Coverage is effective the first day of the month following a move out of the coverage area for a managed care plan.
- Coverage is effective as of the date of marriage for a newly added spouse.
- Coverage is effective as of the date you establish a domestic partnership for a newly added domestic partner.

Newborn and Adopted Children

If they have a baby, or adopt a child or a child is placed in their home for adoption, the child will be a "qualified beneficiary" with independent election rights and multiple qualifying event rights.

If You Have Questions about COBRA Coverage

This summary does not fully describe continuation coverage rights. For more information about your rights and obligations under the medical, vision, and/or dental plans and under federal law, you should review that Plan's SPD. Use the chart below for quick reference if you need more information.

To…	Contact…
Notify Corning of a COBRA qualifying event (such as birth of a child) or ask questions about continuing coverage through COBRA	Corning Benefits Network at 800-858-3875
Ask questions or make changes once covered under COBRA	BenefitConnect Dept.: COBRA PO Box 981915 El Paso, TX 79998 1-877-29-COBRA (1-877-292-6272) International Only: 858-314-5108 Mail initial payments and any ongoing payments to: Willis Towers Watson US LLC FBO Corning 3672 Solutions Center Chicago, IL 60677-3006 Send any overnight payments to: PNC Bank C/O Willis Towers Watson US LLC FBO Corning Lockbox Number 773672 350 East Devon Avenue Itasca, IL 60143

If Age 65 or Older

In general, when you become eligible for Medicare, Medicare becomes your primary medical coverage. If you are age 65 or older at retirement, or you are retired and turn age 65, you have a one-time opportunity to enroll in individual coverage through UnitedHealthcare Medicare Solutions. **This is not the same as the Corning Retiree Medical Plan described in this SPD.** You must contact UnitedHealthcare at 866-658-9432 to begin the enrollment process. Available options may include plans such as AARP Medicare Supplemental plans, Medicare Advantage plans, and Medicare Part D prescription drug plans. Because your benefits are coordinated with Medicare, you must enroll in Medicare Parts A and B when you become eligible, or you will not be able to enroll in a Corning-related plan with UnitedHealthcare Medicare Solutions. Corning does not sponsor or endorse any of the coverage options or plans offered by UnitedHealthcare Medicare Solutions.

If you are not already retired, within 60 days before your planned retirement date, you will need to make your retiree medical elections by calling the Corning Benefits Network or logging on to My Total Rewards. If you enroll, your coverage begins the first day of the month if your retirement date is the first day of the month. If your retirement date is something other than the first day of the month, your coverage will be effective the first day of the month following your retirement date. **If you do not enroll in a plan through UnitedHealthcare Medicare Solutions, your Corning-related retiree medical coverage will end when you retire, unless you elect medical coverage through COBRA (**see the "Continuing Coverage through COBRA" section**).**

If you are already retired, UnitedHealthcare Medicare Solutions will send you information about 60 days before the date you turn age 65. If you enroll, your coverage begins the first day of the month in which you turn age 65. **If you do not enroll in a plan through UnitedHealthcare Medicare Solutions, your Corning-related retiree medical coverage will end when you turn age 65.**

If you do not enroll in a Corning-related plan with UnitedHealthcare Medicare Solutions when first eligible, you and your dependents will no longer be eligible for medical coverage through Corning. This applies even if you are covered under other insurance at that time.

Exception: *If you are a dual career couple, you may elect to defer your participation in your retiree medical coverage until your spouse/domestic partner retires. You may remain a dependent under the active medical plan and you will not need to enroll in Medicare Parts A or B at this time. Once your spouse/domestic partner retires or terminates, you will have another opportunity to enroll in retiree medical coverage and you must be enrolled in Medicare Parts A and B at that time.*

Your benefits in an individual retiree medical plan with UnitedHealthcare Medicare Solutions are coordinated with Medicare; you must be enrolled in Medicare Parts A and B before you may enroll in a UnitedHealthcare Medicare Solutions individual plan. See the "Enrolling in Medicare Parts A and B" section for more information.

