Summary Plan Description

EFFECTIVE JANUARY 1, 2024

GET STARTED

WELCOME TO THE COMPANY BENEFITS

You are vital to the success of the company and we expect you to play a key role in keeping yourself energized, balanced and healthy. Through the company benefits, you can get the health care you need when you need it, prepare for your financial future, and find proper balance in all aspects of your life.

We've designed our benefits program around your needs, including comprehensive health coverage, financial programs to support you today and in the future, and life balance resources.

This summary plan description (SPD) summarizes the key provisions of the benefit plans to help you use them most effectively. The SPD also alerts you to actions that could limit the **benefits** you and your eligible family members might receive.

Red bolded text is interactive. You can find your way through the document using the menus at the top and to the left, as well as the buttons along the bottom.

About this SPD

This document is intended to serve as a Summary Plan Description (SPD) as defined by the **Employee Retirement Income Security Act of 1974 (ERISA)** for such programs described within that are governed by ERISA. It provides many, but not all, of the details of the health and welfare benefit plans offered by the company USA, Inc. (the company) through The company Welfare Benefits Plan (the Plan). If there should be any difference between this document and the official text of the plan documents, trust agreements, and insurance contracts, the official text will always be considered correct and will govern.

Questions?

If you have questions about this SPD, provisions of the Plan, individual benefit programs or to receive a paper copy of this document, please call The company BenIQ Solution Center at **877-737-2363** and select option 1 to talk with a BenIQ representative. They're available weekdays 8 a.m. to 5 p.m. Central time. On **the companyBenIQ.com**, you can find information on your benefits and live chat with a representative.

the company maintains the Plan to provide benefits for the exclusive use of eligible **employees** and their eligible **dependents** and beneficiaries, as described in the **Who's Eligible** chapter and the rest of this SPD. This SPD provides no guarantee that you are eligible to participate in every benefit or plan described. Each plan may have additional eligibility requirements, so be sure to review the benefit plan material carefully.

Keep your records updated

the company may need to contact you to administer your benefits and send you benefits information. If your home address or telephone number changes, be sure to let your Store Director or HR Representative know.

While the company provides a benefit program for its employees and their eligible dependents, this benefit program does not constitute a contract of employment with the company, nor does it mean future employment for the company is guaranteed.

While the company expects to continue the benefits described in this document, benefits may be added, changed, and/or discontinued by the company in its sole discretion. You will be notified of any benefits changes.

Benefits overview

Benefits-eligible employees of the company have access to the following benefits, depending on the country and status as a full-time or part-time **employee**.

	UNITED STATES		PUERTO RICO
	Full-Time (30 to 40 hours)	Part-Time (20 to <30 hours)	Full-Time
Health benefits – You may enroll yourself and your dependents. You and the company share in the cost.			
Medical and prescription drugs	✓	✓	✓
Dental	✓		✓
Vision	✓	✓	✓
Disability insurance – If eligible, you are automatically enrolled. the company pays the full cost.			
Short-term disability (STD)*	✓	✓	✓
Long-term disability (LTD)	✓		✓
Life and accident insurance • If eligible, you are automatically enrolled for basic life, AD&D and BTA insurance and the company pays the full cost. • You may purchase supplemental and dependent life insurance.			
Basic life and Accidental death and dismemberment (AD&D) insurance	✓	✓	✓
Supplemental and dependent life insurance	✓	✓	✓
Business travel accident (BTA) insurance	✓		✓
Other benefits • You and your household are automatically enrolled in the Employee Assistance Program (EAP). the company pays the full cost. • You may participate in the FSAs for you and your family members.			
Employee Assistance Program (EAP)**	✓	✓	✓
Wellness Program (DC and FSC only)	✓	✓	
Health and day care flexible spending accounts (FSAs)	✓	✓	

* In locations that provide state-mandated disability coverage, the company pays the difference in cost between state-mandated disability benefits and Our short-term disability benefit.

** All active employees are eligible for EAP services.

WHO'S ELIGIBLE

This section provides information about who is eligible for the company benefits coverage. You'll also find information about what happens to your the company benefits if you take a leave of absence or if you have other health coverage.

Employees

You are eligible for benefits if you are a regular full-time or part-time employee who meets the hours requirements in the table below.

A regular employee is paid by the company USA, Inc. and has not been hired for a specific or temporary period of time. Regular employees do not include leased, on-call, seasonal, or temporary employees, except where required by law.

Additional eligibility requirements may apply to certain benefits. Please review the benefit sections of this SPD for more information. Coverage takes effect the first of the month following or coincident with your hire date or the end of your waiting period, if applicable.

	UNITED STATES		PUERTO RICO
	Full-Time	Part-Time	Full-Time
Minimum hours worked			
Non-exempt (hourly)	30 hours a week	20 hours a week	26 hours a week
Exempt (salaried)	N/A	N/A	N/A
Coverage begins			
Non-exempt (hourly) and exempt (salaried)	The first day of the month following or coincident with your date of hire		

If you are rehired

If you are eligible for benefits when you leave the company, and you return to a benefits-eligible position within 12 months, you will be eligible for benefits the first of the month following your rehire date. If your return date is 12 months or more from your departure, your benefits eligibility will be determined as if you are a new hire.

If you transfer

Transfers to or from Hawaii or Puerto Rico

If you are eligible for benefits and you transfer to Hawaii or Puerto Rico from another state, or if you transfer from Hawaii or Puerto Rico to another state, you will be eligible to change your medical plan and any other benefits that are different in your new location. If you make your election within 31 days of transfer, there will be no lapse in coverage and no waiting period will apply.

Transfers to or from another company within LVMH

If you are eligible for benefits and you transfer between the company and another company within LVMH, you will be eligible to change your medical plan and any other benefits that are different as a result of your new employer. If you make your election within 31 days, there will be no lapse in coverage and no waiting period will apply.

If both you and your spouse/domestic partner work for the company

Certain rules apply if both you and your spouse/domestic partner work for the company and are both eligible for the company benefit coverage:

- For medical, vision, dental and supplemental life insurance benefits you may elect one coverage option:
  - » You may enroll in your own coverage, OR
  - » You may enroll as a dependent in your spouse's/domestic partner's the company coverage
- An eligible child of two legally married employees or eligible domestic partners employed by the company can be enrolled only under one employee's medical, vision, and dental benefit coverage. If a couple has two children, one employee could cover one child and the other spouse or eligible domestic partner could cover the other child on their plan.

Note: If you and your spouse/domestic partner both work for the company and enroll for coverage in the UHC Silver HSA Plan, be sure to review the additional rules that apply to contributions and eligibility for the Health Savings Account. See the **Health Savings Account** section in the Medical chapter for more information.

Employees who are not eligible for benefits

Independent contractors and temporary employees are not eligible to participate in the company benefits. Any person who is not treated as a common law employee by the company for income tax withholding purposes, regardless of any subsequent determination of an individual's legal employment status, shall not be eligible to participate.

Medical coverage if you are not eligible for the company benefits

Under certain circumstances, the company may offer medical coverage to employees who are otherwise not eligible for the company benefits. If you are determined eligible for medical coverage under this provision, a letter will be mailed to your home to notify you of your opportunity to enroll yourself and your dependents.

the company measures the average hours of service for every **active employee** over a 12-month measurement period.

- As a new hire, your hours are measured starting with the first pay period following your date of hire and all pay periods over the following 12 months.
- After that, your hours are measured on an ongoing annual basis from October 3 through October 2 of the following year.

If your hours of service average 130 hours per month during a measurement period, you are eligible for medical coverage for a subsequent 12-month stability period.

- For new hires, your initial stability period generally begins the first of the 2nd month following completion of your initial measurement period.
- The annual ongoing stability period runs from January 1 through December 31. If you are determined eligible for ongoing coverage while you are in an initial stability period, your ongoing stability period will begin when your initial stability period ends.

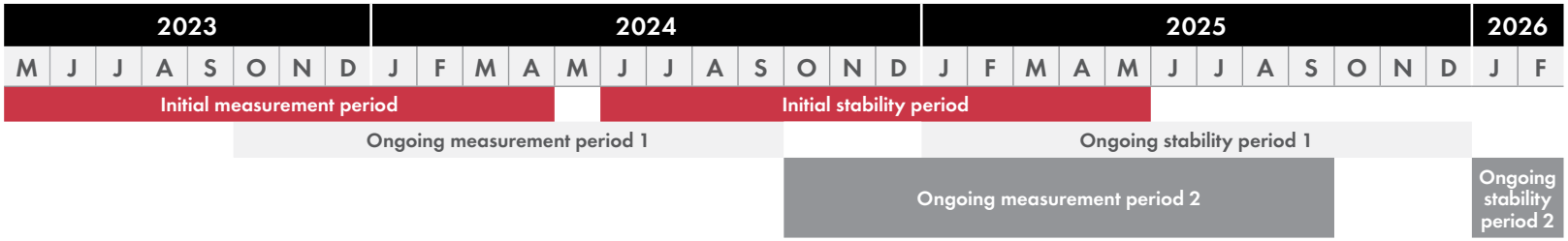
Once you are enrolled for medical coverage under this provision, your coverage must continue through your stability period. You may only make changes to your coverage if you experience a qualified life event, as well as each year during the **open enrollment** period (usually in October, for changes that take effect January 1). At the end of your stability period, you will be notified if your medical

coverage will end or if you meet eligibility requirements to re-enroll for medical coverage for the next stability period.

Here's an example

In the example below, Susan, a non-benefits eligible employee, has an initial measurement period that begins May 1, 2023 and ends April 30, 2024. If Susan is determined to be eligible and she enrolls for coverage, her coverage stays in effect for the initial stability period, which runs from June 1, 2024 through May 31, 2025.

Susan's hours will also be measured during the ongoing measurement period, October 3, 2023 through October 2, 2024. If Susan is determined to be eligible during her first ongoing measurement period, her ongoing stability period will begin January 1, 2025 – like all other ongoing employees – and will overlap with her initial stability period. Her first ongoing stability period will end December 31, 2025. Ongoing, she will be measured for eligibility every October 3 through October 2.



If you transfer from a benefits-eligible position to a non-benefits-eligible position

the company measures hours for all employees, including benefits-eligible positions. If you transfer from a benefits-eligible position to a non-benefits eligible position, you may be eligible for medical coverage – even though your eligibility for other benefits ends.

- If you do not meet the eligibility criteria described above and you are enrolled for medical coverage when you transfer, your medical coverage will end with the rest of your benefits. A letter will be mailed to your home notifying you of your status change. You will also receive a COBRA packet outlining your options for continuing coverage for certain benefits.
- If you meet the eligibility criteria described above and you are enrolled for medical coverage when you transfer, medical coverage for you and your enrolled dependents will continue through the end of your stability period, along with related paycheck deductions. A letter will be mailed to your home notifying you of your status change. If you were enrolled in other coverages, you will also receive a COBRA packet outlining your options for continuing coverage for those benefits.
- If you previously waived medical coverage, meet the eligibility criteria above and experience a qualified life event, you can enroll in medical coverage for the remainder of your stability period. More information about qualified life events, including deadlines for enrolling, are available in the **Mid-year changes (qualified life events)** chapter.

If you are eligible for the next ongoing stability period, a letter will be mailed to your home to notify you of your opportunity to enroll yourself and your dependents.

Dependents

If you enroll for coverage, you may also enroll your eligible dependents for medical, vision, dental and dependent life insurance coverage. In certain cases, your spouse/domestic partner and dependent children are also covered by the business travel accident (BTA) insurance if they are traveling with you on a business trip.

Eligible dependents	
Spouse	Must be the legal spouse of the employee (whether same or opposite sex of the employee), and not legally separated or divorced. In addition, for life and BTA insurance, the legal spouse must not be in active full-time military service and must be a citizen or legal resident of the United States of America, its territories and protectorates.
Domestic partner	Must be the domestic partner of the employee (either of the same or opposite sex) and meet the following requirements: • You and your partner are in a registered domestic partnership or civil union that is legally recognized and registered under the laws of a U.S. state or a non-U.S. country; or • You and your partner have a partnership in which you both: » Are each other's sole domestic partner, and intend to remain so indefinitely » Are both at least 18 years of age and mentally competent to consent to contract » Are not married to or legally separated from anyone else nor have had another domestic partner within the prior six months » Are not related to each other by blood to a degree of closeness that would otherwise prohibit legal marriage in the state in which you reside » Cohabitate and have resided together in the same residence for at least six months and intend to do so indefinitely » Are in a committed relationship of mutual caring and support and are jointly responsible for each other's common welfare and living expenses; your interdependence is demonstrated by at least three of the following: ◦ Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property ◦ Common ownership of a motor vehicle ◦ Driver's license or government-issued identification listing a common address ◦ Proof of joint bank accounts or credit accounts ◦ Proof of designation as the primary beneficiary for life insurance or retirement benefits (other than with respect to a the company-sponsored plan), or primary beneficiary designation under a partner's will ◦ Appointment of each other as agent under a durable property power of attorney or health care power of attorney For life and BTA insurance, your domestic partner must be a citizen or legal resident of the United States of America, its territories and protectorates. You will continue to be considered domestic partners provided you continue to meet the requirements described in the domestic partner affidavit or as required by law.

Eligible dependents

Dependent children under age 26	For health benefits, includes your: • Biological child and/or your spouse's biological child • Your enrolled domestic partner's biological child • Child for whom you or your spouse/domestic partner has been named legal guardian as appointed by the courts • Legally adopted child, or child who has been placed with you for adoption, but not a foster child • Children for whom you are responsible to provide health coverage based on a qualified medical child support order (QMCSO) For life and BTA insurance, includes your unmarried children, stepchildren, legally adopted children, or any other children related to you by blood or marriage or domestic partnership who live with you in a regular parent-child relationship and/or you claimed as a dependent on your last filed federal income tax return. Dependent children are primarily dependent upon you for financial support and maintenance. In addition, your dependent child must be a citizen or legal resident of the United States of America, its territories and protectorates.
Disabled dependent children age 26 or over	An adult child with disabilities is generally eligible for benefits if he or she was totally disabled before age 26. In addition, the person must be incapable of self-support as a result of the disability and dependent on you for financial support and maintenance. Proof of disability must be submitted to the company and the plan administrator, if required, within 31 days of the latest of the child's 26th birthday or your date of hire. You may be required to provide proof to the claims administrator periodically. A disabled dependent child is only eligible for the HMSA plan if he or she was enrolled in an HMSA plan before age 26.

Tax consequences of domestic partner benefits

Domestic partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical, dental, and vision coverage that relate to your partner, or your partner's children, generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained.

This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2 (or Form W-2PR in Puerto Rico).

During any period in which partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from the **company**, the company reserves the right to collect the employee FICA tax liability directly from you. These rules will not apply if your partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code or state tax laws governing state income tax. To certify your domestic partner as your tax dependent go to **the companyBenIQ.com.**

Qualified medical child support orders (QMCSOs)

A QMCSO is an order or judgment from a court or administrative body directing the plan to cover the child of a member as required by applicable law. The plan administrator will confirm the request is qualified under the terms of ERISA and applicable law.

In general, only children who meet the plan's eligibility requirements — for example, by meeting the age requirements — can be covered under a QMCSO. However, a QMCSO can also apply to children who:

- Were born out of wedlock
- Are not claimed as dependents on your federal income tax return
- Do not live with you

Please contact your plan administrator for a copy of their QMCSO procedures.

Dependent verification

If you enroll any family members, you will need to submit documentation to verify their eligibility at the companyBenIQ.com. If you don't complete the dependent verification process by the deadline provided, your dependent's enrollment will be cancelled and their coverage will not take effect.

Leaves of absence

Eligibility for benefits during an approved leave of absence up to 180 days (with the exception of military service leave), is described below.

You may choose to discontinue your benefits within 31 days of going on leave. If you discontinue your benefits while on leave, you must also reinstate your benefits within 31 days of returning to work if you wish to re-enroll. If you do not do so, your next opportunity to enroll will be during the annual **open enrollment**. You can discontinue or reinstate your benefits by contacting The company BenIQ Solution Center at **877-737-2363** (select option 1 to talk with a BenIQ representative).

If you choose to continue coverage, you will need to submit premium payments. See the **Paying for coverage during a leave of absence** section in the How to Enroll chapter for more information.

QUICK TIP

Make sure your home address is up to date before your leave of absence. If you continue benefits while on an approved leave, the company BenIQ will mail payment coupons to your home address on file.

If you have questions about leaves of absence, review the Leave of Absence Guide on **the companyBenIQ.com**.

Benefit	Eligibility for coverage	During your leave	When you return to work
Medical, dental and vision	Coverage continues up to the end of your approved leave, as long as you continue payments for your share of the premium. If you do not submit premium payments, your health coverage will end and your next opportunity to enroll will be the next open enrollment.	Premiums will not be deducted out of payroll while on a leave. Visit **the companyBenIQ.com** to pay your premiums or call a BenIQ representative at **877-737-2363** (option 1) for assistance. Your account will be automatically set up at **the companyBenIQ.com** after three pay cycles have been missed. If you do not submit payment for the month(s) you are invoiced, your coverage will end.	Coverage continues. Payroll deductions for your share of the premium costs will resume. If your leave resulted in a qualified life event, you may be eligible to add or change your health benefit elections. Cancellation of benefits due to non-payment is not a qualifying event to add coverage.
Health Savings Account (HSA)	Coverage continues.	Payroll deductions will stop. You may be reimbursed for eligible health care expenses that are incurred during your leave.	Payroll deductions will resume automatically. You may change your payroll deductions at any time.
Short-term disability (STD) and long-term disability (LTD)	Coverage continues up to the end of your approved leave.	Continues up to the end of your approved leave.	Coverage continues.

Benefit	Eligibility for coverage	During your leave	When you return to work
Employee and dependent life insurance	Basic employee life insurance continues up to the end of your approved leave. Supplemental employee and dependent life insurance also continues up to the limits of your approved leave, as long as you continue payments for your share of the premium. If you do not submit these payments, your supplemental and dependent life insurance coverage will end.	Premiums will not be deducted out of payroll while on a leave. Visit the companyBenIQ.com to pay your premiums or call a BenIQ representative at **877-737-2363** (option 1) for assistance. Your account will be automatically set up at the companyBenIQ.com after three pay cycles have been missed. If you do not submit payment for the month(s) you are invoiced, your coverage will end.	Coverage continues. Payroll deductions for your share of the premium costs will resume. If your leave resulted in a qualified life event, you may be eligible to change your supplemental or dependent life insurance elections. Cancellation of benefits due to non-payment is not a qualifying event to add coverage. Any approved requests for coverage increases will not be effective until you return to work.
Accidental death and dismemberment (AD&D) insurance	Coverage continues up to the end of your approved leave.	Continues up to the end of your approved leave.	Coverage continues.
Employee Assistance Program (EAP)	Coverage continues up to the end of your approved leave.	You and your family members living with you may contact the EAP for support.	Coverage continues.
Wellness Program (DC and FSC only)	Coverage continues up to the end of your approved leave.	You may receive an onsite flu shot, if eligible and when offered, as if you were not on leave.	Coverage continues.
Health care flexible spending account (FSA)	Deductions are suspended while on a leave of absence.	If you wish to use your health care FSA for expenses incurred while on leave, you can make arrangements to make after-tax contributions during your leave. If you choose not to make after-tax contributions while on leave, you may not use your balance to reimburse health care expenses that are incurred during your leave.	If you return to work in the same plan year, your participation will resume upon your return to work. If your leave resulted in a qualified life event, you may be eligible to begin or change your health care FSA contributions.
Day care flexible spending account (FSA)	Deductions are suspended while on a leave of absence.	You may not make contributions to your day care FSA while on a leave of absence. Expenses incurred during your leave of absence will not be eligible for reimbursement.	If you return to work in the same plan year, your participation will resume upon your return to work. If your leave resulted in a qualified life event that changes the amount of day care expenses eligible for reimbursement, you may be eligible to begin or change your day care FSA contributions.

If you do not return to work after the end of your approved leave of absence, your status as an **active employee** of the company ends. Please review the **If you leave the company** section for more information about your coverage in this situation.

If you have other health coverage

You may enroll in the company health coverage if you have other health coverage, such as an employer plan through your spouse/domestic partner or parent. If you have other health coverage, The company plan will coordinate benefits with the other plan to ensure the total paid to you does not exceed the total cost of your care. All of your the company health benefits – medical, prescription drugs, dental, and vision – are subject to these provisions.