If a Dependent Is Younger than Age 65 and Not Currently Eligible for Medicare: As long as you are enrolled in a plan with UnitedHealthcare Medicare Solutions, dependents younger than age 65 are eligible for coverage under the Corning Retiree Medical Plan and can elect coverage under the Corning Retiree CHP or Corning Retiree PPO option. If you would like to enroll a dependent younger than age 65, you must make their retiree medical elections by calling the Corning Benefits Network or logging on to My Total Rewards.

Within 60 days before your eligible dependent turning age 65, they will be sent an information kit from UnitedHealthcare Medicare Solutions regarding the retiree medical benefits for which your dependent is eligible. **If your eligible dependent does not enroll in a plan through UnitedHealthcare Medicare Solutions, their coverage will end on the first day of the month in which they attain age 65.** The eligible dependent will be ineligible to enroll in a retiree medical plan with UnitedHealthcare Medicare Solutions in the future if a plan is not selected upon attaining age 65.

If you or your dependent is over age 65 and currently enrolled in a Medicare Supplemental Plan or Medicare Advantage Plan (if offered in your area) through UnitedHealthcare Medicare Solutions, you will be sent enrollment materials during the annual enrollment period.

You, your covered spouse/domestic partner, and eligible children are also eligible for COBRA if enrolled in active medical coverage at the time of retirement. See the "Continuing Coverage through COBRA" section for more details.

How You Pay for Coverage

UnitedHealthcare Medicare Solutions bills you directly for retiree medical coverage. If you were in the Corning Retiree Medical Plan and had premium contributions deducted from your monthly pension checks, these deductions will stop. You may pay for your medical and prescription drug coverage by check or you may set up automatic payments from your bank account. If you are eligible for a Retiree Reimbursement Account (RRA) (see the "Retiree Reimbursement Account" section), reimbursement for medical plan premium contributions from your RRA will automatically be sent to you in a check or deposited directly into your bank account if you have completed the direct deposit form.

Enrolling in Medicare Parts A and B

In general, you are eligible for Medicare:

- At the beginning of the month in which you attain age 65,
- After you have been entitled to Social Security disability benefits for two years, or
- If you have end-stage renal disease.

You are automatically enrolled in Medicare Part A when you apply for Social Security benefits. To sign up for Medicare Part B, visit your local Social Security office or call the Social Security Administration at 800-772-1213 (TTY/TDD users call 800-325-0778) from 7 a.m. to 7 p.m. Monday through Friday. You can locate your local Social Security office by calling the Social Security Administration or logging on to its website at www.ssa.gov. Your share of the premium for Part B coverage is deducted from your Social Security benefits.

If you did not enroll in Medicare Part B when you were first eligible, you may have to enroll during the general Part B enrollment period (Jan. 1 through March 31 of each year) and you may have to pay a higher premium out of your Social Security check. If you delayed enrolling in Part B because you or your spouse/domestic partner were actively working and had medical coverage through your or your spouse's/domestic partner's employer, a different enrollment period may apply and you may not have to pay higher premiums. Contact the Social Security Administration for more information.

Your share of the Part A premium is covered by the Medicare taxes you and Corning paid while you were working. For more information about Medicare eligibility, enrollment, and premiums, log on to www.medicare.gov.

Coordinating with Medicare

Medicare is always the primary payer if you are eligible for Medicare and it is primary for your Medicare-eligible dependents.

Retiree Reimbursement Account

The Retiree Reimbursement Account for Medicare-eligible Retirees for Retirees Hired or Re-hired Before Jan. 1, 2007

Corning will establish a Retiree Reimbursement Account (RRA) on your behalf when you enroll in a UnitedHealthcare Medicare Solutions Plan. After you enroll for coverage, you will receive a welcome kit, which includes a welcome letter, an RRA fact sheet, information about the auto-premium contribution reimbursement process, a list of eligible expenses, a documentation and reimbursement fact sheet and a claim form.

Upon enrollment and in January of each following year, Corning will make a contribution of benefit dollars to your RRA. These are the only contributions to your account. You may not make any contributions.

You may use RRA benefit dollars to reimburse yourself for premium contribution expenses and eligible medical expenses such as deductibles, coinsurance, copays, prescription drugs, and over-the-counter medications that your doctor prescribes.

The RRA is available after you reach age 65 until the earlier of your death or termination of the RRA. Any unused benefits are carried forward each year. If you die, benefit dollars in your account will be forfeited and will revert to Corning. However, your surviving dependent may submit for reimbursement any unreimbursed eligible expenses that were incurred before your death. You can keep track of your RRA benefit dollars at www.uhcretireeaccounts.com or by calling 877-298-2305.

The RRA is considered a Health Reimbursement Arrangement (HRA) under Internal Revenue Service (IRS) guidance for use in an employee's retirement years. All benefit dollars placed in your RRA are owned and controlled by Corning, and in the event of your death, the balance is forfeited and will revert back to Corning.

Your RRA is an "unfunded" account, and benefit dollars are payable solely from the general assets of Corning. The RRA is set up to allow Corning to allocate a specified amount of benefit dollars into your RRA on an annual basis.

The RRA is considered a Corning benefit. Corning has entered into an arrangement with OptumHealth Financial Services (OHFS), under which OHFS will process reimbursements and provide certain other administrative services pertaining to the RRA. OHFS does not insure the benefits described in this booklet.

You may contact OHFS at:

OptumHealth Financial Services (OHFS)
PO Box 30516
Salt Lake City, UT 84130-0516

You may also contact UnitedHealthcare by phone at 877-298-2305 or online at www.uhcretireeaccounts.com.

A separate RRA will be established for your spouse/domestic partner if your spouse/domestic partner is:

- Age 65 or older,
- Eligible for Medicare,
- Enrolled for coverage through UnitedHealthcare Medicare Solutions, and
- Enrolled in Medicare Parts A and B.

Once your spouse/domestic partner is enrolled for medical coverage, Corning will make an equivalent contribution of benefit dollars to their RRA.

What Is Covered

You may use the benefit dollars in your account to help pay for your retiree medical and prescription drug coverage that you elect through UnitedHealthcare Medicare Solutions, and to reimburse yourself for eligible health care expenses, such as:

- Medicare Part B premiums,
- Medicare Part D premiums,
- Copays, deductibles, coinsurance, and out-of-pocket maximums,
- Prescription medicines and drugs,
- Over-the-counter medications and supplies, if prescribed by a physician, and
- Certain medical expenses not covered by your health plan but considered a medical expense by the Internal Revenue Code (see "Examples of Eligible Medical Expenses" below).

Any expense for which you receive reimbursement through the RRA cannot be used as a medical expense deduction on your federal income tax return. You cannot claim reimbursement for such an expense under any plan covering health benefits, including a spouse's/domestic partner's or dependent's plan.

Examples of Eligible Medical Expenses

Certain medical expenses that are typically not covered by retiree-sponsored health plans or other health plans are covered when you use your RRA benefit dollars. These additional medical expenses must be considered a medical expense under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time, and must also be for medical care. For more information on how a specific benefit below is covered, call OHFS at 877-298-2305.

If you receive any of these medical services, the entire cost of these expenses is your responsibility. If you have funds in your RRA, you may request reimbursement for eligible medical expenses from your RRA. If you choose to use your RRA funds to pay for any of these expenses, you will be required to pay the provider for services and submit a reimbursement form.

You can find a list of eligible medical expenses at www.optumhealthfinancial.com/individualsfamilies/healthaccounts/healthreimbursementaccounts. Or, see IRS Publication 502 for a list of many items that are considered medical expenses.

Corning Contributions to Your RRA

Pre-1996 and Post-1995 Retiree Groups

There are different levels of contributions made by Corning to a RRA depending upon the year of retirement or date of hire.

If You Were Hired or Rehired on or After Jan. 1, 2007, or Employed at Certain Acquired Companies

If you were hired or rehired on or after Jan. 1, 2007, and are age 65 or older, with at least five years of service, you are eligible to enroll in a UnitedHealthcare Medicare Solutions Plan. However, you will not be eligible for a RRA subsidy. This "access-only" coverage means you can take advantage of the group plan that Corning offers, but you will pay 100% of the cost of your coverage.