Your other coverage may include:

- Benefits from another health plan, through another employer, a government plan or **Medicare**. The company plan will coordinate its payments with the other plan – this is called coordination of benefits (COB). Review **Coordination of benefits** for more information.
- Payments for health care from other sources, such as motor vehicle or liability insurance. The company health plan will seek to be reimbursed for benefits paid or take over your right to receive payments from the other party – this is called subrogation. Review **Third party payments** for more information.

CONSIDERING DUAL COVERAGE?

Most health plans, including The company plans, will coordinate benefits with the other health plan so that the total paid does not exceed what The company plan would pay on its own. For most, having coverage through a second plan offers little, if any, advantage.

Coordination of benefits

The company health plan will coordinate coverage with other health plans, including:

- Medicare or other governmental health benefit
- A plan sponsored by another employer or organization whether insured or uninsured
- A medical component of a group long-term care plan, such as skilled nursing
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefit under an auto insurance policy
- A government-sponsored program
- Medical payment benefits under any premises liability or other types of liability coverage

If coverage is provided under two or more plans, coordination of benefits (COB) determines which plan is primary and which plan is secondary. The plan considered primary 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.

the company uses certain rules to determine which plan is primary and which is secondary, as described in the following pages.

When the company is primary or secondary

the company uses the following rules to determine if The company plan is primary or secondary to coverage from another health plan.

For Medicare

As permitted by law, your the company plan will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom The company plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their spouses age 65 or older; and
- Individuals with end-stage renal disease, for a limited period of time; and
- Disabled individuals under age 65 with current employment status and their dependents under age 65.

The company health plan will also coordinate benefits with payments from an auto insurance policy or other liability coverage. The company plan is always secondary in these situations. Please see the **Third party payments** section for more information.

Visit the online guide **Medicare and Other Health Benefits** or call **1-800-MEDICARE** (1-**800-633-4227**) for information about how Medicare coordinates coverage with other health plans.

If in addition to your the company coverage (as an **active employee** or a dependent), you are a Medicare beneficiary and have coverage from another retiree medical plan, The company plan pays first, then Medicare, then your retiree medical plan.

For other health plans

If the other plan does not have coordination of benefits provisions, The company plan is secondary. Otherwise, each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-dependent or dependent.** The plan that covers the person other than as a dependent, for example as an employee, former employee under the **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of 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.
2. **Dependent child covered under more than one plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

ii. If both parents have the same birthday, the plan that covered the parent longest is the primary plan.

B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, then section 2A shall determine the order of benefits.

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, then section 2A shall determine the order of benefits.

iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The plan covering the custodial parent.

b. The plan covering the custodial parent's spouse.

c. The plan covering the non-custodial parent.

d. The plan covering the non-custodial parent's spouse.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

C. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be

determined, as applicable, under section 2A or 2B as if those individuals were parents of the child.

D. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in section 5 applies.

In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in section 2A to the dependent child's parent(s) and the dependent's spouse.

3. **Active employee or retired or laid-off employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. 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 rule labeled 2D can determine the order of benefits.

4. **COBRA or state continuation coverage.** 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 rule labeled 2D can determine the order of benefits.

5. **Longer or shorter length of coverage.** The plan that covered the person the longer period of time is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Kaiser Permanente will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care, which are incorporated in the Evidence of Coverage. HMSA and Triple-S will coordinate benefits under the rules set forth by each plan, refer to each plan's certificate of coverage or plan document for more information.

How the company pays for secondary coverage

If The company plan is secondary, it will pay its share of any remaining costs within plan guidelines after the primary plan has paid and the **deductible** in The company plan, if applicable, has been met. The plan administrator (UnitedHealthcare, Kaiser Permanente, HMSA or Triple-S Salud) will review the allowable charge for the primary plan and the amount the primary plan paid.

- If The company plan would have paid the same amount or less than the primary plan, The company plan will not pay benefits.
- If The company plan would have paid more than the primary plan, The company plan will pay the difference up to the amount it would have paid.

The maximum combined payment you can receive from all plans may not exceed the allowable expense.

Determining allowable expense when The company plan is secondary

The allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a network provider for both the primary plan and The company plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and an out-of-network provider for The company plan, the allowable expense is the primary plan's network rate. When the provider is an out-of-network provider for the primary plan and a network provider for The company plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is an out-of-network provider for both the primary plan and The company plan, the allowable expense is the greater of the two plans' reasonable and customary charges.

Determining allowable expense (when coordinating with Medicare)

If The company plan is secondary to Medicare and the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the allowable expense. The Medicare approved amount is the charge Medicare recognizes and reports on an explanation of Medicare benefits (EOMB) for a given service. For such providers, Medicare typically reimburses a percentage of its approved charge – often 80%. If the provider participates in Medicare but does not accept direct reimbursement, the Medicare limiting charge (the most a provider can charge if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with the company plan benefits, may be less than 100% of the allowable expense.

Medicare Crossover Program

The company UHC plans offer a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims for you and your enrolled dependent, provided you and your dependent are both eligible for Medicare and The company UHC plan is your only secondary coverage. Under this program, you do not have to file a separate claim with UHC to receive secondary benefits for these expenses. Once the Medicare Part A, Part B and DME carrier(s) have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to UHC for processing. When this occurs, your copy of the explanation of Medicare benefits (EOMB) will indicate that your claim has been forwarded to your secondary carrier. The crossover process does not apply to expenses not covered by Medicare, you must file a separate claim for these expenses. Once the Medicare Part A, Part B and DME carrier(s) have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to UHC for processing. When this occurs, your copy of the explanation of Medicare benefits (EOMB) will indicate that your claim has been forwarded to your secondary carrier. The crossover process does not apply to expenses not covered by Medicare, you must file a separate claim for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Overpayment or 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 The company plan should have paid. If this occurs, The company plan may pay the other plan the amount owed.

If The company plan pays you more than it owes under this coordination of benefits provision, you should pay the excess back promptly. Otherwise, the company may recover the amount in the form of salary, wages, or future benefits payable under any sponsored benefit plans. the company also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If The company plan overpays you or your provider, the plan administrator reserves the right to recover the excess amount. You, or any other person or organization that was paid, must make a refund to The company plan if:

- The company plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the **covered person**, but all or some of the expenses were not paid or did not legally have to be paid by the covered person
- All or some of the payment from The company plan exceeded the benefits under The company plan
- All or some of the payment was made in error

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

If the amount is due from another person or organization and is not promptly refunded, The company plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, from future benefits that are payable in connection with services provided to you or other covered persons under The company plan; or future benefits that are payment in connection with services provided to persons under another plan for which the claims administrator processes payments, pursuant to a transaction in which The company 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 equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to The company plan. The company plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Third party payments (subrogation and reimbursement)

If you are injured or become ill due to the actions or inactions of a third party, The company plan will cover eligible expenses. However, you must notify your plan administrator (UnitedHealthcare, Kaiser Permanente, HMSA or Triple-S Salud) of the situation and follow special rules as explained below.

If another party may be liable or legally responsible to pay for a member's care, typically through another insurance plan, The company plan will seek to be reimbursed for amounts paid. The company plan may choose to:

- Subrogate – that is, take over – your right to receive payments from the other party and pursue legal claims that you may be entitled to. This is the plan's right of subrogation.
- Recover any benefits paid by The company plan on your behalf from any payment received from the other party, such as settlement or judgment.

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 in 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
- Any person or entity that is liable for payment to you on any equitable or legal liability theory

You must cooperate with The company 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
- 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 company 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, shall 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" shall 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

HOW TO ENROLL

This section provides information about when you may enroll or make changes to your benefits coverage. You'll also find information about how you'll pay for coverage.

When you may enroll or make changes

You do not have to enroll or elect to participate in the automatic benefits paid by the company. These include:

- **For full-time employees:** Short-term disability, long-term disability, basic employee life and Accidental death and dismemberment (AD&D) insurance, business travel accident (BTA) insurance, the Employee Assistance Program and the Wellness Program (DC and FSC only).
- **For part-time employees:** Short-term disability, basic employee life and Accidental death and dismemberment (AD&D) insurance, the Employee Assistance Program and the Wellness Program (DC and FSC only).

For your other benefits, you can make benefit elections for you and your eligible dependents on **the companyBenIQ.com** when you first become eligible, during the annual **open enrollment** period, or if you experience a qualified life event. The table below and on the following page summarizes what happens during each opportunity to enroll or make changes.

If you believe that an incorrect decision has been made regarding your eligibility to enroll in, maintain, change or terminate any available the company benefits (including COBRA), you may ask the plan administrator to review the decision. You have 60 days from the date of the event to submit a written request for review, which must include specific information regarding the basis for your appeal and any supporting documentation. The plan administrator will provide written notice of its final decision within 10 business days of the date it receives your appeal.

The appeals form is in the Reference Center on **the companyBenIQ.com**, under Appeals.

Enrollment window	Timeframe	What you may do	If you do nothing	When changes take effect
When you first become eligible	You must make your elections within 31 calendar days of your benefits eligibility date	• Enroll yourself and eligible dependents for health coverage and/or supplemental/dependent life insurance • Enroll to participate in the FSAs and/or HSA (if eligible)	• You will not have health, supplemental/dependent life insurance or FSA coverage • You will only receive the automatic benefits paid by the company, if eligible	Coverage begins as of your benefits eligibility date

Enrollment window	Timeframe	What you may do	If you do nothing	When changes take effect
Annual open enrollment period	Usually in October	• End, change or enroll for health and life insurance coverage for yourself and eligible dependents • Add or remove dependents • Continue participation in the FSAs	• FSA coverage will end • All other current coverage will carry forward to the next **plan year**	• January 1 • Changes to life insurance may be subject to satisfactory **evidence of good health (EOGH)** and **active service** requirements
If you experience a qualified life event (review the **Mid-year changes** section for more information)	Make your elections within: • 31 days of the event that produced the change in status • 60 days of the event if coverage or eligibility changes under the Children's Health Insurance Program (CHIP), **Medicaid**, or state premium assistance	Make limited changes to your benefits that are related to your qualified life event	Current benefit coverage will continue with no changes	• Proof of qualified event may be required within your election window in order for the change to be processed • In most cases, the change will be effective on the date of the event and retroactive premium adjustments may occur • Changes to life insurance may be subject to satisfactory evidence of good health and active service requirements

Note: You may make changes to your Health Savings Account and 401(k) contributions at any time.

Late enrollment for life insurance

Late enrollment rules apply to supplemental and dependent life insurance coverage. If you do not enroll in these benefits when you are first eligible, evidence of good health (EOGH) will be required to enroll. If approved, coverage will begin on the date the insurance company approves your coverage. Review the **Evidence of good health** section for more information.

Waiving coverage

You may waive coverage during your enrollment period. If you decide to waive coverage, the next opportunity for you to change your coverage options will be during the next annual open enrollment period, unless you experience a qualified status change as described in the **Mid-year changes** section.

If you are a Hawaii employee and you choose to waive the company medical coverage, you will need to complete and return a State of Hawaii HC-5 form to prove you have other medical coverage. If you do not return this form, you will be automatically enrolled for employee-only coverage in the HMSA Preferred Provider Plan.

Note: It's important that you have medical coverage for your protection. In addition, you may be subject to a state penalty if you do not have medical coverage under the Affordable Care Act.

Mid-year changes (qualified life events)

You can make certain benefit changes outside of **open enrollment** if you have a qualified life event as defined in this section. You may only make changes that are consistent with the qualified life event you experience, as required by federal law. For example, you may only make changes to your day care FSA election if your qualified event affects the cost of day care.

There are two types of qualified life events:

- Special enrollment events, which are provided under the Health Insurance Portability and Accountability Act (HIPAA)
- Other enrollment events

If you experience one of these status changes, you must make any changes to your benefit elections on **the companyBenIQ.com** within:

- 31 days of the event that produced the change in status
- 60 days of the event if you or your dependent lose coverage or gain eligibility under the Children's Health Insurance Program (CHIP), **Medicaid** or state premium assistance

You must submit required documentation within 31 days of the date you requested a change to your benefits. Please see the **Required documentation** section for more information.

Benefit changes are generally effective as of the event date. Retroactive premium deductions may be taken from your paychecks as a result.

If you miss the deadlines for making changes or submitting documentation, you will not be able to make changes to your benefits until the next open enrollment period in October, with coverage changes effective January 1.

Special enrollment events

Under the Health Insurance Portability and Accountability Act (HIPAA), you may make changes to your elections if you lose other coverage or acquire a spouse or dependent. Though not required by HIPAA, the company allows equivalent arrangements for domestic partners and their children if they are otherwise eligible for coverage. These special enrollment events include:

- Your marriage or establishment of your domestic partnership
- The birth or legal adoption (or placement for adoption) of a child, or a child of your domestic partner
- You or your eligible dependent lose coverage or gain eligibility for assistance under a Medicaid or state child health plan
- The loss of other health coverage by you or your eligible dependent, for example:
  - The exhaustion of coverage under **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**
  - The end of employer contributions, resulting in a higher cost of coverage
  - The loss of eligibility for coverage

If you experience a special enrollment event, you can add or remove medical, vision or dental coverage for your dependent or yourself. Depending on your event, you may also be eligible to change other benefit elections.

Other life events

If you experience any of the following life events, you may be eligible to make limited benefit changes for yourself or your eligible dependents:

- The open enrollment period for the employer of your dependent
- A divorce, legal separation, or an annulment, or the dissolution of your domestic partnership
- The death of an eligible dependent
- A change in a dependent child's status such that they satisfy, or no longer satisfy, the requirements for dependent status
- A change in employment for you or your spouse/domestic partner, even if this change does not affect your eligibility for coverage (gain or loss of job, change in hours worked, taking or returning from unpaid leave)
- A change of residence for you or your eligible dependent (for example, an interstate transfer that results in a change of eligibility for a medical plan)
- You or your eligible dependent become eligible for Medicare or Medicaid
- The issuance of a qualified medical child support order (QMCSO) with respect to the health coverage for your eligible dependent child
- A significant change in day care cost or coverage for you or your spouse/domestic partner
- A significant change in coverage in the middle of the plan year, such as the reduction or enhancement, addition or elimination of a program
- A significant change in the cost of coverage (increase or decrease)

Note: You are required to make a benefit change in the case of a divorce, legal separation, annulment, or the dissolution of your domestic partnership.

In addition to the rules above, if you are in a domestic partnership you may make changes to the day care or health care FSA if the change in status affects you or your child or children, but not if the change in status affects your domestic partner or your domestic partner's child or children, unless they are your tax dependent.

Required documentation

The table on the next page summarizes the required documentation for qualified life events. The documentation must include the date of your qualified life event.

In order for your request to be processed, you must submit the required documentation within 31 days of the date you requested the change to your benefits, in one of the following ways:

- **Online:** You can take a photo of the required document with your smartphone and upload it to The company BenIQ Solution Center. To upload your documentation, go to your personal Message Center at **the companyBenIQ.com**, and open the "Action Required Regarding Your Qualifying Life Event Change" message.
- **By mail:** the company will send you a request form; you can sign the request form and mail it with a copy of the required documentation to:

  the company BenIQ Solution Center
  c/o Businessolver
  P.O. Box 310552
  Des Moines, IA 50331

If you need help or have questions, call The company BenIQ Solution Center at **877-737-2363** and select option 1 to talk with a BenIQ representative. They're available weekdays 8 a.m. to 5 p.m. Central time.

Note: Your changes will only be approved if the documentation is submitted on time and has the correct information. It is your responsibility to check the status of your pending request.

Qualifying life event	Required documentation
Divorce, end of domestic partnership, legal separation or annulment	Divorce decree, court documentation showing legal separation or annulment, or signed affidavit ending the domestic partnership; documents must show date of change
Marriage or start of domestic partnership	Marriage certificate or signed domestic partner affidavit showing date of marriage or domestic partnership
Birth or adoption	Birth certificate naming you as parent or legal adoption paperwork naming you as legal parent; documents must show date of birth or adoption
Legal guardianship	Court order naming you as legal guardian and date guardianship commenced
Gain or loss of other benefits coverage, such as: • Your spouse or domestic partner gains coverage through his or her own employer • Coverage begins for you as a dependent on your spouse or domestic partner's employer's plan • You lose eligibility for your parent's plan due to reaching age 26	Letter from plan sponsor or carrier that includes the names of everyone who gained or lost coverage, the effective date and the reason coverage was gained or lost (a COBRA notice is acceptable documentation, for example)
Death of spouse/domestic partner or dependent child	Death certificate

Paying for coverage

You and the company share in the cost of medical and dental coverage. Your portion of the cost varies according to the benefits and the level of coverage you elect.

You pay the full cost of coverage under these benefit programs:

- Vision
- Supplemental employee life insurance
- Dependent life insurance
- Health care flexible spending account (FSA)
- Day care flexible spending account (FSA)
- Health Savings Account (available only if you enroll in the UHC Silver HSA Plan)

Taxes and your benefits

Generally speaking, your contributions for health benefits, FSAs and the HSA are usually taken out of your paycheck before federal income and employment taxes are deducted. In the following situations, you may be taxed:

- If you reside in Puerto Rico
- Medical, dental, vision, FSA and HSA benefits are taxed for your domestic partner and/or children of your domestic partner who are not your tax dependents. Depending on state tax laws that apply to you, benefits for domestic partner and/or children of your domestic partner may not be subject to state taxes.
- Your contributions to your Health Savings Account (with the UHC Silver HSA Plan) are taxable at the state level in Alabama, California and New Jersey. New Hampshire and Tennessee, which do not have state income tax, have not yet exempted HSA earnings from taxes on interest or dividends.

Paying for benefits on a pre-tax basis means that the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement.

You will pay for supplemental employee life insurance and dependent life insurance on an after-tax basis.

Certain benefits will be recorded as taxable income, or imputed income, in your paycheck and W-2 statement according to Internal Revenue Service (IRS) regulation, including:

- Medical and dental coverage for your domestic partner and children of your domestic partner who are not your tax dependents
- Employee life insurance coverage above $50,000
- Long-term disability coverage

Missed payroll contributions

You pay for the cost of your benefits coverage (including applicable taxes) through automatic payroll deductions. If you do not receive a paycheck or do not have enough funds in your paycheck to cover the cost of your benefits, your missed deductions will be taken from your next available paycheck.

Paying for coverage during a leave of absence

If you are on an unpaid leave of absence, you may continue coverage in the following plans as long as you make payments for your share of the premium:

- Medical
- Dental
- Vision
- Supplemental employee life insurance
- Dependent life insurance

Premiums will not be deducted out of payroll while on a leave. Visit **the companyBenIQ.com** to pay your premiums or call a BenIQ representative at **877-737-2363** (option 1) for assistance.

Your account will be automatically set up at **the companyBenIQ.com** after three pay cycles have been missed. If you do not submit payment for the month(s) you are invoiced, your coverage will end.

If you wish to use your health care FSA for expenses incurred while on leave, you can make arrangements to make after-tax contributions during your leave. If you do not make after-tax contributions while on leave, you may not use your balance to reimburse health care expenses that are incurred during your leave.

You may not make contributions toward your day care FSA while you are on a leave of absence.

If you are on unpaid leave, imputed income for long-term disability and/or basic life insurance coverage that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.

Note: If payments are not made in a timely manner, you may lose coverage. Your next opportunity to enroll will be the next open enrollment.

MEDICAL AND PRESCRIPTION DRUGS

the company provides comprehensive medical and prescription drug coverage for you and your family to help you get and stay well. Coverage is available for all full-time and part-time benefit-eligible team members and their eligible **dependents**. This chapter provides an overview of your plan options, as well as more detailed information about each plan.

TERMS YOU SHOULD KNOW

Important definitions and phrases can be found in the **Glossary** at the end of the SPD. It's a good idea to take a minute to look up a term or phrase you do not know so you better understand how the plan works.

Your plan options

This introduction provides an overview of these options and common plan terms and conditions. For specific information on each plan, please refer to the section on each plan option.

Your plan options vary depending on where you live, as shown in the table below.

Each medical plan features a comprehensive network of providers and facilities where you may receive care at lower, negotiated rates. The Kaiser HMO plans and the Triple-S plan do not typically cover out-of-network care. The UnitedHealthcare (UHC) and HMSA plans cover in- or out-of-network care, but provide more value if you use in-network providers. In all of the plans, out-of-network care is covered at in-network levels in the event of an **emergency**.

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is provided by Express Scripts for employees who enroll in a medical plan, as described in the Prescription drugs (for UHC or HMSA plans) section. Kaiser Permanente and Triple-S provide prescription drug coverage for employees who enroll in a Kaiser HMO or Triple-S plan.

	UHC Medical Plans	Kaiser Permanente HMO Plans	HMSA Preferred Provider Plan	Salud Blue Cross Blue Shield Triple-S Plan
Eligible employees	U.S. mainland employees	**Kaiser California:** Employees in California **Kaiser Hawaii:** Employees in Hawaii	Employees in Hawaii	Employees in Puerto Rico
Where you can get care	In- or out-of-network	In-network only	In- or out-of-network	In-network only

UnitedHealthcare plans

(United States only, except Hawaii and Puerto Rico)

the company offers three UnitedHealthcare (UHC) medical plans to all employees in the United States, except Hawaii and Puerto Rico.

- The Gold Plan
- The Rose Gold Plan
- The Silver HSA Plan

In many ways, these medical plans are similar. All plans feature:

- Comprehensive medical coverage
- Flexibility to see any provider you choose
- Preventive care covered at 100% with **in-network** providers
- For other services, you pay a share of the cost up to an annual maximum amount
- Prescription drug coverage through Express Scripts (please review the **Prescription drugs** section for more information)

The three plans are different in the amount you pay in paycheck premiums and when you seek care.

In addition, if you enroll in the UHC Silver HSA Plan, you also have access to a tax-advantaged Health Savings Account to help cover your out-of-pocket costs.

UnitedHealthcare is a private healthcare claims administrator for these medical plans. As claims administrator, UnitedHealthcare has discretion and authority to decide whether a treatment or supply is covered by the plan and how benefits will be paid. Although UnitedHealthcare will assist you in many ways, it does not guarantee any benefits. the company is solely responsible for paying benefits.

CONVENIENT CARE AT WORK

Employees at the Belcamp, Maryland Distribution Center (MDC) can receive care, such as annual physicals, flu shots and more, at the onsite clinic.

The clinic is only available to employees enrolled in a UHC medical plan. All visits will be billed directly through your medical plan.

Where you can get medical care

You have the flexibility to visit the provider or facility you choose and still have medical coverage. However, you can save money by using in-network providers.

In-network

Providers in the nationwide UnitedHealthcare network feature certain advantages, including:

- The highest level of coverage and the lowest out-of-pocket costs
- Your provider files claims for you directly with UnitedHealthcare
- Lower, negotiated rates for care, called the **eligible expense**
- Your provider accepts the allowable charge as payment in full; you are not charged any additional costs
- **UnitedHealth Premium℠** providers and facilities, who have UnitedHealthcare's quality and efficiency criteria for certain medical conditions

Visit **myuhc.com** or call **866-480-4988** to find an in-network UnitedHealthcare provider or facility.

VIRTUAL VISITS

If you're in a UHC medical plan, you can use Virtual Visits to talk with a doctor from your mobile device or computer. See the **Plan highlights** table in the **What's covered** section for coverage information. Access Virtual Visits through **myuhc.com**.

Note: Before obtaining services you should always verify the network status of your provider, as network status can change. Additionally, don't assume that a provider or facility is contracted for all **covered health services** at the in-network level. Some providers and facilities contract with UnitedHealthcare to provide only certain services at the in-network level and other services are covered at the out-of-network level. Refer to the UnitedHealthcare provider directory or contact UnitedHealthcare for assistance.

Transition of care

There may be situations where you need to find a new network provider, such as when your provider or facility leaves the UnitedHealthcare network.

When this occurs, if you are actively receiving treatment for certain covered health services from a network provider whose network status changes from in-network to out-of-network, you may be able to continue care with your current provider or facility at the in-network level of benefits for a specified amount of time, this is known as transition of care. You must contact UnitedHealthcare at **866-480-4988** to apply for transition of care before receiving any services.

Out-of-network

If you knowingly seek non-emergency care with an out-of-network provider or facility, services are covered at a lower out-of-network benefit level. Additional considerations include:

- You may have to pay the provider and submit a claim for reimbursement
- Coverage under the plan is limited to the eligible expense; out-of-network providers may not accept the eligible expense negotiated by in-network providers as payment in full
- You are responsible for any amount charged above the eligible expense (known as **balance billing**) and the excess amounts you pay do not apply to your deductible, coinsurance or out-of-pocket maximum (all described under **What you pay**)
- You may have access through UnitedHealthcare's **Shared Savings Program** to out-of-network providers who have agreed to discount their charges for covered health services; You will still have out-of-network benefit coverage with these providers, but the total cost of care may be less than with other out-of-network providers

Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
You have an **emergency**	**Emergency health services,** including **air ambulance** transport, are always covered at the in-network level	Go to the nearest emergency facility
You unknowingly receive services from an out-of-network provider in an in-network facility	Certain services received from an out-of-network provider in an in-network hospital, hospital outpatient department, critical access hospital, ambulatory surgery center or other network facility, as required by law, will be covered at the in-network benefit level	Contact UnitedHealthcare if you are billed for amounts in excess of your applicable deductible, coinsurance or copay. You are not responsible for any amount charged above the eligible expense.
You cannot find the provider specialty that you need in the UnitedHealthcare network who is reasonably accessible or available to provide covered health services	If the UnitedHealthcare network does not include a provider specialty in your area, treatment at an out-of-network provider may be covered at the in-network level	Your in-network provider will notify **Personal Health Support** and they will coordinate care through an out-of-network provider
You live outside the UnitedHealthcare network	Out-of-Area coverage provides **in-network benefits** for care with providers and facilities outside the UnitedHealthcare network	UnitedHealthcare will determine eligibility and you will be automatically enrolled

Travel outside the United States

If you are traveling outside the United States and need care, the UHC plans will pay benefits for covered services. **Emergency health services** will be covered at the in-network level and all other care will be covered at the out-of-network level. You will need to submit claim forms to UHC for reimbursement.

Possible limitations on provider use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select an in-network provider to coordinate your future care. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select an in-network provider for you. In the event that you do not use the in-network provider to coordinate all of your care, any care you receive will be paid at the out-of-network level. This limitation does not apply if you have Out-of-Area coverage.

Relationship with Providers

UnitedHealthcare has agreements in place that govern the relationships between it and the company and network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide covered health services to covered individuals.

the company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the company and UnitedHealthcare arrange for health care providers to participate in a network and administer payment of benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials. They are not Our employees nor are they employees of UnitedHealthcare. the company and UnitedHealthcare are not responsible for any act or omission of any provider.

UHC resources

UHC Advocate4Me offers personalized support to help you resolve claims issues, find a provider, obtain objective second opinions and more. Information can be found on your ID card.

At UnitedHealthcare's website, **myuhc.com**, you can learn about your health plan, find care when you need it and access support to get and stay healthy.

Learn about your health plan	Find care when you need it	Access support to get and stay healthy
• Make real-time inquiries into the status and history of your claims • View eligibility and benefit information, including your annual deductible • View and print all of your **Explanation of Benefits (EOB)** • Order an ID card or print a temporary ID card	• Search for in-network providers • Estimate the costs of various procedures in your area • Compare hospitals in your area on various patient safety and quality measures	• Research a health condition and treatment options • Complete a health survey • Register for Real Appeal to reduce your risk for obesity-related diseases (access through **company.realappeal.com**)

Your UnitedHealthcare plan comes with support help you take care of yourself and your family members. These programs are available at no cost. Participation in these programs is voluntary and confidential.

I want to	Resources available	Contact
Understand my health	**Health Survey** You and your spouse or **domestic partner** can complete a questionnaire to identify healthy habits as well as potential health risks. You can also access information and online tools on a variety of health topics.	Log in to **myuhc.com**. Go to your Health & Wellness page.
Manage weight-related conditions	**Real Appeal** Any UHC member 18 years of age or older can receive support through Real Appeal, a virtual lifestyle intervention for weight-related conditions. Real Appeal is designed to help those at risk from obesity-related diseases. This intensive, multi-component behavioral intervention provides 52 weeks of support, including: • Virtual support and self-help tools: Personal one-on-one coaching with a live virtual coach, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications. • Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes. • Behavioral change counseling by a specially trained coach for clinical weight loss.	Register at **company.realappeal.com**
Get help making decisions about treatment	**Treatment Decision Support** Support to make informed decisions, including: • Access to health care information • Support by a nurse to help you make more informed decisions in your treatment and care • Expectations of treatment • Information on providers and programs Available for: • Back pain • Knee and/or hip replacement • Prostate disease • Prostate cancer • Benign uterine conditions • Breast cancer • Coronary disease • Bariatric surgery	Call **866-480-4988**

I want to	Resources available	Contact
Have personalized, efficient care for a chronic condition or complex health issue	**Personal Health Support Nurse** UnitedHealthcare may assign a primary nurse to guide you through your treatment. Your **Personal Health Support Nurse** will answer questions, explain options, identify your needs and may refer you to specialized care programs. Support is provided by phone and may include: • Admission counseling, to help you prepare for a successful surgical admission and recovery • Inpatient care management, to ensure you have the care you need when you are hospitalized • Readmission management, including follow-up calls following hospitalization to lower your risk of readmission to the hospital • Risk management, including assistance finding specialists, information and coordination of equipment and supplies for your condition • Cancer management, engage with a nurse that specializes in cancer, and can provide education and guidance • Kidney management, engage with a nurse that specializes in kidney disease, and can provide education and guidance with CKD stage 4/5 or ERSD • Disease management support for certain chronic conditions including heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD)	Call **866-480-4988**
Get best practice information	**HealtheNotes℠** This program identifies patients whose care may benefit from information using the established standards of evidence-based medicine. HealtheNotes reports are provided to you and your provider regarding: • Preventive care • Testing or medications • Potential interactions with medications you have been prescribed • Certain treatments • Health tips and other wellness information	Call **866-480-4988**
Get help coping with my chronic medical condition	**Health Management Virtual Behavioral Health Therapy and Coaching Program** Provides virtual support for mental health challenges that often accompany chronic medical issues such as diabetes, cancer and cardiac conditions. The program provides coaching from a licensed social worker or coach and includes access to a personalized online portal where you can find tools and resources and track your progress.	Call **866-480-4988**
Get a second opinion	**2ND.MD** Provides participants the voluntary opportunity to receive a second opinion when they receive a diagnosis or recommendation for surgery. 2nd.MD connect patients with specialists to help them learn more their condition and treatment options. Consultations are available by phone or video visit. A dedicated nurse will oversee medical records collection and scheduling.	Call **866-480-4988**

I want to	Resources available	Contact
Get support with pregnancy and newborn care	**Maven Maternity and Newborn Care Program** This program is part of Maven's comprehensive digital women's and family health solution providing support throughout pregnancy, postpartum, returning to work, and the newborn stage. With Maven, you have 24/7 access to unlimited coaching and education from providers across 35+ specialties like OB-GYNs, lactation consultants, midwives, infant sleep coaches, and more – anytime of the day and night. You also have a dedicated Care Advocate to help you navigate your health benefits and connect you to in-person support if needed.	Online at **mavenclinic.com/join/getsupport**
Get menopause support	**Maven Menopause and Ongoing Care Program** This program is part of Maven's comprehensive digital reproductive and family health solution providing support for people experiencing menopause. With Maven, you have 24/7 access to unlimited coaching and education from providers specializing in the menopause journey like OB-GYNs, pelvic floor physical therapists, mental health providers, career coaches, wellness coaches, and more. You also have a dedicated Care Advocate to help you navigate your health benefits and connect you to in-person support if needed.	Online at **mavenclinic.com/join/getsupport**
Get parenting and pediatric support	**Maven Parenting and Pediatrics Program** This program is part of Maven's comprehensive digital women's and family health solution providing support for parents of children up to 10 years old. With Maven, you have 24/7 access to unlimited coaching and education from various pediatric specialists like developmental psychologists, pediatricians, speech pathologists, and more – anytime of the day and night. You also have a dedicated Care Advocate to help you navigate your health benefits and connect you to in-person support if needed.	Online at **mavenclinic.com/join/getsupport**
Get fertility support	**Fertility Solutions Plus** 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. • Reimbursement may be available through Maven Wallet for expenses not covered by the medical plan, including adoption or surrogacy. • Mobile apps for personalized support to help live healthier. • 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.	Call **866-774-4626**

What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care in other situations, such as for the treatment of illnesses, injuries and chronic conditions, you pay a portion of the cost up to an annual maximum amount. The following pages walk through it, step-by-step.

Putting it all together

When you have eligible health care expenses, here's how you and the company share in the cost of coverage:

Deductible and copays
You pay

Coinsurance (Silver HSA only)
You and the company share the cost

Once your costs reach the out-of-pocket maximum, the company pays 100% of covered expenses

Preventive care is always covered at 100%

COVERING DEPENDENTS?

If you cover dependents, your deductible and out-of-pocket maximum accumulate differently depending on the plan you pick.

- In the Silver HSA Plan, only the family deductible applies if you cover dependents. All of the **eligible expenses** you pay for any covered person apply toward your family deductible. Once you meet this deductible, no further deductible will apply to any covered person in your family. The out-of-pocket maximum works the same way.
- In the Gold and Rose Gold plans, each individual's expenses apply to an individual deductible, as well as the family deductible. If one individual meets their individual deductible, no further deductible will apply to that person. If the expenses for all family members combined meet the family deductible, no further deductible will apply to any family member. The out-of-pocket maximum works the same way.

Step one: Deductible and copays

For the Gold and Rose Gold plans, you pay a copay for most services, and a deductible applies for other services. (Copays do not apply toward the deductible.) On the Silver HSA Plan, you pay 100% of your **eligible expenses**, or recognized amount when applicable, until you spend up to the amount of the deductible.

The eligible expense is the rate the plan has negotiated with in-network providers. Eligible expenses charged by both in-network and out-of-network providers apply towards both the in-network and out-of-network deductibles. However, if you seek out-of-network care, only the eligible expense is applied to your deductible.

PLAN YEAR DEDUCTIBLES

Gold Plan	
In-Network	Out-of-Network
$650 per person	$1,000 per person
$1,000 family	$3,000 family
Rose Gold Plan	
In-Network	Out-of-Network
$1,500 per person	$4,500 per person
$2,400 family	$9,000 family
Silver HSA Plan	
In-Network	Out-of-Network
$1,600 employee-only	$2,025 employee-only
$4,050 if covering dependents	$6,075 if covering dependents

Massachusetts residents only: The UHC Silver HSA Plan deductible is $4,000 if you cover **dependents**. All other coverage details are the same.

Step two: Coinsurance

If you reach the deductible on the Silver HSA Plan, then you begin to pay only a portion of the cost, called **coinsurance**, and the plan pays the rest. The coinsurance amount you pay depends on where you seek care. Please see the **What's covered** section for more information on coinsurance levels.

Step three: Out-of-pocket maximum

If you meet your out-of-pocket maximum, the plan pays 100% of eligible expenses and you pay nothing for covered services for the rest of the year. You will still be responsible for the difference between the provider's bill and the eligible expense if you seek non-emergency out-of-network care.

Your deductible, copays and coinsurance payments count toward your out-of-pocket maximum.

Just as with your deductible, eligible expenses charged by both in-network and out-of-network providers apply towards both the in-network and out-of-network out-of-pocket maximum. If you seek out-of-network care, only the eligible expense, or recognized amount when applicable, is applied to your out-of-pocket maximum.

PLAN YEAR OUT-OF-POCKET MAXIMUM

Gold Plan	
In-Network	Out-of-Network
$2,600 per person	$4,500 per person
$4,000 family	$13,500 family
Rose Gold Plan	
In-Network	Out-of-Network
$6,000 per person	$9,000 per person
$8,000 family	$18,000 family
Silver HSA Plan	
In-Network	Out-of-Network
$2,700 employee-only	$4,050 employee-only
$6,850 if covering dependents	$9,825 if covering dependents

Lifetime maximum

There is no dollar limit to the amount the plan will pay for essential benefits during the entire period you are enrolled in this plan. Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance-related and addictive disorders services (including behavioral health treatment)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Expenses not applied to the deductible or out-of-pocket maximum

Some amounts you pay do not count toward your deductible or out-of-pocket maximum. They include:

- Charges above the eligible expense, or recognized amount when applicable, as determined by the plan's claims administrator
- Charges for expenses not covered by the plan – such as for care that is not medically necessary
- Charges above the plan's maximum benefit for a specific service (such as chiropractic care)
- Benefit penalties for failing to get prior authorization when it is required
- Specialty copay assistance programs, coupons or offers from pharmaceutical manufacturers or affiliates that reduce your out-of-pocket costs for prescription drugs

Copays do not count toward your deductible, but they do apply toward the out-of-pocket maximum.

What's covered

Our UnitedHealthcare medical plans cover services as long as they are medically necessary and provided to a **covered person** who meets the plan's eligibility requirements. Services are medically necessary if they are provided for the purpose of preventing, diagnosing or treating **sickness**, **injury**, **mental illness**, substance-related and addictive disorders or their symptoms. Please review **medically necessary** for a full definition.

Benefits are provided for **telehealth/telemedicine** services and are covered to the same extent as in-person services under the applicable benefit category.

In-network benefits (including **designated network benefits**) are provided for the eligible expense, which is the negotiated amount that in-network providers and facilities have agreed to accept as payment in full for a covered service. Out-of-network providers and facilities may not accept the eligible expense as payment in full. Except as outlined below, you may receive a bill for the excess amount, which is known as **balance billing**. However, when you receive the following out-of-network care, eligible expenses are the amount negotiated by UnitedHealthcare or the amount permitted by law:

- **Ancillary services** received unknowingly from an out-of-network provider at certain in-network facilities (including a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center and any other network facility as required by law),
- Non-ancillary services received from an out-of-network provider that have not satisfied the notice and consent requirements or non-ancillary services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied,
- Emergency health services provided by an out-of-network provider,
- **Air ambulance** services provided by an out-of-of network provider, or
- Services arranged by UnitedHealthcare

The plan will not pay for excessive charges or amounts you are not legally obligated to pay. Please review **eligible expenses** for more information on how the eligible expense is determined.

The following sections provide information about what's covered:

- **Prior authorization** reviews when the plan must provide authorization before services will be covered
- **Plan highlights** summarizes what the plans cover
- **Additional coverage details** provides more information about covered health services, including eligibility criteria and benefit limitations

All of the benefits for each medical plan are subject to the plan's exclusions and limitations, as described in the **What's not covered** section.

Advocacy services

If you have questions about eligible expenses, how eligible expenses are determined or believe you have been billed for amounts in excess of your applicable deductible, coinsurance or copay, contact UnitedHealthcare at **866-480-4988**.

Prior authorization

Some covered health services require prior authorization (or precertification), as noted in the **Plan highlights** table on the following page.

- **For in-network care**, your network provider will handle the prior authorization process when it is needed, although it is recommended that you confirm with UnitedHealthcare that the prior authorization has been approved before you obtain a service that requires it. You are responsible for obtaining prior authorization if an out-of-network provider admits you to an in-network facility or refers you to an in-network provider.
- **For out-of-network care**, you or your out-of-network health care provider must call **866-480-4988** to request prior authorization. If you do not obtain prior authorization, your benefits will be reduced as described in this section.

Authorization is required as soon as is reasonably possible after you are admitted to an out-of-network hospital as a result of an emergency.

If you choose to receive a service that has been determined to not be a medically necessary covered health service, you will be responsible for paying all charges and no benefits will be paid.

SPECIAL NOTE REGARDING MEDICARE

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the plan, you are not required to receive prior authorization from Personal Health Support before receiving care.

Plan highlights

The table below summarizes what the UnitedHealthcare plans cover, including what the plans pay for in-network and out-of-network care. Please also review the **Additional coverage details** and **What's not covered** sections for complete benefit coverage information. Prescription drug coverage is provided in the **Prescription drugs** section.