The following table shows the RRA contributions made by Corning:

Retiree Group	Current Annual Contribution by Corning to RRA
Medicare-Eligible Pre-1996 Retirees	
▪ Retiree	$2,350
▪ Spouse/Domestic Partner	$2,350
Medicare-Eligible Post-1995 Retirees	
▪ Retiree	$1,350
▪ Spouse/Domestic Partner	$1,350
Medicare-Eligible Pre-2004 CCS Retirees	
▪ Retiree	$2,350
▪ Spouse/Domestic Partner	$2,350
Access-Only (if you were hired or rehired after Jan. 1, 2007)	
▪ Retiree	$0
▪ Spouse/Domestic Partner	$0

Note: Contributions may be applied to your RRA before the effective date of your account, but disbursements only will occur after the date your RRA becomes effective.

If you retire and enroll in UnitedHealthcare Medicare Solutions mid-year, Corning will contribute the full amount of benefit dollars to your RRA.

Retiree Reimbursement Account Claims and Appeals (for Medicare-eligible Retirees)

Filing a Retiree Reimbursement Account Claim

If you have funds available in your RRA, you may be reimbursed for eligible expenses from your RRA. UnitedHealthcare will automatically submit your monthly premium contribution reimbursement on your behalf. This requires no action on your part. Once the premium contribution reimbursement has been processed, you may receive your reimbursement amount via direct deposit if you choose by filling out the direct deposit form within your RRA welcome kit. If you choose not to fill out the direct deposit form, your will receive your reimbursement via the default method of payer check.

If you submit a request for reimbursement of eligible medical expenses, the request must be received no later than 60 days following the end of the Plan year and during which you were eligible under this Plan. If you do not provide this information to the Claims Administrator within this time frame, your claim will not be eligible for reimbursement, even if there are funds available in your RRA. This time limit does not apply if you are legally incapacitated. Any eligible expenses for which you are reimbursed from your RRA cannot be included as a deduction or credit on your federal income tax return.

The RRA's benefits are administered by Corning Incorporated, the Plan Administrator. OptumHealth Financial Services (OHFS) is the Claims Administrator and processes claims for the RRA and provides first level appeal services; however, OHFS and Corning Incorporated are not responsible for any decision you or your dependents make to receive treatment, services, or supplies you receive from providers. OHFS and Corning Incorporated are neither liable nor responsible for the treatment, services, or supplies you receive from providers.

OptumHealth Financial Services (OHFS)
PO Box 30516
Salt Lake City, UT 84130-0516
877-298-2305

Once you are enrolled in a UnitedHealthcare Medicare Solutions Plan, your total benefit dollars in your RRA are available for reimbursement of any expenses incurred under the Plan. You may request reimbursement for eligible expenses up to your total benefit dollars as soon as such eligible medical expenses and/or premium contribution expenses have been incurred. You can submit a *Retiree Reimbursement Request Form* at any time. If you request reimbursement by check, you will be reimbursed for eligible expenses as long as the amount requested is at least $25 (amounts below $25 will be accumulated and processed with future payments). The date on which the Claims Administrator processes your claim is used when deducting benefit dollars from your RRA. This allows the benefit dollars in your RRA to act like a savings account, available for your use when your claim is paid.

Required Information for Filing an RRA Claim for Eligible Medical Expenses

To be reimbursed from your RRA for eligible medical expenses, submit a reimbursement form, called a *Retiree Reimbursement Request Form*, for the eligible expenses that have been incurred. A form is available at www.uhcretireeaccounts.com. You must include proof of the expenses incurred. For eligible medical expenses, proof can include a bill, an invoice, or an Explanation of Benefits (EOB) from any group medical/dental plan under which you are covered. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans.

You may view your RRA online via www.uhcretireeaccounts.com. This website includes many features such as the option to:

- View your RRA summary page detailing contributions and the amount left in your RRA, and
- View your RRA Claims Summary including claim transaction details.

Note: You or your authorized representative may submit a claim for reimbursement from your RRA or file an appeal if your claim is denied. To designate an authorized representative for submitting claims and filing appeals for your RRA, please contact OptumHealth Financial Services (OHFS) at 877-298-2305.

Required Information for RRA Premium Contribution Reimbursements

To be automatically reimbursed for premium contribution expenses each month from your RRA, you must complete a one-time form to request your desired method of reimbursement (check, direct deposit, etc.). You may also elect to have a direct debit from your checking or savings account to pay for your premium contributions, or you may elect to send a check on a monthly basis.