	UNITEDHEALTHCARE PLANS[1]	
	In-Network (including designated network)	Out-of-Network
Benefit	**Amount you pay**	
Acupuncture services Up to 20 visits per plan year (combined in- and out-of-network)	Gold and Rose Gold: $25 copay primary/$35 copay specialist Silver HSA: 20% after deductible	20% after deductible
Ambulance services • Emergency ground and air ambulance • Non-emergency ambulance (prior authorization required)	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible Eligible expenses for **air ambulance** services are determined as outlined in **What's covered**
Cellular and gene therapy Prior authorization required	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	Not covered
Chiropractic services (including manipulative treatment) Up to 20 visits per plan year (combined with in- and out-of-network)	Gold and Rose Gold: $35 copay Silver HSA: 20% after deductible	50% after deductible
Clinical trials Prior authorization required	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	
Congenital heart disease (CHD) services Prior authorization required	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Dental services – accident only	Gold and Rose Gold: $25 copay primary care/$35 copay specialist Silver HSA: 20% after deductible	50% after deductible
Diabetes services • Diabetes self-management, training, diabetic eye examinations and foot care	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	
• Diabetes self-management items » Diabetes equipment » Diabetes supplies	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible

1. For Out-of-Area coverage, use in-network information only.

	UNITEDHEALTHCARE PLANS[1]	
	In-Network (including designated network)	Out-of-Network
Benefit	**Amount you pay**	
Durable medical equipment (DME) Prior authorization required for DME exceeding $1,000	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% from designated vendor
Emergency health services – outpatient (eligible expenses for out-of-network emergency health services are determined as outlined in **What's covered**) • True emergency	Gold and Rose Gold: $250 copay (waived if admitted) Silver HSA: 20% after deductible	
• Non-emergency	Gold and Rose Gold: $250 copay (waived if admitted) Silver HSA: 20% after deductible	Gold and Rose Gold: $250 copay (waived if admitted) Silver HSA: 50% after deductible
Enteral nutrition	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Family planning	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	
Fertility preservation (Iatrogenic infertility)	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Fertility services Up to $20,000 per covered person's lifetime; additional limits apply Prior authorization required	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section (only covered if services rendered by a designated facility through the FS+ program)	
Gender identity/dysphoria services	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	
Hearing aids • Equipment	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
• Exam	Gold and Rose Gold: $25 copay primary care/$35 copay specialist Silver HSA: 20% after deductible	50% after deductible
Home health care Up to 120 days per plan year (combined in- and out-of-network) Prior authorization required	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible

1. For Out-of-Area coverage, use in-network information only.

	UNITEDHEALTHCARE PLANS[1]	
	In-Network (including designated network)	Out-of-Network
Benefit	**Amount you pay**	
Hospice care Prior authorization required for inpatient hospice care	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Hospital – inpatient stay Prior authorization required	Gold: $250 copay per day (3-day max) Rose Gold: $500 copay per day (3-day max) Silver HSA: 20% after deductible	50% after deductible
Lab, X-ray and diagnostics – outpatient Prior authorization required for sleep studies	Gold and Rose Gold: $25 copay Silver HSA: 20% after deductible	50% after deductible
Lab, X-ray and major diagnostics – CT, PET, MRI, MRA and nuclear medicine – outpatient	Gold: $125 copay Rose Gold: $250 copay Silver HSA: 20% after deductible	50% after deductible
Mental health services Prior authorization required for inpatient care (including partial hospitalization/day treatment and services at a residential treatment facility)		
• Outpatient	Gold and Rose Gold: $25 copay Silver HSA: 20% after deductible	50% after deductible
• Inpatient	Gold: $250 copay per day (3-day max) Rose Gold: $500 copay per day (3-day max) Silver HSA: 20% after deductible	50% after deductible
• Virtual behavioral health therapy and coaching (provided through AbleTo network)	Gold and Rose Gold: $0 Silver HSA: 0% after deductible (initial consultation not subject to deductible)	Not covered
Neurodevelopmental disorders – autism spectrum disorder services Prior authorization required for inpatient care (including partial hospitalization/day treatment and services at a residential treatment facility)		
• Outpatient	Gold and Rose Gold: $25 copay Silver HSA: 20% after deductible	50% after deductible
• Inpatient	Gold: $250 copay per day (3-day max) Rose Gold: $500 copay per day (3-day max) Silver HSA: 20% after deductible	50% after deductible
Nutritional counseling	Gold and Rose Gold: $25 copay primary care/$35 copay specialist Silver HSA: 20% after deductible	50% after deductible

1. For Out-of-Area coverage, use in-network information only.

	UNITEDHEALTHCARE PLANS[1]	
	In-Network (including designated network)	Out-of-Network
Benefit	**Amount you pay**	
Obesity surgery Prior authorization required	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	Not covered
Ostomy supplies	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Pharmaceutical products – outpatient	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Physician fees for surgical and medical services (eligible expenses for covered health services provided by an out-of-network provider in certain in-network facilities are determined as outlined in What's covered)	Gold and Rose Gold: $25 copay primary care/$35 copay specialist Silver HSA: 20% after deductible	50% after deductible
Physician's office services – sickness and injury Prior authorization required for BRCA genetic testing	Gold and Rose Gold: $25 copay primary care/$35 copay specialist Silver HSA: 20% after deductible	50% after deductible
Pregnancy – maternity services Prior authorization required for inpatient stays longer than 48 hours for vaginal delivery or 96 hours for caesarean section delivery	Benefits will be the same as those stated under each benefit category in this section	
Preimplantation genetic testing (PGT) and related services	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Preventive care services • Physician office services • Lab, X-ray or other preventive tests • Breast pumps • PSA • Preventive colonoscopy and polyp removal First two in-network MRIs and in-network mammograms for the plan year regardless of diagnosis will be covered at 100%.	$0 Cost is based on the type of expense incurred and the place where the service is provided	50% after deductible Cost is based on the type of expense incurred and the place where the service is provided
Private duty nursing – outpatient Up to 70 shifts per plan year (combined in- and out-of-network)	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible

1. For Out-of-Area coverage, use in-network information only.

	UNITEDHEALTHCARE PLANS[1]	
	In-Network (including designated network)	Out-of-Network
Benefit	**Amount you pay**	
Prosthetic devices Prior authorization required for prosthetic devices costing more than $1,000	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Reconstructive procedures Prior authorization required	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	
Rehabilitation services – outpatient therapy Visit limits apply Combined 90 visit maximum for Physical, Speech and Occupational Therapy	Gold and Rose Gold: $25 copay primary care/$35 copay specialist Silver HSA: 20% after deductible	50% after deductible
Scopic procedures – outpatient diagnostic and therapeutic		
• Office visits	Gold and Rose Gold: $25 copay primary care/$35 copay specialist Silver HSA: 20% after deductible	50% after deductible
• Outpatient hospital	Gold: $125 copay Rose Gold: $250 copay Silver HSA: 20% after deductible	
Skilled nursing facility/inpatient rehabilitation facility services Prior authorization required, up to 120 days per plan year	Gold: $250 copay per day (3-day max) Rose Gold: $500 copay per day (3-day max) Silver HSA: 20% after deductible	50% after deductible
Substance-related and addictive disorders services Prior authorization required for inpatient care (including partial hospitalization/day treatment and services at a residential treatment facility)		
• Outpatient	Gold and Rose Gold: $25 copay Silver HSA: 20% after deductible	50% after deductible
• Inpatient	Gold: $250 copay per day (3-day max) Rose Gold: $500 copay per day (3-day max) Silver HSA: 20% after deductible	50% after deductible
• Partial hospitalization/intensive outpatient	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible

1. For Out-of-Area coverage, use in-network information only.

	UNITEDHEALTHCARE PLANS[1]	
	In-Network (including designated network)	Out-of-Network
Benefit	**Amount you pay**	
Surgery – outpatient Prior authorization required for sleep apnea surgeries and orthognathic surgeries	Gold: $125 copay Rose Gold: $250 copay Silver HSA: 20% after deductible	50% after deductible
Temporomandibular joint (TMJ) services	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Therapeutic treatments – outpatient Prior authorization required	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Transplantation services (If services rendered by a designated facility) Prior authorization required	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	Not covered
Treatment of gender dysphoria (gender identity disorder)	Depending upon where the service is provided, benefits will be the same as those stated under each benefit category in this section	
Travel and lodging Limits apply	Allowance for travel and lodging related to covered services for complex medical conditions, gender dysphoria, elective pregnancy termination, mental health care and substance-related addictive disorder services and surgeries when services are not available within 50 miles of your home address	
Urgent care center services	Gold and Rose Gold: $35 copay Silver HSA: 20% after deductible	50% after deductible
Urinary catheters	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible
Virtual care services Available only through a designated virtual network provider. Go to myuhc.com or call the telephone number on your ID card. Telehealth is covered at normal plan benefits.	Gold and Rose Gold: $20 copay Silver HSA: 20% after deductible	Not covered
Wigs	Gold and Rose Gold: $0 after deductible Silver HSA: 20% after deductible	50% after deductible

1. For Out-of-Area coverage, use in-network information only.

Additional coverage details

Acupuncture services

The plan pays benefits for acupuncture services for pain therapy provided in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Chiropractor
- Acupuncturist

Covered health services also include treatment of nausea as a result of:

- Chemotherapy
- Pregnancy
- Post-operative procedures

Any combination of in-network and out-of-network visits is limited to 20 visits per plan year. If you have Out-of-Area coverage, benefits are limited to 20 visits per plan year. This visit limit does not apply if acupuncture is provided in lieu of anesthesia. Acupuncture services by any licensed provider count toward this visit limit.

Ambulance services

The plan pays benefits for emergency ambulance services and transportation provided by a licensed ambulance service to the nearest **hospital** that offers **emergency health services**. See the Glossary for the definition of **emergency**.

Ambulance service by air is covered in an emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services.

The plan also covers transportation provided by a licensed professional ambulance (either ground or **air ambulance**, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From an out-of-network hospital to a network hospital
- To a hospital that provides a higher level of care that was not available at the original hospital
- To a more cost-effective acute care facility
- From an acute facility to a sub-acute setting

In most cases, UnitedHealthcare will initiate and direct non-emergency ambulance transportation.

For out-of-network benefits, you must obtain prior authorization as soon as possible prior to non-emergency transport by air ambulance (including any affiliated non-emergency ground ambulance transport in conjunction with non-emergency air ambulance transport). If prior authorization is not obtained, benefits will be reduced by $200. This penalty does not apply if you have Out-of-Area coverage.

Cellular and gene therapy

Cellular therapy and **gene therapy** received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under **transplantation services**.

Clinical trials

The plan pays benefits for routine patient care costs incurred during participation in a qualifying **clinical trial** for the treatment of:

- Cancer or other life-threatening disease or condition; for purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below

- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below
- Other diseases or disorders for which, as determined by UnitedHealthcare, a clinical trial meets the qualifying clinical trial criteria stated below

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the covered person is clinically eligible for participation in the clinical trial as defined by the researcher.

Routine patient care costs for clinical trials include covered health services:

- For which benefits are typically provided absent a clinical trial
- Required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service or the prevention of complications
- Needed for reasonable and necessary care arising from the provision of an investigational item or service

Routine patient care costs for clinical trials do not include:

- The experimental or investigational service or item. The only exceptions to this are:
  - Certain category B devices
  - Certain promising interventions for patients with terminal illnesses; or
  - Other items and services that meet specified criteria in accordance with the claims administrator's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH) (includes National Cancer Institute (NCI))
  - Centers for Disease Control and Prevention (CDC)
  - Agency for Healthcare Research and Quality (AHRQ)
  - Centers for Medicare and Medicaid Services (CMS)
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA)
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs)

before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial

- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the plan

For out-of-network benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If prior authorization is not obtained, benefits will be reduced by $200. This penalty does not apply if you have Out-of-Area coverage.

Congenital heart disease services

The plan pays benefits for **congenital heart disease (CHD)** services ordered by a **physician** and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- Outpatient diagnostic testing
- Evaluation
- Surgical interventions
- Interventional cardiac catheterizations (insertion of a tubular device in the heart)
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology)
- Approved fetal interventions

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at **888-936-7246** or Personal Health Support at **866-480-4988** for information about CHD services.

If you receive CHD services from a facility that is not a **designated facility**, the plan pays benefits as described under:

- **Hospital – inpatient stay**
- **Physician fees for surgical and medical services**
- **Physician's office services – sickness and injury**
- **Scopic procedures – outpatient diagnostic and therapeutic**
- **Surgery – outpatient**
- **Therapeutic treatments – outpatient**

For out-of-network benefits, you must obtain prior authorization from United Resource Networks or Personal Health Support as soon as the possibility of CHD surgery arises. If prior authorization is not obtained, benefits will be reduced by $200. This penalty does not apply if you have Out-of-Area coverage.

Dental services – accident only

Dental services are covered by the plan when all of the following are true:

- Treatment is necessary because of accidental damage
- Dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth
- Dental services are received from a Doctor of Dental Surgery or a doctor of medical dentistry
- The dental damage is severe enough that initial contact with a physician or dentist occurs within 72 hours of the accident; you may request an extension of this time period provided that you do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury

The plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system)
- Direct treatment of acute traumatic injury, cancer or cleft palate

Dental services for final treatment to repair the damage caused by accidental injury must be started within three months of the accident or if not covered at the time of the accident, within the first three months of coverage under the plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 24 months of the accident (or if not covered at the time of the accident, within the first 24 months of coverage under the plan).

The plan pays for treatment of accidental injury only for:

- Emergency examination
- Necessary diagnostic X-rays
- Endodontic (root canal) treatment

- Temporary splinting of teeth
- Prefabricated post and core
- Simple minimal restorative procedures (fillings)
- Extractions
- Post-traumatic crowns if such are the only clinically acceptable treatment
- Replacement of lost teeth due to the injury by implant, dentures or bridges

Diabetes services

The plan pays benefits for the covered health services identified below.

Diabetes self-management training, diabetic eye examinations and foot care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a physician and provided by appropriately licensed or registered healthcare professionals. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for covered persons with diabetes.
Diabetic self-management items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the covered person including, but not limited to: • Blood glucose monitors • Insulin syringes with needles • Blood glucose and urine test strips • Ketone test strips and tablets • Lancets and lancet devices Benefits for diabetes equipment that meet the definition of **durable medical equipment (DME)** are not subject to the limit stated under the durable medical equipment benefit.

To receive in-network benefits, you must purchase or rent the durable medical equipment for the management and treatment of diabetes from the vendor Personal Health Support identifies or purchase it directly from the prescribing network physician.

You must obtain prior authorization before obtaining any durable medical equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of durable medical equipment will cost more than $1,000. If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Durable medical equipment (DME)

The plan pays benefits for **durable medical equipment (DME)** that is:

- Ordered or provided by a physician for outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a sickness, injury or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home

Note: DME is different from prosthetic devices – see the **prosthetic devices** benefit.

To receive in-network benefits, you must purchase or rent the DME from the vendor Personal Health Support identifies or purchase it directly from the prescribing network physician.

You must obtain prior authorization if the purchase, rental, repair or replacement of DME will cost more than $1,000. If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

If more than one piece of DME can meet your functional needs, you will receive benefits only for the most **cost-effective** piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of DME that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most cost-effective.

Examples of DME include but are not limited to:

- Equipment to administer oxygen

- Equipment to assist mobility, such as a standard wheelchair
- Hospital beds
- Delivery pumps for tube feedings
- Negative pressure wound therapy pumps (wound vacuums)
- Burn garments
- Insulin pumps and all related necessary supplies as described under **diabetes services** in this section
- External cochlear devices and systems.

  Surgery to place a cochlear implant is also covered by the plan. Cochlear implantation can either be an inpatient or outpatient procedure. See **hospital – inpatient stay**, **rehabilitation services – outpatient therapy** and **surgery – outpatient**.
- Orthotic devices when prescribed by physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets), shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces.

  Braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME and are a covered health service. Braces that straighten or change the shape of a body part are orthotic devices and are a covered health service. Dental braces are excluded from coverage.
- Equipment for the treatment of chronic or acute respiratory failure or conditions

The plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Speech aid and voice devices

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to sickness or injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period.

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a covered person is enrolled under the plan. These devices are included in the annual limits stated above.

Repair and replacement

Benefits are provided for the repair/replacement of a type of DME once every three plan years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price or when a change in the covered person's medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

Emergency health services – outpatient

The plan pays benefits for outpatient treatment at a **hospital** or **alternate facility** when required to stabilize a patient or initiate treatment.

In-network benefits will be paid for an emergency admission to an out-of-network hospital as long as Personal Health Support is notified as soon as reasonably possible after you are admitted to an out-of-network hospital. If you continue your stay in an out-of-network hospital after the date your physician determines that it is medically appropriate to transfer you to a network hospital, out-of-network benefits will apply.

Benefits under this section are available for services to treat a condition that does not meet the definition of an **emergency**.

For out-of-network benefits, you must notify Personal Health Support as soon as reasonably possible if you are admitted to a hospital as a result of an emergency. If Personal Health Support is not notified, benefits for the inpatient hospital stay will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Enteral nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a physician.

Family planning

The plan pays benefits for the following services:

- Voluntary sterilization
- Surgical, non-surgical or drug induced pregnancy termination
- Health services and associated expenses for elective abortion
- Fetal reduction surgery
- Contraceptives obtained in a physician's office such as diaphragm, IUD and Depo-Provera

Fertility preservation (Iatrogenic infertility)

Benefits are provided 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
- Embryo cryo-preservation

Benefits for medications related to the treatment of fertility preservation are provided as described in the **Prescription drugs** section.

Benefits are not available for elective fertility preservation, embryo transfer or long-term storage costs (greater than one year).

This benefit limit also includes services as described under **Preimplantation genetic testing (PGT-M and PGT-SR) and related services**.

Fertility services

The plan pays benefits for therapeutic services for the treatment of fertility when provided by or under the direction of a physician. Benefits under this section are limited to the following procedures:

- **Assisted Reproductive Technology (ART)**, including but not limited to, in vitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval
  - Fresh or frozen embryo transfer
  - Intracytoplasmic sperm injections (ICSI)
  - Cyropreservation and storage of embryos for 12 months
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD)
- Frozen embryo transfer cycle including the associated cryopreservation and storage of embryos
- Insemination procedures (Artificial Insemination (AI) and IntraUterine Insemination (IUI))
- Ovulation induction (for controlled ovarian stimulation)
- Testicular sperm aspiration/microsurgical epididymal sperm aspiration (TESA/MESA) – male factor associated surgical procedures for retrieval of sperm
- Surgical procedures including laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization and ovarian cystectomy
- **Pre-implantation genetic testing** for a monogenic disorder (PGT-A) or structural rearrangement (PGT-SR) for diagnosis of genetic disorders only
- Electroejaculation

Fertility preservation for medical reasons

Benefits are available when cancer or other medical treatment is likely to result in **infertility**. Covered services include collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization and embryo cryopreservation. Long-term storage (greater than 12 months) is not covered.

Fertility preservation for non-medical reasons

Benefits are available when you choose to delay pregnancy for non-medical reasons. Covered services include collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization and embryo cryopreservation. Long-term storage (greater than 12 months) is not covered.

Criteria to be eligible for benefits

You are eligible for benefits if you are female and under age 44 and using your own oocytes (eggs), or under age 55 and using donor oocytes. Note: For treatment initiated prior to a pertinent birthday, services will be covered to completion of initiated cycle. (You do not need to have a diagnosis of **infertility** to be eligible for benefits.)

Child dependents (up to age 26) are eligible for fertility preservation for certain medical treatments.

Benefits for fertility services is limited to $20,000 per covered person during the entire period you are covered under the plan (except pharmacy). This limit includes benefits for fertility preservation (Iatrogenic infertility) and pre-implantation genetic testing (PGT-M and PGT-S) and related services.

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.
- Reimbursement may be available through Maven Wallet for expenses not covered by the medical plan, including adoption or surrogacy.
- Mobile apps for personalized support to help live healthier.
- 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.

Please contact Fertility Solutions Plus at **866-774-4626** for additional information.

Gender dysphoria (gender identity disorder) services

The plan pays benefits for the treatment of gender dysphoria (**gender identity disorder**) as described below.

Non-surgical treatment of gender dysphoria

The plan covers the following non-surgical treatments for gender dysphoria:

- Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses as described under **mental health services**
- Continuous hormone replacement therapy, hormones of the desired gender injected by a medical provider

Note: Coverage may be available for oral and self-injected hormones under the prescription drug benefits. See the **Prescription drugs** section for more information.

- Laboratory testing to monitor the safety of continuous hormone therapy
- Reproduction services including sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos and oocyte preservation

Surgical treatment of gender dysphoria

The plan covers the following surgical treatment for gender dysphoria when all of the following eligibility qualifications for surgery are met:

- Genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy and augmentation mammoplasty) and related services
  - The treatment plan must conform to identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance
  - For irreversible surgical interventions, the covered person must be age 18 years or older
  - Prior to surgery, the covered person must complete 12 months of successful continuous full time real life experience in the desired gender

Important

- Certain patients will be required to complete continuous hormone therapy prior to surgery. In consultation with the patient's physician, this will be determined on a case-by-case basis.
- Augmentation mammoplasty is allowed 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.

UnitedHealthcare has specific guidelines regarding benefits for treatment of gender dysphoria (gender identity disorder). Contact UnitedHealthcare at the telephone number on your ID card for information about these guidelines.

For out-of-network surgical treatment, you must obtain prior authorization as soon as the possibility of surgery arises. If prior authorization is not obtained, benefits will be reduced by $200. Additionally, for out-of-network benefits, you must contact UnitedHealthcare 24 hours before admission for scheduled admissions or as soon as reasonably possible for non-scheduled admissions.

Prior authorization for non-surgical treatment: Depending on where the covered health service is provided, any applicable prior authorization requirements will be the same as those stated under each covered health service category in this section.

Hearing aids

The plan pays benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

If more than one type of hearing aid can meet your functional needs, benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the plan will pay only the amount that the plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider.

Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam
- A fitting by an audiologist
- A written prescription

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are covered under the applicable medical/surgical categories in this section for covered persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid

Home health care

The plan pays benefits for covered health services provided by a home health agency if you need care in your home due to the nature of your condition. A **home health agency** is a program or organization authorized by law to provide health care services in the home.

Services must be:

- Ordered by a physician
- Provided by or supervised by a registered nurse in your home or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse
- Not considered **custodial care**
- Provided on a part-time, **intermittent schedule** when **skilled care** is required

Personal Health Support will decide if skilled care is needed by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of in-network benefits and out-of-network benefits is limited to 120 days per plan year. If you have Out-of-Area coverage, benefits are limited to 120 days per plan year. Additional visits may be available upon review. One day equals

four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

For out-of-network home health care benefits, you must obtain prior authorization five business days before receiving services, or as soon as reasonably possible. If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Hospice care

Hospice care is an integrated program recommended by a physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling (known as bereavement counseling) for immediate family members while the covered person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

For out-of-network hospice care benefits, you must obtain prior authorization five business days before receiving services, or as soon as reasonably possible. If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage. Additionally, you must contact UnitedHealthcare within 24 hours of admission for an inpatient stay in a hospice facility.

Hospital – inpatient stay

Benefits for an **inpatient stay** in a hospital are available only when necessary to prevent, diagnose or treat a sickness or injury. The plan pays benefits for inpatient hospital stays, including:

- Non-physician services and supplies received during an inpatient stay
- Room and board in a **semi-private room** (a room with two or more beds)
- Physician services for anesthesiologists, emergency room physicians, pathologists and radiologists

The plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for other hospital-based services are described in the following sections:

- **Emergency health services – outpatient**
- **Physician fees for surgical and medical services**
- **Scopic procedures – diagnostic and therapeutic services**
- **Surgery – outpatient**
- **Therapeutic treatments – outpatient**

For out-of-network inpatient hospital benefits, you must:

- Obtain prior authorization for elective admissions five business days before admission or as soon as reasonably possible
- Notify Personal Health Support for non-elective admissions (or admissions resulting from an emergency) as soon as is reasonably possible
- Contact UnitedHealthcare 24 hours before admission for scheduled admissions or as soon as reasonably possible for non-scheduled admissions.

If prior authorization is not obtained (or Personal Health Support is not notified for a non-elective admission), benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Lab, X-ray and diagnostics – outpatient

The plan pays benefits for sickness and injury-related diagnostic services received on an outpatient basis at a hospital, alternate facility or in a physician's office. Covered health services include, but are not limited to:

- Lab
- Radiology/X-ray
- Mammography

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Physician services for anesthesiologists, pathologists and radiologists
- Presumptive drug tests and definitive drug tests (any combination of in-network and out-of-network benefits is limited to 18 presumptive and 18 definitive drug tests per calendar year)

Benefits for related services are found in the following sections:

- Other physician services are under **physician fees for surgical and medical services**
- Lab, X-ray and diagnostic services for preventive care are under **preventive care services**
- CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under **lab, X-ray and major diagnostics**

For out-of-network benefits for genetic testing and sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Lab, X-ray and major diagnostics – CT, PET scans, MRI, MRA and nuclear medicine – outpatient

The plan pays benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a hospital, alternate facility or in a physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Physician services for anesthesiologists, pathologists and radiologists

Benefits for other physician services are described in this section under **physician fees for surgical and medical services**.

Mental health services

The plan pays benefits for **mental health services** received on an inpatient or outpatient basis in a hospital, an alternate facility or a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their license.

Benefits include the following levels of care:

- Inpatient treatment
- Residential treatment
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds). Benefits include the following services:

- Diagnostic evaluations, assessment and treatment and/or procedures
- Medication management
- Individual, family, and group therapy
- Crisis intervention

The **mental health/substance-related and addictive disorders services administrator** determines coverage for all levels of care.

You are encouraged to contact the mental health/substance-related and addictive disorders administrator for assistance locating providers and coordination of care. Call **866-480-4988**.

For out-of-network benefits, you must obtain prior authorization from the mental health/substance-related and addictive disorders administrator to receive inpatient benefits for inpatient care (including partial hospitalization/day treatment and services at a residential treatment facility). Please call **866-480-4988**. Without prior authorization, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Virtual Behavioral Health Therapy and Coaching

Virtual therapy and coaching services are available through the AbleTo Therapy 360 Program for covered individuals with certain behavioral and medical conditions. These services are individualized and tailored to meet specific health needs. Virtual therapy is provided by licensed therapists and coaching services are supervised by licensed professionals.

Neurodevelopmental disorders – autism spectrum disorders

The plan pays benefits for psychiatric services for **autism spectrum disorders** (otherwise known as neurodevelopmental disorders) that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider
- 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 psychiatric component of treatment for autism spectrum disorders. Medical treatment of autism spectrum disorders is covered under the applicable medical service categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment
- Residential treatment
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds). Benefits include the following services:

- Diagnostic evaluations, assessment and treatment and/or procedures
- Medication management
- Individual, family, and group therapy
- Crisis intervention

The **mental health/substance-related and addictive disorders services administrator** determines coverage for all levels of care.

You are encouraged to contact the mental health/substance-related and addictive disorders administrator for assistance locating providers and coordination of care. Call **866-480-4988**.

For out-of-network benefits, you must obtain prior authorization from the mental health/substance-related and addictive disorders administrator to receive inpatient benefits for inpatient care (including partial hospitalization/day treatment and services at a residential treatment facility). Please call **866-480-4988**. Without authorization, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Nutritional counseling

The plan will pay benefits for medical education services provided in a physician's office by an appropriately licensed or healthcare professional. This education is a covered health service when:

- Education is required for a disease in which patient self-management is an important component of treatment
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional

Some examples of such medical conditions include:

- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

Obesity surgery

The plan covers surgical treatment of obesity provided under the direction of a physician when all of the following are true:

- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4;
- You have a minimum **Body Mass Index (BMI)** of 40, or >35 with at least one co-morbidity condition (such as sleep apnea or diabetes) present;
- You enroll in the Optum Bariatric Resource Services (BRS) program;
- You use an Optum designated Bariatric Resource Services (BRS) provider and facility;
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation;
- You have a three month physician supervised diet documented within the last two years; and
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

All authorization information and enrollment for bariatric surgery must be initiated through Optum's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should 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.

If you receive obesity surgery services that are not part of the Bariatric Resource Services program, the services will not be covered.

For out-of-network benefits, you must obtain prior authorization as soon as the possibility of obesity surgery arises. If prior authorization is not obtained, benefits will be subject to a $200 reduction. Additionally, you must contact UnitedHealthcare 24 hours before admission for scheduled admissions or as soon as reasonably possible for non-scheduled admissions (including emergency admissions).

Bariatric Resource Services (BRS)

Bariatric Resource Services (BRS) 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. Access the Bariatric Resource Services Centers of Excellence program at **888-936-7246**.

Ostomy supplies

The plan pays benefits for ostomy supplies, limited to:

- Pouches, face plates and belts
- Irrigation sleeves, bags and ostomy irrigation catheters
- Skin barriers

Pharmaceutical products – outpatient

The plan pays benefits for **pharmaceutical products** that are administered on an outpatient basis in a hospital, alternate facility, physician's office or in a covered person's home by a health care provider. Examples of what would be included under this category are antibiotic injections in the physician's office or inhaled medication in an **urgent care center** for treatment of an asthma attack.

Benefits under this section are provided only for pharmaceutical products, which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Depending on where the pharmaceutical product is administered, benefits will be provided under the corresponding benefit category of this summary plan description. Benefits under this section do not include medications for the treatment of infertility.

If you require certain pharmaceutical products, including specialty pharmaceutical products, UnitedHealthcare may direct you to a designated dispensing entity that is contracted with UnitedHealthcare to provide these products. These entities may include outpatient pharmacies, specialty pharmacies, home health providers, hospital-affiliated pharmacies or hemophilia treatment center pharmacies. Network benefits are only available through these entities.

Certain pharmaceutical products are subject to step-therapy, which means that in order to receive benefits you must use a different product or prescription drug first. Contact UnitedHealthcare at **myuhc.com** or by calling the number on your ID card to find out if a certain medication is subject to step therapy.

UnitedHealthcare has programs that provide benefits based on your actions and adherence to medication treatment regimens and/or participation in health management programs. Contact UnitedHealthcare at **myuhc.com** or by calling the number on your ID card to learn more.

Physician fees for surgical and medical services

The plan pays benefits for physician fees for surgical procedures and other medical care received from a physician in a hospital, skilled nursing facility, inpatient rehabilitation facility, alternate facility or for physician house calls.

Physician's office services – sickness and injury

The plan pays benefits for covered health services received in a physician's office or in a covered person's home for the evaluation and treatment of a sickness or injury. Benefits are provided under this section regardless of whether the physician's office is free-standing, located in a clinic or located in a hospital. Benefits under this section include allergy injections and hearing exams in case of injury or sickness.

Covered health services include **genetic counseling**. Benefits are available for **genetic testing** that is determined to be **medically necessary** following genetic counseling, when ordered by the physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under **preventive care services** in this section.

When a test is performed or a sample is drawn in the physician's office and then sent outside the physician's office for analysis or testing, benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the physician's office are described in **lab, X-ray and diagnostics – outpatient.**

Note: Your physician does not have a copy of your SPD and is not responsible for knowing or communicating your benefits.

Pregnancy – maternity services

The plan pays benefits for pregnancy at the same level as benefits for any other condition, sickness or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Covered health services performed by a midwife are covered provided the midwife is licensed or certified in accordance with the requirements of the state or jurisdiction of practice, practicing within the scope of the license or certification and rendering a service covered under the plan.

The plan will pay benefits for an **inpatient stay** of at least:

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

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this plan. The hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a pregnancy, benefits include the services of a genetic counselor when provided or referred by a physician. These benefits are available to all covered persons in the immediate family. Covered health services include related tests and treatment.

For out-of-network benefits, you must obtain prior authorization as soon as reasonably possible if the inpatient stay for the mother and/or the newborn will be longer than the timeframes indicated above. If prior authorization is not obtained, benefits for the extended stay will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

HEALTHY MOMS AND BABIES

The plan provides a special prenatal program to help during pregnancy. Participation is voluntary and free of charge. For details, see **UHC resources**.

Preimplantation genetic testing (PGT-M and PGT-SR) and related services

The plan pays benefits for preimplantation genetic testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for benefits the following must be met:

- PGT must be ordered by a physician after genetic counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a physician:
  - Ovulation induction (or controlled ovarian stimulation)
  - Egg retrieval, fertilization and embryo culture
  - Embryo biopsy
  - Embryo transfer
  - Cryo-preservation and short-term embryo storage (less than one year)

Benefits are not available for long-term storage costs (greater than one year).

This benefit limit also includes services as described under **fertility preservation (Iatrogenic infertility)**.

Preventive care services

The plan pays benefits for 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
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)

Preventive care benefits defined under the HRSA requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. These benefits are described under **Plan highlights**.

If more than one breast pump can meet your needs, benefits are available only for the most cost-effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost-effective
- Whether the pump should be purchased or rented
- Duration of a rental
- Timing of an acquisition

Benefits are only available if breast pumps are obtained from a DME provider or physician.

For questions about your preventive care benefits under this plan call **866-480-4988**.

Private duty nursing – outpatient

The plan pays benefits for **private duty nursing** care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.).

Any combination of in-network benefits and out-of-network benefits is limited to 70 shifts per plan year. If you have Out-of-Area coverage, benefits are limited to 70 shifts per plan year. One shift is equivalent to eight hours. Additional visits may be available upon review.

Prosthetic devices

The plan pays benefits for prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work.

Examples include, but are not limited to:

- Artificial arms, legs, feet and hands
- Artificial face, eyes, ears and nose
- Breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most **cost-effective** prosthetic device. The device must be ordered or provided either by a physician or under a physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the plan may pay only the amount that would have paid for the prosthetic that meets the minimum specifications and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three plan years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the covered person's medical condition occurs sooner than the three-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME – see the **durable medical equipment (DME)** benefit.

For out-of-network benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Reconstructive procedures

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or **congenital anomaly**. The primary result of the procedure is not a changed or improved physical appearance. Review the definition of **reconstructive procedures**.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

The plan pays benefits for reconstructive procedures including breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about benefits for mastectomy-related services.

The plan pays benefits for orthognathic surgery (when it meets the definition of a reconstructive procedure and both skeletal deformity and functional impairment exist).

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a cosmetic procedure. This plan does not provide benefits for **cosmetic procedures**.

The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

You must obtain prior authorization from Personal Health Support:

- Five business days before a scheduled reconstructive procedure is performed
- Within one business day or as soon as is reasonably possible before a non-scheduled reconstructive procedure

If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage. In addition, for out-of-network benefits you must contact UnitedHealthcare 24 hours before admission for scheduled admissions or as soon as reasonably possible for non-scheduled admissions.

Rehabilitation services – outpatient therapy and manipulative treatment

The plan pays benefits for short-term outpatient rehabilitation services for the following types of therapy:

- Physical therapy
- Occupational therapy
- **Manipulative treatment**
- Speech therapy
- Post-cochlear implant aural therapy
- Pulmonary rehabilitation
- Cardiac rehabilitation

For all rehabilitation services, a licensed therapy provider, under the direction of a physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a physician's office or on an outpatient basis at a hospital or alternate facility. Rehabilitative services provided at home by a home health agency are provided as described under **home health care**. Rehabilitative services provided at home other than by a home health agency are provided as described under this section.

Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for covered persons who are not progressing in goal-directed manipulative treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive manipulative treatment.

Habilitative services

For the purpose of this benefit, "habilitative services" means medically necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is medically necessary to maintain a covered person's current condition or to prevent or slow further decline
- It is ordered by a physician and provided and administered by a licensed provider
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair
- It requires clinical training in order to be delivered safely and effectively
- It is not custodial care

UnitedHealthcare will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

The plan pays benefits for habilitative services provided on an outpatient basis for covered persons with a disabling condition when the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or physician
- The initial or continued treatment must be proven and not experimental or investigational

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. **Custodial care**, respite care, day care, therapeutic recreation, educational/vocational training and residential treatment are not habilitative services. A service or treatment plan that does not help the covered person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the covered person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The plan may require that a treatment plan be provided, request medical records or other necessary data to allow the plan to prove that initial or continued medical treatment is needed and that the covered person's condition is clinically improving as a result of the habilitative service. When the treating provider expects that continued treatment is or will be required to allow the covered person to achieve demonstrable progress, the claims administrator may request additional medical records.

Benefits for durable medical equipment and prosthetic devices, when used as a component of habilitative services, are described under **durable medical equipment (DME)** and **prosthetic devices**.

Other than as described under habilitative services above, please note that the plan will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer or congenital anomaly.

Any combination of in-network benefits and out-of-network benefits is limited to:

- 90 visits per plan year for physical, occupational and speech therapy combined
- 20 visits per plan year for manipulative treatment (additional visits may be available upon review)
- 36 visits per plan year for pulmonary rehabilitation therapy
- 36 visits per plan year for cardiac rehabilitation therapy

If you have Out-of-Area coverage, the limits above apply to all visits.

These visit limits include all procedure types regardless of the provider who performs the service.

Scopic procedures – outpatient diagnostic and therapeutic

The plan pays benefits for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a hospital, an alternate facility or in a physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Physician services for anesthesiologists, pathologists and radiologists

Please note that benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under **surgery – outpatient**. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Skilled nursing facility/inpatient rehabilitation facility services

The plan pays benefits for facility services for an **inpatient stay** in a **skilled nursing facility** or **inpatient rehabilitation facility**. Benefits include:

- Non-physician services and supplies received during the inpatient stay
- Room and board in a **semi-private room** (a room with two or more beds)
- Physician services for anesthesiologists, pathologists and radiologists

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a skilled nursing facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.

Benefits for other physician services are described in this section under **physician fees for surgical and medical services**.

UnitedHealthcare will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital
- You will receive skilled care services that are not primarily **custodial care**

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when:

- It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient
- It is ordered by a physician
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair
- It requires clinical training in order to be delivered safely and effectively

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The plan does not pay benefits for **custodial care** or **domiciliary care**, even if ordered by a physician.

Any combination of in-network benefits and out-of-network benefits is limited to 120 days per plan year. If you have Out-of-Area coverage, benefits are limited to 120 days per plan year.

For out-of-network benefits, you must:

- Obtain prior authorization for a scheduled admission five business days before admission
- Notify Personal Health Support for a non-scheduled admission (or admission resulting from an emergency) as soon as is reasonably possible
- Contact UnitedHealthcare 24 hours before admission for scheduled admission or as soon as is reasonably possible for non-scheduled admissions

If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Substance-related and addictive disorders services

Substance-related and addictive disorders services include those received on an inpatient or outpatient basis in a hospital, an alternate facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their license. Review the definition of **substance-related and addictive disorders services**.

Benefits include the following levels of care:

- Inpatient treatment
- Residential treatment
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Inpatient treatment and residential treatment includes room and board in a **semi-private room** (a room with two or more beds). Benefits include the following services:

- Diagnostic evaluations, assessment and treatment and/or procedures
- Medication management
- Individual, family, and group therapy
- Crisis intervention

Inpatient therapy

The **mental health/substance-related and addictive disorders services administrator** determines coverage for all levels of care.

You are encouraged to contact the mental health/substance-related and addictive disorders administrator for assistance locating providers and coordination of care. Call **866-480-4988**.

For out-of-network benefits, you must obtain prior authorization from the mental health/substance-related and addictive disorders administrator to receive inpatient benefits, partial hospitalization/day treatment, intensive outpatient treatment, psychological testing and extended outpatient treatment visits, with or without medication management. Please call **866-480-4988**. Without prior authorization, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Surgery – outpatient

The plan pays benefits for surgery and related services received on an outpatient basis at a hospital or alternate facility or in a physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment
- Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy)
- Physician services for anesthesiologists, pathologists and radiologists

Benefits for other physician services are described in this section under **physician fees for surgical and medical services**.

For out-of-network benefits, you must obtain prior authorization for diagnostic catheterization, electrophysiology implant, sleep apnea surgeries and orthognathic surgeries five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If prior authorization is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Temporomandibular joint (TMJ) services

The plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a **congenital anomaly**, developmental defect or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- There is clearly demonstrated radiographic evidence of significant joint abnormality
- Non-surgical treatment has failed to adequately resolve the symptoms
- Pain or dysfunction is moderate or severe

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services

also include U.S. Food and Drug Administration (FDA)-approved TMJ implants only when all other treatment has failed.