If Your RRA Claim is Denied

If a claim for benefits is denied in part or in whole, you may call OHFS at 877-298-2305 before requesting a formal appeal. If OHFS cannot resolve the issue to your satisfaction over the telephone, you have the right to file a formal appeal as described below.

How To Appeal a Denied RRA Claim

If your RRA claim for benefits is denied in part or in whole, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and address,
- The claim number,
- The employer's name,
- The provider's name,
- The date of your medical service or expense,
- The reason you disagree with the denial, and
- Any documentation or other written information to support your appeal.

If you wish to request a formal appeal of a denied claim for reimbursement, call OHFS at 877-298-2305 to obtain the address where the appeal should be sent.

Review of an RRA Claim Appeal

OHFS will conduct a full and fair review of your appeal. The appeal may be reviewed by an appropriate individual(s) who did not make the initial benefit determination.

You have the right to submit any additional written comments, documents, records, or other information that you would like OHFS to consider in reviewing your appeal.

If OHFS upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. If you claim for reimbursement continues to be denied or you do not receive a timely decision, in limited circumstances, you may be able to request an external review of your claim by an independent third party who will review the denial and issue a final decision.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claims and/or appeals and submit opinions and comments. Corning will review all claims in accordance with the rules established by the U.S. Department of Labor. Corning's decision will be final. The table below describes the time frames for you and OHFS.

Type of Claim or Appeal	Timing
If your claim is incomplete, OHFS must notify you	Within 30 days
You must provide completed claim information to OHFS	Within 45 days after receiving an extension notice*
If OHFS denies your initial claim, they must notify you of the denial:	
If the initial claim is complete	Within 30 days
After receiving the completed claim (if the initial claim is incomplete)	Within 30 days
You must appeal the claim denial	No later than 180 days after receiving the denial
OHFS must notify you of the appeal decision	Within 60 days after receiving the appeal

* OHFS may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Your Resources, Rights, and Responsibilities

The Corning Retiree Medical Plan is subject to the requirements of ERISA. ERISA is a federal law designed to protect your rights under your benefit plans. The law includes specific provisions about your access to information about the plans, your right to appeal denied claims, and your rights when a benefit plan is amended or terminated.

This section contains important information about the steps you can take to exercise your rights under these Corning benefit plans and your right to continue coverage under certain plans. Take the time to read this section carefully and become familiar with your rights and responsibilities under your Corning benefit plans.

Need Help?

If you have questions about your Corning benefits or need help with a claim:

- Call the Corning Benefits Network at 800-858-3875 (+1 678-981-2762 outside the U.S.), or
- Contact the Plan directly.

Plan Information

Below, and in the chart in the "Facts about Plan Administration" section, you will find contact information as well as the official Plan name, type, and funding source for each Corning benefit plan described in this SPD subject to ERISA.

Plan Sponsor and Employer Identification Number

The Plan Sponsor for your Corning benefit plans is Corning Incorporated, One Riverfront Plaza, Corning, NY 14831, 607-974-9000. Corning's Employer Identification Number (EIN) is 16-0393470.

Plan Year

The Plan year for all Corning benefit plans is Jan. 1 through Dec. 31.

Plan Administrators

The Corning Incorporated Benefits Committee is the Plan Administrator for each Plan, except to the extent that a Plan's insurance policies or other contracts extend such responsibility to insurance companies or third-party administrators. You may contact the Corning Incorporated Benefits Committee at the following address:

Benefits Committee
Corning Incorporated
MP-HQ-01-E03
One Riverfront Plaza
Corning, NY 14831
607-974-9000

The Plan Administrator interprets the terms and provisions of the Plans.

Contact Information, Marital Status, and Beneficiary Changes

It is important to keep your contact information (telephone and mailing address), marital status, and beneficiary information up-to-date with the Corning Benefits Network so the Company can continue to send you important benefits information or contact you, if necessary, with important information.

If you need to make a change to your contact information, marital status, or beneficiary designation, call the Corning Benefits Network at 800-858-3875 and speak with a Benefit Services Representative.

Address Changes

Please notify the Corning Benefits Network of any address change. You should keep a copy of any notices you send to the Corning Benefits Network, and any confirmation statements you receive from the Corning Benefits Network, for your records.