Benefits for an **inpatient stay** in a hospital and hospital-based physician services are described in this section under **hospital – inpatient stay** and **physician fees for surgical and medical services**, respectively.

Therapeutic treatments – outpatient

The plan pays benefits for therapeutic treatments received on an outpatient basis at a hospital, alternate facility or in a physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered health services include medical education services that are provided on an outpatient basis at a hospital or alternate facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment
- Physician services for anesthesiologists, pathologists and radiologists

Benefits for other physician services are described in this section under **physician fees for surgical and medical services**.

For out-of-network benefits, you must obtain prior authorization for outpatient therapeutic services including dialysis, IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound, five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, benefits will be subject to a $200 reduction. This penalty does not apply if you have Out-of-Area coverage.

Transplantation services

Inpatient facility services (including evaluation for transplant organ procurement and donor searches) for transplantation procedures must be ordered by an in-network provider and received at a **designated facility**. Benefits are available to the donor and the recipient when the recipient is covered under this plan. The transplant must meet the definition of a covered health service and cannot be experimental or investigational or unproven. Examples of transplants for which benefits are available include but are not limited to:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy; not all bone marrow transplants meet the definition of a covered health service

SUPPORT IN THE EVENT OF SERIOUS ILLNESS

If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or Personal Health Support for a cornea transplant nor is the cornea transplant required to be performed at a designated facility.

Donor costs that are directly related to organ removal are covered through the organ recipient's coverage under the plan.

The plan has specific guidelines regarding benefits for transplant services. Contact United Resource Networks at **888-936-7246** or Personal Health Support at **866-480-4988** for information about these guidelines.

You must obtain prior authorization from United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If prior authorization from United Resource Networks or Personal Health Support is not obtained, benefits will be subject to a $200 reduction. Additionally, if the services are not performed at a designated facility, services may not be covered and you may be responsible for paying all charges.

For out-of-network benefits (including Out-of-Area coverage), you must obtain prior authorization 24-hours before admission for scheduled admissions or as soon as reasonably possible for non-scheduled admissions.

Travel and lodging for complex medical conditions

Travel and lodging benefits are available for complex medical conditions. United Resource Networks or Personal Health Support will assist the covered person and family with travel and lodging arrangements related to **obesity surgery, congenital heart disease (CHD) services,** neonatal, **fertility services** or **transplantation services.** For travel and lodging services to be covered, the covered person must be receiving services at a designated facility through United Resource Networks.

Additionally, the plan provides a covered person with a travel and lodging allowance related to the covered health services for gender dysphoria, elective termination of pregnancy, mental health care and substance-related and addictive disorders services and surgeries when the covered health services are not available within 50 miles of the covered person's home address.

If you have specific questions, call the Travel and Lodging office at **800-842-0843**.

The plan covers expenses for travel and lodging for the covered person and a companion as follows:

- Transportation of the covered person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure
- Eligible expenses for lodging of the covered person (while not a hospital inpatient) and one companion; benefits are paid at a per diem (per day) rate of up to $50 per day for the covered person or up to $100 per day for the covered person plus one companion
- If the covered person is an enrolled dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day

Travel and lodging expenses are only available if the covered person lives more than 50 miles from the designated facility (for complex medical conditions) or if the covered health services for the conditions listed above are not available within 50 miles of the covered person's address. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed.

A maximum benefit of $10,000 per covered person applies for all travel and lodging expenses reimbursed under this plan in connection with all eligible treatments during the entire period that person is covered under this plan.

Urgent care center services

The plan provides benefits for services, including professional services, received at an **urgent care center**. When **urgent care** services are provided in a physician's office, the plan pays benefits as described under the **physician's office services – sickness and injury** benefit.

Urinary catheters

The plan pays benefits for external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit)
- Anchoring device
- Irrigation tubing set

Virtual care services

Virtual care services are available for the diagnosis and treatment of less serious medical conditions. These services provide communication of medical information in real-time between the patient and physician or health care specialist through live audio with video or audio only technology, outside of a medical facility.

Benefits are available only when services are delivered through a designated virtual network provider. To find virtual providers go to myuhc.com or call the telephone number on your ID card.

Please note: Not all medical conditions can be treated through virtual care. The designated virtual network provider will identify any condition for which treatment by an in-person physician is necessary.

Wigs

The plan pays benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from chemotherapy, alopecia or cancer.

What's not covered

The plans do not pay benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When benefits are limited, those limits are stated in the **Plan highlights** table and the **Additional coverage details** section. Please review all limits carefully, as the plans will not pay benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when this section states "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the plans do intend to limit a list of services or examples, this section specifically states that the list "is limited to."

Alternative treatments

- Acupressure
- Aromatherapy
- Hypnotism
- Massage therapy
- 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** for which benefits are provided as described in the **Additional coverage details** section.

Dental

- Dental care, except as identified under the **dental services – accident only** benefit.

  Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded; examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
- Endodontics, periodontal surgery and restorative treatment
- Diagnosis or 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
  - 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. This exclusion also does not apply to accident-related dental services for which benefits are provided as described under **dental services – accident only**.
- Dental implants, bone grafts and other implant-related procedures.

  This exclusion does not apply to accident-related dental services for which benefits are provided as described under **dental services – accident only**.
- 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, as identified under **dental services – accident only**.
- 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
- Powered and non-powered exoskeleton devices

- Orthotic appliances and devices that straighten or re-shape a body part, except as described under the **durable medical equipment (DME)** benefit. This exclusion does not apply to cranial molding helmets and cranial banding.

  Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a covered person with diabetic foot disease.
- Cranial banding (except when prescribed and medically necessary)
- The following items are excluded, even if prescribed by a physician:
  - Blood pressure cuff/monitor
  - Enuresis alarm
  - Non-wearable external defibrillator
  - Trusses
  - Ultrasonic nebulizers
- The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect
- The replacement of lost or stolen prosthetic devices
- Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheoesophageal voice devices for which benefits are provided as described under **durable medical equipment (DME)**
- Oral appliances for snoring

Drugs

- 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 which, 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to covered individuals for self-infusion.
- Growth hormone therapy
- Non-injectable medications given in a physician's office except as required in an emergency and consumed in the physician's office
- Over-the-counter drugs and treatments
- New pharmaceutical products and/or new dosage forms until the date they are reviewed, 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 such circumstances, benefits may be available.
- Benefits for pharmaceutical products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit
- Benefits for certain pharmaceutical products, including specialty pharmaceutical products, for the treatment of infertility that are administered on an outpatient basis in a hospital, alternate facility, physician's office or in your home.
- Compounded drugs that contain bulk chemicals. Compounded drugs that are available as a similar commercially available pharmaceutical product.

Experimental or investigational or unproven services

Experimental or investigational services or **unproven services**, unless the plan has agreed to cover them as defined in the Glossary.

This exclusion applies even if experimental or investigational services or unproven services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described under **clinical trials**.

Foot care

- Routine foot care, except when needed for severe systemic disease for covered persons with diabetes for which benefits are provided as described under **diabetes services**.
- Routine foot care services that are not covered include:
  - Cutting or removal of corns and calluses
  - Nail trimming, nail cutting or nail debridement

- Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone
- Other services that are performed when there is not a localized sickness, injury or symptom involving the foot

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease.

- Treatment of flat feet
- Shoe inserts
- Arch supports
- Shoes (standard or custom), lifts and wedges
- Shoe orthotics

Gender dysphoria (gender identity disorder)

Treatment received outside of the United States is not covered.

Medical supplies and equipment

Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

- Elastic stockings, ace bandages, diabetic strips and syringes.
  This exclusion does not apply to:
  - Ostomy bags and related supplies for which benefits are provided as described under **ostomy supplies**
  - Urinary catheters for which benefits are provided as described under **urinary catheters**
  - Disposable supplies necessary for the effective use of durable medical equipment for which benefits are provided as described under **durable medical equipment (DME)**
  - Diabetic supplies for which benefits are provided as described under **diabetes services**
- Tubings, nasal cannulas, connectors and masks except when used with DME
- The repair and replacement of durable medical equipment when damaged due to misuse, malicious breakage or gross neglect
- The replacement of lost or stolen DME
- Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under ostomy supplies

Mental health, neurodevelopmental disorders – autism spectrum disorder, and substance-related and addictive disorders services

In addition to all other exclusions listed in this section, the exclusions listed directly below apply to services described under the benefits for **mental health services**, **neurodevelopmental disorders – autism spectrum disorder services** and/or **substance-related and addictive disorders services**:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Health services or supplies that do not meet the definition of a **covered health services**. Covered health services are those health services, including services, supplies or pharmaceutical products, which the claims administrator determines to be all of the following:
  - **Medically necessary**
  - Described as a covered health service in this plan under **Plan highlights** and the **Additional coverage details** section
  - Not otherwise excluded in this plan under this **What's not covered** section
- Mental health services as treatments for R, T and Z code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental health services as treatment for a primary diagnosis of insomnia, other sleep-wake disorders, feeding disorders, sexual dysfunctions, binge eating disorders, communication disorders, motor disorders, neurological disorders and other disorders with a known physical basis
- Treatments for the primary diagnoses of learning disabilities, personality disorders, pyromania, kleptomania, gambling disorders and paraphilic disorder
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act

- Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental health services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine or their equivalents for drug addiction
- Gambling disorders
- Substance-induced sexual dysfunction disorders and substance-induced sleep disorders
- Any treatments or other specialized services designed for autism spectrum disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered **experimental or investigational services** or **unproven services**
- Intensive behavioral therapies such as Applied Behavior Analysis for autism spectrum disorders
- **Non-medical 24-hour withdrawal management**
- High intensity residential care including American Society of Addiction Medicine (ASAM) criteria for covered persons 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
- Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula and other modified food products for which benefits are provided as described under **enteral nutrition**.
- 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
  - Home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails and stair glides)

Physical appearance

- **Cosmetic procedures** are excluded from coverage. Examples include:
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple, this exclusion does not apply to liposuction covered health services described in **reconstructive procedures**
  - Pharmacological regimens
  - Nutritional procedures or treatments
  - Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
  - Sclerotherapy treatment of veins
  - Hair removal or replacement by any means
  - Treatments for skin wrinkles or any treatment to improve the appearance of the skin
  - Treatment for spider veins
  - Skin abrasion procedures performed as a treatment for acne
  - Treatments for hair loss
  - Varicose vein treatment of the lower extremities, when it is considered cosmetic
  - Replacement of an existing intact breast implant if the earlier breast implant was performed as a cosmetic procedure
- 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 loss of hair due to chemotherapy, alopecia or cancer
- Treatment of benign gynecomastia (abnormal breast enlargement in males)

Procedures and treatments

- Biofeedback
- 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 but not limited to 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 impairment or speech dysfunction that results from injury, stroke, cancer, **autism spectrum disorders**, developmental delay or a **congenital anomaly** or is needed following the placement of a cochlear implant as identified under the **rehabilitation services – outpatient therapy and manipulative treatment** benefit
- Habilitative services or therapies for the purpose of general well-being or condition in absence of a disabling condition
- 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)
- Treatment of tobacco dependency
- 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, alignment of the vertebral column, 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
- The following treatments for obesity:
  - Non-surgical treatment, even if for morbid obesity
  - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under the **obesity surgery** benefit
- Medical and surgical treatment of hyperhidrosis (excessive sweating)
- The following services for the diagnosis and treatment of TMJ: Surface electromyography, doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment or dental restorations

- Breast reduction surgery that is determined to be a cosmetic procedure.

  This exclusion does not apply to breast reduction surgery which the claims administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which benefits are described under **reconstructive procedures**.
- Intracellular micronutrient testing
- Cellular and gene therapy services not received from a designated provider

Providers

Services:

- Performed by a provider who is a family member by birth or marriage, including your spouse or **domestic partner**, brother, sister, parent or child
- A provider performs 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 his/her license
- Provided at a diagnostic facility (hospital or free-standing) without a written order from a provider
- Which are 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 your medical care prior to ordering the service or after the service 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 under **fertility services**. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which benefits are provided as described in **Additional coverage details**.
  - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue
  - 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 a covered person
- 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):
  - Known egg donor (altruistic donation i.e., friend, relative or acquaintance) – the cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
  - Purchased egg donor (i.e., clinic or egg bank) – the cost of donor eggs. 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.

- Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – the cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
- Purchased donor sperm (i.e., clinic or sperm bank) – the cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

- 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
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation)
- Infertility treatment following unsuccessful reversal of voluntary sterilization
- Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy)
- Pre-implantation genetic testing for aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception

Services provided under another plan

Services for which coverage is available:

- Under another plan, except for **eligible expenses** payable as described in the **Coordination of benefits (COB)** section
- 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
- Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy

Transplants

- Health services for organ and tissue transplants, except as identified under the **transplantation services** benefit, unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines
- Health services for transplants involving animal organs
- Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)
- Transplants that are not performed at a designated facility (this exclusion does not apply to cornea transplants)
- Donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan)

Travel

Travel or transportation expenses (including meals that are not provided as part of inpatient care), even if ordered by a physician, except as identified under the **travel and lodging for complex medical conditions** benefit. Additional travel expenses related to covered health services received from a **designated facility**, designated physician or other network provider may be reimbursed at the plan's discretion.

Types of care

- **Custodial care** or maintenance care
- **Domiciliary care**
- 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 described under the **hospice care** benefit.
- 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 when either of the following applies:
  - For covered persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid
  - For covered persons with 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 covered person who meets the above coverage criteria during the entire period of time the covered person is enrolled in this plan. In addition, repairs and/or replacement for a bone-anchored hearing aid for covered persons who meet the above coverage 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
  - 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
  - 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 persons 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 which 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 benefit plan
  - That exceed **eligible expenses** or any specified limitation in this benefits booklet
  - For which an out-of-network provider waives the **annual deductible (or deductible)** or **coinsurance** amounts
- Foreign language and sign language services
- Long-term (more than 30 days) storage of blood, umbilical cord or other material, such as cryopreservation of tissue, blood and blood products
- Health services and supplies that do not meet the definition of a **covered health service**. Covered health services are those health services including services, supplies or prescription drugs, which the claims administrator determines to be all of the following:
  - **Medically necessary**
  - Described as a covered health service in this summary plan description
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
  - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration
  - Conducted for purposes of medical research; this exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described under **clinical trials**

- Related to judicial or administrative proceedings or orders
- Required to obtain or maintain a license of any type
- In the event an out-of-network provider waives, does not pursue, or fails to collect, copayments, coinsurance and/or any deductible or other amount owed for a particular health care service, no benefits are provided for the health care service when the copayments, coinsurance and/or deductible are waived, not pursued, or not collected

How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to UnitedHealthcare and this submission is your claim for benefits. If your provider does not submit a bill directly to UnitedHealthcare, you will need to submit a claim for benefits.

The rest of this section reviews:

- **Submitting a claim**
- **Claim review**
- **Claim payment**
- **Claim denials and appeals**
- **Limitation of action**
- **Right of recovery**

Submitting a claim

You do not need to submit urgent care claims in writing. You should call UnitedHealthcare at **866-480-4988** for urgent care. If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

To submit a claim:

1. Download a claim form from **myuhc.com** or request a claim form by calling **866-480-4988** or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill.
2. Complete the claim form or prepare a brief letter of explanation that includes all of the following information:
   - Your name and address
   - The patient's name, age and relationship to the employee
   - The number as shown on your ID card
   - The name, address and tax identification number of the provider of the service(s)
   - A diagnosis from the physician
   - The date of service
   - An itemized bill from the provider that includes:
     - The current procedural terminology (CPT) codes
     - A description of and the charge for each service
     - The date the sickness or injury began
   - A statement indicating whether you are enrolled for coverage under any other health insurance plan or program; if you are enrolled for other coverage, you must include the name and address of the other carrier(s)
3. Sign the form in the space provided if using the claim form and attach the itemized provider bill
4. Mail the completed form to:

   UnitedHealthcare – Claims
   P.O. Box 30555
   Salt Lake City, UT 84130-0555

Failure to provide all the information listed above may delay any reimbursement that may be due to you.

In the following circumstances, you may submit claims according to the appeals process described in the **Claim denials and appeals** section:

- If you cannot submit the claim in a timely manner due to circumstances beyond your control
- If your claim regards plan eligibility for you, your spouse/**domestic partner** or dependent child

Claim review

UnitedHealthcare will review your claim within the timeframes in the table below.

	Urgent care	Pre-service	Post-service
If your request is incomplete, UnitedHealthcare will notify you within:	24 hours	5 days if your request is filed improperly 15 days if your claim is incomplete	30 days
You must respond to UnitedHealthcare's request within:	48 hours	45 days	45 days
UnitedHealthcare will notify you of their determination within:	72 hours of receiving a complete claim	15 days of receiving a complete claim	30 days of receiving a complete claim

Concurrent care claims

A concurrent care claim is a request to extend an ongoing course of treatment that was previously approved for a specific period of time or number of treatments.

- **Urgent claims:** If you submit your claim at least 24 hours before the end of the approved treatment, UnitedHealthcare will make a determination within 24 hours of receiving your request. Otherwise, your request will be reviewed according to the timing described above for urgent care claims.
- **Non-urgent claims:** Your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Notification

UnitedHealthcare will prepare an **explanation of benefits (EOB)** notifying you of their decision. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You may review and print your EOBs at **myuhc.com** or you may request paper copies by calling **866-480-4988**. See the Glossary for the definition of Explanation of Benefits.

You will receive a **health statement** by mail each month in which UnitedHealthcare processes at least one claim for you or a covered dependent. The health statement summarizes your claims information in easy-to-understand terms. You may elect to discontinue paper health statements on **myuhc.com**.

Claim payment

After UnitedHealthcare has processed your claim, UnitedHealthcare will make a payment to you unless you arrange for payment to your out-of-network provider, as described below.

As a matter of convenience to a covered person, and where practicable for the claims administrator (as determined in its sole discretion), the claims administrator may make payment of benefits directly to a provider.

Any such payment to a provider:

- Is NOT an assignment of your benefits under The company plan or of any legal or equitable right to institute any proceeding relating to your benefits; and
- Is NOT a waiver of the prohibition on assignment of benefits under The company plan; and
- Shall NOT estop The company plan, plan sponsor, or claims administrator from asserting that any purported assignment of benefits under The company plan is invalid and prohibited.

If this direct payment for your convenience is made, The company plan's obligation to you with respect to such benefits is extinguished by such payment. If any payment of your benefits is made to a provider as a convenience to you, the claims administrator will treat you, rather than the provider, as the beneficiary of your claim for benefits, and The company plan reserves the right to offset any benefits to be paid to a provider by any amounts that the provider owes The company plan (including amounts owed as a result of the assignment of the other plans' overpayment recovery rights to The company plan), pursuant to **Overpayment or underpayment of benefits**.

Note: It is your responsibility to pay the out-of-network provider the charges you incurred, including any difference between what you were billed and what the plan paid.

Assignment of benefits

You may not assign, transfer, or in any way convey your benefits under The company plan or any cause of action related to your benefits under The company plan to a provider or to any other third party. Nothing in this plan shall be construed to make The company plan, plan sponsor, or plan administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for benefits.

The company plan will not recognize claims for benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a covered person or beneficiary, or derivatively, as an assignee of a covered person 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 a covered person, and where practicable for the plan administrator (as determined in its sole discretion), the plan administrator may make payment of benefits directly to a provider.

Any such payment to a provider:

- Is NOT an assignment of your benefits under The company plan or of any legal or equitable right to institute any proceeding relating to your benefits; and
- Is NOT a waiver of the prohibition on assignment of benefits under The company plan; and
- Shall NOT estop The company plan, plan sponsor, or plan administrator from asserting that any purported assignment of benefits under The company plan is invalid and prohibited.

If this direct payment for your convenience is made, The company plan's obligation to you with respect to such benefits is extinguished by such payment. If any payment of your benefits is made to a provider as a convenience to you, the plan administrator will treat you, rather than the provider, as the beneficiary of your claim for benefits, and The company plan reserves the right to offset any benefits to be paid to a provider by any amounts that the provider owes The company plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to The company plan), as detailed in **Coordination of Benefits**.

Eligible expenses due to an out-of-network provider for covered health services that are subject to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Payment of benefits

Payment of benefits as described in this section shall be in cash or cash equivalents, or in the form of consideration UnitedHealthcare determines to be adequate.

Episode of care

In general, claims from multiple providers are combined and paid at a consistent benefit level as they relate to an episode of care. An episode of care (EOC) is defined as the set of services required to manage a specific medical condition of a patient over a defined period of time.

For example: You have a preventive screening colonoscopy at an in-network facility. There are bills from the surgeon, facility, anesthesiologist and pathologist. For purposes of this example, in-network preventive colonoscopies are payable at 100%. Non-preventive in-network services are subject to deductible and coinsurance. The surgeon, facility, anesthesiologist and pathologist claims will all process at the preventive benefit of 100%. Episode of care logic will identify the other associated services and process them by applying a consistent benefit level as the claim is processed.

If you have questions on episode of care, call **866-480-4988**.

Claim denials and appeals

If a claim for benefits is denied in part or in whole, please call UnitedHealthcare at **866-480-4988** before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

Appeal for internal review

If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the denial.

Expedited internal reviews

For urgent care appeals, if a delay in treatment could significantly increase the risk to your health, the ability to regain maximum function or cause severe pain, you or your provider can call UnitedHealthcare at **866-480-4988** to request an expedited internal review, and if applicable, file an external review at the same time. You do not need to submit urgent care appeals in writing. UnitedHealthcare must notify you of their determination within 72 hours.

Standard internal reviews

You must submit a written appeal as described below for appeals for pre-service, post-service and recession of coverage claims. You must provide the following information:

- The patient's name and ID number as shown on the ID card
- The provider's name
- The date of medical service
- The reason you disagree with the denial
- Any documentation or other written information to support your request

Send your written request for an appeal to:

UnitedHealthcare – Appeals
P.O. Box 740816
Atlanta, GA 30374-0816

UnitedHealthcare will conduct a full and fair review of your appeal. Your appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process

You may request, free of charge, documents relevant to the claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

If UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare.

The following timeframes apply to the internal review process. UnitedHealthcare may require a one-time extension for the initial claim determination of no more than 15 days only if more time is needed due to circumstances beyond their control.

	Pre-service	Post-service
UnitedHealthcare must respond to your first level appeal within:	15 days of receiving the appeal	30 days of receiving the appeal
You may submit a second level appeal within:	60 days of receiving the first level appeal decision	60 days of receiving the first level appeal decision
UnitedHealthcare will notify you of their determination within:	15 days of receiving the appeal	30 days of receiving the appeal

Appeal for external review

You may request an external review by an independent review organization (IRO) at no charge if one of the following conditions is met:

- If, after exhausting your internal appeals, you are not satisfied with the final determination made by UnitedHealthcare
- If UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing

Your request for an external review may be based upon any of the following:

- Clinical reasons
- The exclusions for **experimental or investigational services** or **unproven services**
- Rescission of coverage (coverage that was cancelled or discontinued retroactively)
- As otherwise required by applicable law

External reviews are standard or expedited, as described in the following section.

Expedited external review

For urgent situations, you or your representative may request an expedited external review by calling **866-480-4988**.

You are eligible for an expedited external review if your claim or internal appeal involves a medical condition for which the standard process would seriously jeopardize life, health or ability to regain maximum function for the patient and you have received any of the following:

- A denial for a claim (you must also file a request for an expedited internal appeal if you have only received a denial for the claim)
- A denial for a first level internal review appeal
- A denial for a second level internal review appeal
- You may also request an expedited external review if the internal appeal concerns an admission, availability of care, continued stay or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility

UnitedHealthcare will follow steps described below for a standard external review as quickly as possible. Documentation will be provided electronically, by telephone or fax to the IRO.

The IRO will provide notice of the final external review decision as quickly as the claimant's medical condition or circumstances require, but in no more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the IRO will provide written confirmation of the decision to you and to UnitedHealthcare within 48 hours of receiving the initial notice.

You may contact UnitedHealthcare at **866-480-4988** for more information regarding external review rights.

Standard external review

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter for the second level internal review. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review
- The covered person's name, address and insurance ID number
- Your designated representative's name and address, when applicable
- The service that was denied
- Any new, relevant information that was not provided during the internal appeal

If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

Upon receiving your request for an external review, UnitedHealthcare will confirm:

- The person whose treatment is at issue is or was covered under the plan at the time the health care service or procedure that is at issue was provided
- The applicable internal appeals process has been completed
- All the required information and forms are included in the request

If these requirements are met, UnitedHealthcare will inform you that your request has been assigned to an IRO for external review. UnitedHealthcare will provide all information considered as part of the internal review to the assigned IRO, including:

- All relevant medical records
- All other documents relied upon by UnitedHealthcare
- All other information or evidence submitted by you or your physician

UnitedHealthcare will assign requests by either rotating claims assignments among three or more IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO's request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination, the Final External Review Decision, within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver their Final External Review Decision to you and UnitedHealthcare and it will include the clinical basis for the determination.

If the Final External Review Decision reverses the determination by UnitedHealthcare, the plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the plan and any applicable law regarding plan remedies.

If the Final External Review Decision agrees with UnitedHealthcare's determination, The company plan will not be obligated to provide benefits for the health care service or procedure.

Limitation of action

You cannot bring any legal action against the company or the claims administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the company or the claims administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the company or the claims administrator.

You cannot bring any legal action against the company or the claims administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the company or the claims administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against the company or the claims administrator.

Right of recovery

The plan 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 plan year deductible
- Advanced during the time period of meeting the out-of-pocket maximum for the plan year
- Benefits paid because you or your dependent misrepresented facts

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
- 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 plan 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
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the plan

Health Savings Account (HSA)

The UHC Silver HSA Plan features a Health Savings Account (HSA) that you can use to cover eligible health care expenses. Here's how they work together:

- The Silver HSA Plan is your health insurance and provides coverage for health care that you might need during the year
- The HSA is basically a bank account that comes with certain tax benefits when you use it only to pay for health care expenses – now or in the future

The HSA is an interest-bearing savings account designed to allow you to pay for medical expenses (both now and in the future) with tax-advantaged dollars. The HSA is yours – you own, manage and control the funds in the account. If you do not spend it, you get to keep it and you can watch it grow over time. You don't pay federal taxes on your contributions, earnings or withdrawals when you use it to pay for eligible out-of-pocket health care expenses for you and your dependents.

The HSA is available only to those enrolled in a high-deductible health plan, such as the UHC Silver HSA Plan, that meets certain Internal Revenue Service (IRS) criteria.

Opening and contributing to an HSA

If you enroll in the UHC Silver HSA Plan, an HSA will automatically be opened for you with Fidelity and you can contribute to it through before-tax payroll deductions.

The maximum you can contribute is set by federal regulations. If you are age 55 and not yet Medicare-eligible, you may contribute additional funds up to the maximum. The maximum limits may be found on the IRS website at **irs.gov**.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15 of the following year.

Eligibility for an HSA

You can only open and contribute to an HSA if you are enrolled in a high-deductible health plan like the Silver HSA Plan. There are also a few other eligibility requirements you need to know:

- You cannot be covered by any other health plan that is considered non-qualified by the IRS, including as a dependent on a spouse's or parent's non-high-deductible health plan.
- You cannot be claimed as a dependent on another person's tax return.
- You and your spouse cannot have a Health Care Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA).
- You cannot be enrolled in Medicare (parts A, B, C or D) or TRICARE and you may not have received medical or prescription benefits from the Veteran's Administration (VA) in the past three months.

Building a balance

When you open and contribute to an HSA, the money is always yours, even if you leave the company. HSA funds are not subject to "use it or lose" rules like FSAs – your balance carries over from year to year. You can contribute to it as long as you are enrolled in an HSA-compatible medical plan and continue to meet all the other eligibility requirements. An HSA can be a powerful savings tool, allowing you to build a balance to use all the way through retirement.

You can also choose to invest all or a portion of your HSA funds. Your account allows you to manage a portion of your savings in cash and invest the rest. You can start investing at any time and there is no required minimum to begin. For more information on investing, including available investment options, contact Fidelity at **netbenefits.com** or **401k.com** or contact a Fidelity representative at **800-544-3716**.

Eligible expenses

The money in your HSA can be withdrawn on a tax-free basis to pay for qualified medical expenses, as defined by IRS section 223(d)(2) and section 213(d). Eligible expenses include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return. For more information on qualified medical expenses, refer to IRS Publication 502.

If the amount withdrawn is used for something other than qualified medical expenses, then it will be subject to income tax and an additional 20% tax.

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** premiums and Medicare premiums.

For more information on tax treatment for HSAs, refer to IRS Publication 969.

When you reach age 65, the funds in your HSA can be used for additional medical expenses, such as insurance premiums (Medicare Part A&B, Medicare Supplemental plans and so on) and your share of retiree medical insurance premiums.

You are responsible for maintaining records of the medical expenses paid through the HSA. In the event of an IRS audit, you may need to provide documentation, including receipts and records that the HSA was used for qualified medical expenses.

Each year, Fidelity will provide you and the IRS a Form 5498-SA, which summarizes contributions to and the fair market value of your HSA. If a distribution is taken from your account, a Form 1099-SA will be provided for the year in which the distribution was taken. You can use this information when you file your tax return.

Paying for eligible expenses

There are multiple ways to use your HSA for payment, including:

- Fidelity HSA debit card
- Fidelity HSA checkbook
- Online through Fidelity's Track and Pay feature, and
- Fidelity BillPay for Health Savings Account

You can use these features to pay your provider directly or reimburse yourself for eligible expenses that you have paid for out of pocket. Just be sure to always keep your receipts.

RESOURCES

Access your account online anytime through Fidelity NetBenefits at **netbenefits.com** or **401k.com**. If you have questions or need assistance you can contact a Fidelity representative at **800-544-3716**.

HMSA Plan (Hawaii only)

The HMSA Preferred Provider Plan provides medical coverage for employees in Hawaii.

The HMSA plan provides comprehensive medical coverage and the flexibility to see any provider you choose. Preventive care is covered at 100% with in-network providers and you pay a share of the cost for other covered health services up to an annual maximum amount. Prescription drug coverage is provided through Express Scripts, as described in the **Prescription drugs** section.

HMSA is a private, not-for-profit mutual benefit society, covering more than half of Hawaii's population with reliable, affordable health plans. Headquartered on Oahu with centers and offices statewide to serve their members, HMSA is an independent licensee of the Blue Cross and Blue Shield Association.

HMSA is a private healthcare claims administrator for the HSMA Preferred Provider Plan. As claims administrator, HMSA has discretion and authority to decide whether a treatment or supply is covered by the plan and how benefits will be paid. HMSA is solely responsible for paying benefits.

You can find all the details about benefit coverage and the claims process in the HMSA Plan Document, which is incorporated by reference in this SPD. The Plan Document is available in the Reference Center at **the companyBenIQ.com**. If there is a discrepancy between this document and the Plan Document, the Plan Document will govern.

Where you can get medical care

In the HMSA plan, you have the flexibility to visit the provider or facility you choose and still have coverage.

In-network providers

Providers in the nationwide HMSA network feature certain advantages:

- The highest level of coverage and the lowest out-of-pocket costs
- Your provider files claims for you directly with HMSA
- Lower, negotiated rates, called the eligible expense
- Your provider accepts the eligible expense as payment in full; you are not charged any additional costs

Find in-network providers at **hmsa.com** or call **800-776-4672**.

Out-of-network providers

If you seek care with an out-of-network provider or facility, services are covered at a lower out-of-network benefit level. Additionally:

- You may have to pay the provider and submit a claim for reimbursement
- Coverage under the plan is limited to the eligible expense; out-of-network providers may not accept the eligible expense negotiated by in-network providers as payment in full
- **You are responsible for any amount charged above the eligible expense** (known as **balance billing**) and the excess amounts you pay do not apply to your **deductible**, **coinsurance** or **out-of-pocket maximum**

Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
Emergency care	Emergency care is always covered at the in-network level	Go to the nearest emergency facility Outside of Hawaii, check **hmsa.com** to find providers in specific city and state or call **800-810-BLUE** for BlueCard providers
You cannot find the provider specialty that you need in the HMSA network	Coverage may be available	Call **948-6111** (on Oahu) or toll free **800-776-4672** and provide your HMSA ID number
Your provider's contract with HMSA is ending and you are receiving ongoing treatment	Coverage may be available	Your provider will give you contact information for his/her replacement

Resources to help you stay healthy

Your HMSA plan comes with support help you take care of yourself and your family members. These programs are available at no cost. Participation in these programs is voluntary and confidential.

I want to	Resources available	Visit
Develop my own well-being plan	Well-Being Connect program includes an online assessment, tools and tracker	**hmsa.com/well-being**
Talk to a doctor	HMSA Online Care allows members to talk to a doctor 24/7, 365 days a year	**hmsa.com/well-being/online-care**

What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care in other situations, such as for the treatment of illnesses, injuries and chronic conditions, you pay a portion of the cost up to an annual maximum amount. For full details, please refer to the Plan Document, which is available in the Reference Center at **the companyBenIQ.com**.

Prescription drug coverage is provided in the **Prescription drugs** section.

COVERING DEPENDENTS?

If you cover dependents, each individual's expenses apply to an individual deductible, as well as the family deductible. If one individual meets their individual deductible, no further deductible will apply to that person. If the expenses for all family members combined meet the family deductible, no further deductible will apply to any family member. The out-of-pocket maximum works the same way.

The annual out-of-pocket maximum is the maximum deductible and copayment amounts you pay in a calendar year. Your prescription drug copayment amounts do not count toward this maximum, the prescription drug plan has a separate out-of-pocket maximum. If you meet your out-of-pocket maximum, the plan pays 100% of eligible expenses and you pay nothing for covered services for the rest of the year.

You will still be responsible for the difference between the provider's bill and the eligible expense if you seek out-of-network care.

The eligible expense is the lower of either the provider's actual charge or the amount HMSA establishes as the maximum allowable fee. HMSA's payment and your copayment are based on the eligible expense.

Summary of benefits

	IN-NETWORK	OUT-OF-NETWORK[1]
Plan year deductible	$200 per person/$600 family	
Plan year out-of-pocket-maximum	$2,200 per person/$6,600 family	
Covered health services	**What you pay**	**What you pay**
Office visits		
Preventive care	$0, no deductible	$0, no deductible
Non-preventive	$12 copay, no deductible	$12 copay, no deductible
Diagnostic lab and X-ray		
Inpatient	20% after deductible	20% after deductible
Outpatient	Blood work: No charge Diagnostic testing: 20%, no deductible X-ray and imaging: 20% after deductible	Blood work: No charge Diagnostic testing: 20%, no deductible X-ray and imaging: 20% after deductible
Hospital		
Inpatient	$12 copay plus 20% of facility fees after deductible	$12 copay plus 20% of facility fees after deductible
Outpatient	$12 copay plus 20% of facility fees after deductible	$12 copay plus 20% of facility fees after deductible
Emergency and urgent care		
Urgent care clinic	$12 copay, no deductible	$12 copay, no deductible
Emergency room	• $12 copay physician visit • 20% coinsurance for emergency room after deductible • Lab and other services as noted above	• $12 copay physician visit • 20% coinsurance for emergency room after deductible • Lab and other services as noted above

1. Out-of-network providers may charge more than the eligible expense, if this occurs you will be responsible for the additional amount.

Lifetime maximum

There is no dollar limit to the amount the plan will pay for essential benefits during the entire period you are enrolled in this plan. Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expenses not applied to the deductible or out-of-pocket maximum

Some amounts you pay do not count toward your deductible or out-of-pocket maximum. They include:

- Charges above the eligible expense, as determined by the plan's claims administrator
- Charges for expenses not covered by the plan – such as for care that is not medically necessary
- Charges above the plan's maximum benefit for a specific service (such as chiropractic care)
- Benefit penalties for failing to get prior authorization when it is required

Triple-S Plan (Puerto Rico only)

The Triple-S Plan provides medical, dental, vision and prescription drug coverage for employees and their dependents who live in Puerto Rico.

Triple-S Salud Blue Cross Blue Shield is a private healthcare claims administrator for the Triple-S Plan. As claims administrator, Triple-S Salud has discretion and authority to decide whether a treatment or supply is covered by the plan and how benefits will be paid. Triple-S Salud is solely responsible for paying benefits.

This is a brief summary for informative purposes and does not substitute or modify the policy. The dispositions, limitations, and exclusions of the policy and group contract will prevail in the presence of any discrepancies.

You can find all the details – including complete description of terms, conditions, limitations and claims process – in the Triple-S Certificate of Coverage (Policy), which is incorporated by reference in this SPD. The Policy is available in the Reference Center at **the companyBenIQ.com**. If there is a discrepancy between this document and the Policy, the Policy will govern.

Where you can get medical care

The Triple-S Plan provides coverage with contracted providers and facilities through the Triple-S Salud Blue Cross Blue Shield network in Puerto Rico. Services provided outside the Triple-S Salud network may not be covered. The plan will cover care from specialists without a referral from your primary care physician.

To find an in-network provider, facility or pharmacy, visit **ssspr.com** or call **787-774-6060**.

Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
Emergency care	Emergency care is always covered at the in-network level	Go to the nearest emergency facility
You cannot find the provider specialty that you need in Triple-S Salud network	Triple-S Salud will reimburse the lesser of the cost incurred or the in-network cost, as long as there is a compelling medical reason why the patient cannot be transferred to a participating provider	Contact Triple-S Salud for pre-authorization

What you pay

The plan only covers services from in-network providers. You don't pay anything for preventive care as covered by federal law. For other care, you pay a share of the cost, in the form of a flat copay or a percentage (called **coinsurance**), and the plan pays the rest.

The table starting on the following page summarizes the copays and coinsurance that apply under this plan.

The amount you pay for medical services and prescription drugs is capped each plan year at the out-of-pocket maximum, as listed below. The plan year runs from May 1 through April 30.

- $6,350 per person
- $12,700 per family

Summary of benefits

Preventive care, screenings and immunizations	
Preventive services by federal law	No charge
Vaccine for syncytial respiratory virus	20% coinsurance
Other immunizations	No charge
Dental care	
Diagnostic and preventive services	No charge
Periodontic services	20% coinsurance, up to a maximum benefit of $1,000 per year
Endodontics and oral surgery	20% coinsurance
Orthodontic services (by reimbursement)	Lifetime maximum benefit of $1,000
Doctor visits	
Telemedicine visit	$10 copay
Salus Clinic visit	No charge
General practitioner	$5 copay
Specialist	$15 copay
Subspecialist	$15 copay
Podiatrist, optometrist, audiologist	$15 copay
Lab and X-ray	
X-rays and lab tests	$0 at Salus Clinics/20% coinsurance Selective network/30% coinsurance non-Selective network
Diagnostic tests	$0 at Salus Clinics/20% coinsurance Selective network/30% coinsurance non-Selective network
Outpatient surgery	
Facility fee	$75 copay per visit
Physician/surgeon fees	No charge
Emergency/urgent care services	
Urgent care center	$35 copay
Emergency room services	$75 copay per visit ($25 if recommended by TeleConsulta)
Emergency medical transportation	Up to $80 per trip
Hospital stay	
Facility fee (e.g., hospital room)[1]	Preferred: $75 copay per admission Non-preferred: $150 copay per admission

1. Copay level varies based on admitting hospital. See plan document for details on cost for medical-surgical services during hospitalization.