All notices, summaries of material modification, statements, and other documents will be sent to you at the last known address on file with the Plan Administrator.

Records Retention

You may request that Corning (or its agents) provide copies of archived records dating back no more than seven years, unless otherwise required by law.

You are responsible for maintaining important benefit-related documents, as you do other financial and tax-related documents. Typically, you should retain these records (in particular, year-end statements) until the funds from these plans have been distributed to you.

Legal Process

You may serve legal process upon the Plan Administrator or Plan Trustee for any plan. Legal process should be directed to the address listed below:

Benefits Committee
Corning Incorporated
One Riverfront Plaza
MP-HQ-01-E03
Corning, NY 14831

Authority of Plan Administrators

The Plan Administrators for all Corning benefit plans have the complete authority, in their sole and absolute discretion, to construe the terms of the Plans, to resolve any and all ambiguities or inconsistencies, and to decide the eligibility for, and the extent of, benefits under the Plans. All decisions of the Plan Administrator will be final and binding upon all parties affected. The Plan Administrators also reserve the right to amend any (or all) of the benefit plans at their sole discretion, at any time and from time to time, by providing written notice to eligible Plan participants.

Facts about Plan Administration

Plan Name	Corning Incorporated Retiree Medical Plan
Type of Plan	Health and welfare (this booklet describes medical benefits)
Plan Administrator	Corning Incorporated Benefits Committee 607-974-9000
Plan Insurer, Administrator, or Trustee	▪ Corning Retiree Consumer Health Plan administered by UnitedHealthcare ▪ Corning Retiree PPO administered by UnitedHealthcare ▪ Corning Consumer Health Plan and PPO prescription drug benefits administered by CVS Caremark **Note:** The Corning Medicare Supplemental Plan and UnitedHealthcare Medicare Solutions Plan are described in separate materials.
Type of Plan Administration and Funding	Contract Administration Self-insured; Company and retiree share the cost for coverage and Company pays benefits from its general assets
Plan Number	555
Contacts for Questions or Claims	**Corning Retiree Consumer Health Plan and Corning Retiree PPO – Medical** UnitedHealthcare PO Box 740800 Atlanta GA 30374-0800 877-644-4334 **Corning Retiree Consumer Health Plan and Corning Retiree PPO – Prescription Drugs** CVS Caremark, Inc. Appeals Department MC109 PO Box 52084 Phoenix, AZ 85072-2084 800-826-7122
Claims and Appeals Administrators	**Corning Retiree Consumer Health Plan and Corning Retiree PPO – Medical** ▪ ***Claims:*** UnitedHealthcare PO Box 740800 Atlanta GA 30374-0800 877-644-4334 ▪ ***First Level Appeals:*** UnitedHealthcare PO Box 30432 Salt Lake City, UT 84130-0432 ▪ ***Second Level Appeals:*** UnitedHealthcare PO Box 30432 Salt Lake City, UT 84130-0432 **Corning Retiree Consumer Health Plan and Corning Retiree PPO – Prescription Drugs** ▪ ***Claims:*** CVS Caremark, Inc. Appeals Department MC109 PO Box 52084 Phoenix, AZ 85072-2084 800-826-7122 ▪ ***First Level Appeals:*** CVS Caremark Appeals Department 800 Biermann Court Mount Prospect, IL 60056 Fax: 855-230-5548 ▪ ***Second Level Appeals:*** CVS Caremark Appeals Department 800 Biermann Court Mount Prospect, IL 60056 Fax: 855-230-5548

Plan Amendment and Termination

Corning intends to continue the Plan described in this SPD but reserves the right to modify, suspend, change, or terminate the Plan at any time for any reason. Corning's Board of Directors has the sole discretion to modify, suspend, change, or terminate the Plan at any time, including changes that relate to cost-sharing, benefits entitlement, and benefits affecting retirees, active employees, and beneficiaries. The Board of Directors has delegated the responsibility for routine Plan administration to the Corning Incorporated Benefits Committee. The Company's decision to change or end the Plan may be due to changes in laws governing employee benefit plans, the requirements of the Internal Revenue Code or ERISA, changes in Company policy, changes in provider benefits, or any other reason.

If the Plan is terminated, claims arising before the date of termination will be reviewed and honored if the Plan Administrator determines such claims are valid.

Legal Action

A claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Designated Reviewer, the Plan Administrator, the Plan Sponsor, or any other person or committee, with respect to a claim for benefits without first exhausting the claims procedures set forth in the preceding paragraphs. No suit or legal action contesting in whole or in part any denial of benefits under the Plan will be commenced later than the earlier of:

- The first anniversary of:
  - The date of the notice of the Appeals Reviewer's final decision on appeals, or
  - If the claimant fails to request any level of administrative review within the time frame permitted under the Claims Review Procedures, the deadline for requesting the next level of administrative review, and
- The last date on which such legal action could be commenced under the applicable statute of limitations under ERISA (including, for this purpose, any applicable state statute of limitations that applies under ERISA to such legal action).

Your Rights as a Plan Member

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

Receive Information about Your Plan and Benefits

You have the right to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and 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.

You have the right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

You have the right to 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

You have the right to continue health care coverage for yourself, spouse/domestic partner, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the "Continuing Coverage through COBRA" section and the documents governing the Plan for information on the rules governing COBRA continuation coverage rights.

You also have the right to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under any Corning medical plan option (if any) if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request the certificate before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your Plan, called "fiduciaries" of the Plan, 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, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may 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 Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may 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 your Plan, you should contact the Corning Benefits Network at 800-858-3875 or the Plan Administrator, or insurer for the Plan (see the "Facts about Plan Administration" section). 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 the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

If You Have Questions about Your Rights

If you have questions about how these requirements apply to your benefits, you may contact the Corning Benefits Network at 800-858-3875, the Plan Administrator or the U.S. Department of Labor.

If You Have Questions

To Find Out About…	Contact…
COBRA	Willis Towers Watson at 877-292-6272 if you are covered under COBRA
CVS Caremark Prescription Drug Benefits for non-Medicare-eligible	Caremark at 800-826-7122, 24 hours a day, 7 days a week www.caremark.com (first-time user group code: RX1379)
CVS Caremark Specialty Pharmacy Services	CVS Specialty Pharmacy at 800-273-2767 www.cvsspecialty.com
Health Savings Account (HSA) administered by Optum Financial	Optum Bank at 866-234-8913 www.optumbank.com
Medical Plans administered by UnitedHealthcare for non-Medicare-eligible ▪ Corning Retiree CHP ▪ Corning Retiree PPO (claims, coverage inquiries, and participating network providers)	UnitedHealthcare at 877-644-4334, 8 a.m. to 11 p.m. Eastern time, Monday through Friday www.myuhc.com
Mental Health/Substance Use Disorder Benefits/EAP for non-Medicare-eligible	UnitedHealthcare at 877-683-8546, 8 a.m. to 11 p.m. Eastern time, Monday through Friday www.liveandworkwell.com (access code: corning)
MetLife TakeAlong Dental Insurance	MetLife at 844-263-8336 www.metlifetakealongdental.com
Retiree Reimbursement Account (RRA)	OptumHealth Financial Services at 877-298-2305 www.uhcretireeaccounts.com
UnitedHealthcare Medicare Solutions Plan administered by UnitedHealthcare for post-65 participants (described in a separate SPD)	UnitedHealthcare Medicare Solutions at 866-658-9432, TTY 711, 8 a.m. to 8 p.m. local time, 7 days a week

When in Doubt, Call the Corning Benefits Network

Not sure who to call? Call the Corning Benefits Network at:

- 800-858-3875 (U.S., toll free)
- +1 678-981-2762 (if calling from outside the U.S., toll call)
- TTY/TDD: 711 (for hearing-impaired)

Benefit Services Representatives will either assist you or refer you to the appropriate resource. Representatives are available from 9 a.m. to 7 p.m. Eastern time, Monday through Friday, excluding holidays.

If You Move

It is important to keep your telephone and address information up-to-date with the Corning Benefits Network so the Company can continue to send you important benefits information or contact you, if necessary, with important messages.

If you change your mailing address, call the Corning Benefits Network at 800-858-3875 and speak with a Benefit Services Representative.