Mental, behavioral and substance abuse services	
Outpatient services	$15 copay per visit
Mental, behavioral and substance abuse services	
Inpatient services[1]	Preferred: $75 copay per admission, $35 copay per partial admission Non-preferred: $150 copay per admission, $75 copay per partial admission
Pregnancy services	
Prenatal and postnatal care	$15 copay per visit
Delivery and all inpatient services[1]	Preferred: $75 copay per admission Non-preferred: $150 copay per admission
Special needs	
Home health care	25% coinsurance Up to 40 visits per policy year for physical, occupational and speech therapy; precertification required
Rehabilitation/habilitation services	$7 copay for therapy and manipulations Up to 20 physical therapies and manipulations per policy year Up to 20 combined occupational and speech therapies per policy year
Skilled nursing care	$75 copay Up to 120 days per policy year, per insured person; precertification required
Durable medical equipment	25% coinsurance; precertification required
Hospice service	No charge; covered under the Individual Case Management Program, subject to the set requirements and precertification required
Prescription drugs[2] (up to 30-day supply retail and 90-day supply mail order)	
Preventive medications and contraceptives[3]	$0
Tier 1: Generic drugs	Retail: $5 copay/Mail order: $10 copay
Tier 2: Preferred brand drugs	Retail: $30 copay/Mail order: $60 copay
Tier 3: Non-preferred brand drugs	Retail: 30% coinsurance/Mail order: 23% coinsurance
Tier 4: Specialty drugs	40% coinsurance
Drugs for chemotherapy	10% coinsurance
Vision services	
Eye exam	$0; up to one exam per year per insured person
Diagnostic tests	20% coinsurance
Prescription glasses/contact lenses (in lieu of lenses and frames)	Up to $100 per year

1. Copay level varies based on admitting hospital. See plan document for details on cost for medical-surgical services during hospitalization.
2. Some medications require precertification from the plan and the use of step therapy. Coverage is subject to a drug list and mail order is not available for specialty drugs.
3. Only certain preventive drugs qualify for 100% benefit. Please call Triple-S at **787-774-0606** to see if your drug qualifies.

COVERING DEPENDENTS?

If you cover dependents, each individual's expenses apply to an individual deductible, as well as the family deductible. If one individual meets their individual deductible, no further deductible will apply to that person. If the expenses for all family members combined meet the family deductible, no further deductible will apply to any family member. The out-of-pocket maximum works the same way.

Lifetime maximum

There is no dollar limit to the amount the plan will pay for essential benefits during the entire period you are enrolled in this plan. Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expenses not applied to the out-of-pocket maximum

Some amounts you pay do not count toward your out-of-pocket maximum. They include:

- Charges from out-of-network providers and facilities, unless otherwise approved by Triple-S Salud
- Charges for expenses not covered by the plan – such as for care that is not medically necessary
- Charges above the plan's maximum benefit for a specific service (such as chiropractic care)
- Benefit penalties for failing to get prior authorization when it is required

Prescription drugs (for UHC and HMSA)

If you enroll in a UnitedHealthcare or HMSA medical plan, prescription drug coverage is provided by Express Scripts.

As claims administrator, Express Scripts has discretion and authority to decide whether a prescription drug is covered by the plan and how benefits will be paid. Although Express Scripts will assist you in many ways, it does not guarantee any benefits. the company is solely responsible for paying benefits.

Where you can fill a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery or a specialty pharmacy.

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply
Additional clinical support for members using specialty drugs			
Express Scripts pharmacies	Log in at express-scripts.com or call **800-903-8638**		Your doctor may contact Accredo, the specialty pharmacy, at **888-327-9791**
Out-of-network pharmacies	Submit a reimbursement form with your receipt	Not available	Not available

If you use a participating pharmacy, the pharmacy will submit your claim on your behalf and charge you directly for any balance you owe. If you think your claim for benefits under this plan have been wrongfully denied, please contact Express Scripts directly at **800-903-8638.**

Specialty pharmacy

The Express Scripts specialty pharmacy is Accredo. This pharmacy helps members meet the particular needs and challenges of using certain medications, many of which require injections or special handling. These medications treat conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis.

The benefits of the specialty pharmacy include:

- Support and guidance from Accredo nurses and pharmacists
- Expedited delivery of all your specialty prescription medications to your home or, if needed, doctor's office
- Related supplemental supplies such as needles and syringes at no additional charge
- Scheduling of refills and coordination of services with home care providers, case managers and doctors or other healthcare professionals

If you are currently using a participating retail pharmacy to fill your specialty medication and you would like to transfer to Accredo, you will need a new prescription from your doctor. Your doctor may contact Accredo at **888-327-9791** for instructions on how to submit your prescription by fax.

SPECIALTY COPAY ASSISTANCE

The SaveonSP program is available to the company members enrolled in the UHC and HMSA plans. SaveonSP identifies third-party and manufacturer copay assistance programs that are offered for certain specialty medications. If you are taking an eligible specialty medication, you may be able to get a portion of or all of your copay paid through the SaveonSP Program.

If you are eligible, the cost of the medication that is offset through the SaveonSP Program would not apply to your annual deductible (if applicable) or out-of-pocket maximum.

What you pay

The table below summarizes prescription drug benefits under the UnitedHealthcare and HMSA plans. When you present your ID card at a participating pharmacy, you are charged the amounts below.

Prescription drug costs paid through coupons or offers from pharmaceutical manufacturers or affiliates will not apply toward the annual deductible (if applicable) or out-of-pocket maximum. Please review the section of this SPD for your medical plan for more information.

Note: In all locations except Hawaii, you may only purchase long-term or maintenance medications at participating retail pharmacies four times. Beginning with the fifth purchase, you will pay double the regular 30-day supply copay. To avoid paying the increased amount, use mail order for these medications.

Covered prescription drugs

	UHC Gold Plan and Rose Gold Plan	UHC Silver HSA Plan	HMSA Plan (Hawaii Only)
Plan year deductible	No deductible	Same as medical plan	Same as medical plan
Plan year out-of-pocket maximum	Same as medical plan	Same as medical plan	Separate from medical plan – $1,500 per person/$4,500 family
Covered prescription drugs	Amount you pay after deductible (unless otherwise noted)		
Preventive medications and contraceptives[1]	$0	$0, no deductible	$0
Retail[2] (up to 30-day supply)			
Generic	$10 copay	$10 copay after deductible	$5 copay[3]
Brand-name formulary	25% ($25 min/$75 max)	25% after deductible ($25 min/$75 max)	$20 copay
Non-formulary	40% ($40 min/$120 max)	40% after deductible ($40 min/$120 max)	$20 copay
Mail order (up to 90-day supply)			
Generic	$20 copay	$20 copay after deductible	$10 copay[3]
Brand-name formulary	25% ($50 min/$150 max)	25% after deductible ($50 min/$150 max)	$35 copay
Non-formulary	40% ($80 min/$240 max)	40% after deductible ($80 min/$240 max)	$65 copay

1. Only certain preventive drugs qualify for 100% benefit. Please call Express Scripts Member Services at **800-903-8638** to see if your drug qualifies.
2. Fertility medications are covered to a lifetime maximum of $10,000. Prior authorization is required for all fertility medications.
3. When a generic drug is available and you purchase a brand name drug, you will pay the brand name formulary or non-formulary copay, plus the difference in the cost between the brand name drug and the generic drug. This will apply even if you or your doctor requests a brand name prescription.

If you do not use your ID card or choose to fill a prescription at a non-participating pharmacy, you will have to pay the full cost and submit a claim for reimbursement from Express Scripts. Claim forms may be found online at express-scripts.com, under Forms & Cards on the left-hand menu after you log in.

Express Scripts will not cover any price difference between the amount charged by the pharmacy and the discounted amount you would have been charged if you had used your ID card or used a participating pharmacy.

MEDICARE PART D COVERAGE

This benefit is equal to or greater than the Medicare Part D prescription drug benefit. Eligible members who are also eligible for Medicare Part D pharmacy benefits can remain covered under the plan and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date.

For more information about prescription drug policies or benefits under The company plan, call Express Scripts at **800-903-8638**. For more information about your options under Medicare prescription drug coverage, visit medicare.gov or call **800-633-4227**.

What's covered

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also included in this benefit are injectable supplies.

Express Scripts will periodically review the drugs in each tier level and adjust the status of existing or new drugs. You will be notified directly of any changes that affect you directly.

Preventive drugs

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit.

Note: The list of covered and excluded drugs is subject to change. Please call Express Scripts Member Services at **800-903-8638** for up-to-date information.

Prior authorization

Some medications are covered only for certain uses or in certain quantities. In these cases, the pharmacy will let you know if additional information is required for your prescription to be covered. If you need one of these medications, your physician should call Express Scripts at **800-753-2851** to request prior authorization.

Kaiser Permanente HMO Plans

The Kaiser HMO plans are available to employees in the following locations:

- The Kaiser HMO California plan is available in California
- The Kaiser HMO Hawaii plan is available in Hawaii

Kaiser Permanente is a private healthcare claims administrator for these plans. As claims administrator, Kaiser Permanente has discretion and authority to decide whether a treatment or supply is covered by the plan and how benefits will be paid. Kaiser Permanente is solely responsible for paying benefits.

You can find all the details – including complete description of terms, conditions and limitations – in the Kaiser Permanente Evidence of Coverage for each plan, which are incorporated by reference in this SPD. If there is a discrepancy between this document and the Evidence of Coverage, the Evidence of Coverage will govern. The Evidence of Coverage for each plan is available in the Reference Center at **the companyBenIQ.com**.

Where you can get medical care and prescriptions

The HMO plans provide coverage with contracted providers, facilities and pharmacies through the Kaiser Permanente network. Services provided outside the Kaiser Permanente's network may not be covered. You may need a referral from your primary care physician before the plan will cover care from specialists.

To find an in-network provider, facility or pharmacy, go to **kp.org** or contact the Member Service Contact Center:

- For the Kaiser HMO California plan, call **800-464-4000**
- For the Kaiser HMO Hawaii plan, call **808-432-5955** if you are on Oahu, or **800-966-5955** if you are on a neighbor island

You may seek out-of-network care and receive in-network coverage levels in the event of an emergency. Emergency care is always covered at the in-network level, even if you are at an out-of-network facility.

What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care in other situations, such as for the treatment of illnesses, injuries and chronic conditions, you may pay a portion of the cost up to an annual maximum amount.

As summarized in the table on the next page, there is no deductible or lifetime maximum for these plans. Your costs are capped at the annual out-of-pocket maximum each calendar year.

Summary of benefits

This table summarizes the most frequently asked-about benefits. This chart does not explain benefits, cost share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost share amounts. For a complete explanation, refer to the Evidence of Coverage. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

	KAISER CALIFORNIA	KAISER HAWAII*
Calendar year deductible	None	None
Calendar year out-of-pocket maximum	$3,000 per individual $6,000 per family	$2,500 per individual $7,500 per family
Covered services	**Amount you pay**	
Office visits		
Preventive care visit	$0	$0
Primary care visit	$20 copay	$15 copay
Specialist visit	$30 copay	$15 copay
Chiropractic care (20-visit maximum)	$15 copay	$15 copay
Acupuncture (visit maximums apply)	$20 copay, referral required	Not covered
Diagnostic tests and imaging		
Diagnostic test (X-ray, blood work)	$10 per visit	$15 copay per department per day
Imaging (CT/PET scan, MRI)	$75 copay per procedure	20%
Hospital		
Outpatient surgery (facility and physician fees)	$250 copay per procedure	Medical office: $15 copay Surgery center or hospital: 20%
Inpatient (facility and physician fees)	$500 copay per day	20%
Emergency and urgent care		
Emergency room	$150 copay per visit (waived if admitted)	20%
Emergency medical transportation	$150 copay per trip	20%
Urgent care	$20 copay	$15 copay
Mental/behavioral health or substance abuse		
Outpatient visit	$20 copay for individual visit $10 copay for group mental/behavioral health visit $5 copay for group substance abuse visit	$15 copay
Inpatient services	$500 copay per visit	20%

* Reflects coverage inside the Hawaii service area. If you are outside the Hawaii service area, see the Evidence of Coverage on the companyBenIQ.com for more detail.

	KAISER CALIFORNIA	KAISER HAWAII*
Other services		
Home health care (visit maximums apply)	$0	$0
Skilled nursing care (day limits apply)	$0	20%
Hospice services	$0	$0
Durable medical equipment	$0	20% (50% for diabetes equipment)
Prescription drugs		
Generic drugs	Retail: $15 copay, up to 30-day supply Mail-order: $30 copay, up to 100-day supply	**Generic maintenance:** Retail: $3 copay, up to 30-day supply Mail-order: $3 copay, up to 90-day supply **Other generic:** Retail: $15 copay, up to 30-day supply Mail-order: $30 copay, up to 90-day supply
Preferred brand drugs	Retail: $35 copay, up to 30-day supply Mail-order: $70 copay, up to 100-day supply	Retail: $50 copay, up to 30-day supply Mail-order: $100 copay, up to 90-day supply
Non-preferred brand drugs	Same as preferred brand, covered when medically necessary	Same as preferred brand, covered when medically necessary
Specialty drugs (mail-order not available)	20%, up to $250 max per prescription	$200 copay

* Reflects coverage inside the Hawaii service area. If you are outside the Hawaii service area, see the Evidence of Coverage on the companyBenIQ.com for more detail.

VISION

Benefits-eligible employees may enroll for the Vision Basic and Vision Plus plans, administered by Vision Service Plan (VSP®). The plan covers vision exams and glasses or contacts.

The Kaiser HMO plans also cover eye exams. Kaiser HMO members can enroll in a VSP vision plan to cover additional vision expenses, such as glasses or contacts. If you enroll for both a Kaiser HMO medical plan and a VSP vision plan, you can use a Kaiser or VSP provider for your vision exam.

Puerto Rico employees enrolled in the Triple-S health care plan receive limited vision benefits through Triple-S. See **What you pay** for coverage details. For additional vision benefits, Triple-S members can enroll in the Vision Basic plan described in this section. The Vision Plus plan is not available in Puerto Rico.

All of the benefits for each vision plan are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations. Specific coverage by each vision plan is outlined on the following pages.

To be covered under the plans, vision services and supplies must be medically necessary and provided by a licensed vision provider practicing within the scope of their license.

VSP Vision Basic and Vision Plus plans

Where you can get care

In the VSP vision plans, you may seek care from any provider. However, if you go to a VSP network doctor, including participating Costco and Walmart locations, you have better benefits and you can get discounts on vision-related expenses that are not covered by the plan.

You can find a VSP network doctor in your area at **vsp.com** or by contacting VSP Member Services at **800-877-7195**.

When you make an appointment with a VSP network doctor, let them know that you have VSP coverage and the doctor will obtain benefit authorization directly from VSP. There are no ID cards issued, and claim forms are not required if you visit VSP network doctors. You pay only the applicable copays, if any, for services covered by the plans. VSP will pay the doctor directly for the remainder of eligible charges.

If you receive services from a non-VSP provider, you are responsible for paying the provider in full and then submitting an itemized bill to VSP. Claim forms are available on **the companyBenIQ.com**, or you can request one from VSP Member Services at **800-877-7195**.

If you do not notify your VSP network doctor about your VSP coverage, your claim for reimbursement will only be paid at the out-of-network level.

What's covered

	VISION BASIC		VISION PLUS	
Benefit	**VSP provider**	**Out-of-network provider**	**VSP provider**	**Out-of-network provider**
Eye exam (every 12 months)	$10 copay	Reimbursed up to $50	$10 copay	Reimbursed up to $50
Frame	1 pair every 24 months, $150 allowance, and 20% off your share	1 pair every 24 months, up to $70	2 pairs every 12 months, $200 allowance per pair, and 20% off your share	2 pairs every 12 months, up to $70 per pair
Lenses:	$25 copay, one pair every 12 months	Reimbursed every 12 months:	$25 copay for each pair, two pairs every 12 months	2 pairs every 12 months, reimbursed:
Single vision		Up to $50		Up to $50
Lined bifocal		Up to $75		Up to $75
Lined trifocal		Up to $100		Up to $100
Polycarbonate lenses for dependent children		Not covered		Not covered
Lens enhancements:		Reimbursed up to $75		Reimbursed up to $75
Anti-reflective lens coating	Not covered		**Covered in full**	
Standard progressive	**Covered in full**		**Covered in full**	
Premium progressive	$80-$90 copay		$80-$90 copay	
Custom progressive	$120-$160 copay		$120-$160 copay	
Extra benefits at VSP providers	• Extra $20 for featured frame brands • 20% off amounts over allowance • Average savings of 30% on additional glasses and sunglasses and other lens enhancements			
Contacts (instead of glasses)	$150 allowance every 12 months	Reimbursed up to $105 every 12 months	2 sets of contacts every 12 months, $200 allowance per set	2 sets of contacts every 12 months, reimbursed up to $105 per set
Contact lens exam (fitting and evaluation)	Up to $60 copay		Up to $60 copay	

Additional benefits

The VSP vision plans offer the following additional benefits:

- Diabetic Eyecare Plus Program
- Extra discounts and savings
- Low vision

Diabetic Eyecare Plus Program

If you have type 1 or type 2 diabetes and ophthalmological conditions, the plan will cover certain services with VSP network providers. The plan will cover services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD), as needed.

This program supplements your medical coverage. Any amounts not paid by your medical plan will be considered for payment by VSP.

Benefits include:

- Eye exams are covered in full after a $20 copay
- Special ophthalmological services are covered in full

The following symptoms may result in seeking services under this program:

- Blurry vision
- Transient loss of vision
- Trouble focusing
- "Floating" spots

The following conditions may require management under this program:

- Diabetic retinopathy
- Diabetic macular edema
- Rubeosis

Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.

Extra discounts and savings

If you use VSP network providers, you may benefit from the following additional discounts and savings.

Glasses and sunglasses

You have an extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.

You receive 30% savings on additional glasses and sunglasses, including lens enhancements, if purchased through your VSP provider on the same day as your well vision exam. Or, you may receive a 20% discount from any VSP provider within 12 months of your last well vision exam.

Laser vision correction

VSP provides an average of 15% off the regular price or 5% off the promotional price for laser vision correction. Discounts are only available from contracted facilities.

After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Retinal screening

No more than a $39 copay on routine retinal screening as an enhancement to a well vision exam.

Hearing aids

TruHearing offers all VSP members and their covered dependents free access ($108 value) to the TruHearing Memberplus® Program, which saves members up to $2,600 on a pair of hearing aids. This program can be combined with a funded hearing aid benefit to reduce members' out-of-pocket expense. VSP members can learn more about this program and sign up at vsp.com or by calling **877-396-7194**.

Low vision

The plan will cover professional services for severe visual problems not corrected with regular lenses, including:

- Supplemental testing: Covered in full, up to $125, including evaluation, diagnosis and prescription of vision aids where indicated
- Supplemental aids: 75% of the cost

The maximum benefit for all low vision benefits is $1,000 every two years.

What's not covered

There is no benefit under these plans for:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an experimental nature
- Services and/or materials above plan benefit allowances
- Services/materials not listed as covered plan benefits

These plans cover visual needs rather than cosmetic materials. If you select any of the following extras, this plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional costs for the options, unless the extra is defined as a plan benefit:

- Optional cosmetic processes
- Anti-reflective coating (except under the VSP Plus plan)
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses

Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Covered persons may obtain details regarding frame brand availability from their VSP network doctor or by calling VSP Member Services at **800-877-7195**.

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

Under the Diabetic Eyecare Plus Program, the following services are not covered:

- Orthoptics or vision training and any associated supplemental testing
- Surgery of any type, and any pre- or post-operative services
- Treatment for any pathological conditions
- An eye exam required as a condition of employment
- Insulin or any medications or supplies of any type
- Local, state and/or federal taxes, except where VSP is required by law to pay

Filing a claim

In most cases, when you receive care from a VSP network provider, your provider will submit bills directly to VSP and this submission is your claim for benefits.

If your provider does not submit a bill directly to VSP or you receive services from an out-of-network provider, you will need to pay for the services and submit a claim to VSP for reimbursement. Claim forms are available on **the companyBenIQ.com** or from VSP Member Services at **800-877-7195**.

VSP will pay or deny claims from VSP network doctors within 30 calendar days of the receipt of the claim. In the event that a claim cannot be resolved within 30 days, VSP may extend the time for decision by up to 15 calendar days.

If your claim is denied

If your claim is denied by VSP in whole or in part, VSP will notify you in writing of the reason for the denial. The denial can be appealed within 180 days of receipt of the notice by verbal or written request. The request should contain sufficient information to identify the covered person for whom a claim for benefits was denied, including the name of the VSP enrollee, Member Identification Number of the VSP enrollee, the covered person's name and date of birth, the name of the provider of services and the claim number. The covered person may state the reasons the covered person believes that the claim denial was in error. The covered person may

also provide any pertinent documents to be reviewed. Call VSP Member Services for more information, or submit a written request to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the covered person within 30 calendar days after receipt of a request for appeal from the covered person or covered person's authorized representative.

Complaints and grievances

If a covered person ever has a question or problem, they should call VSP Member Services. Member Services will make every effort to answer the question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of the individual, they may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from Member Services. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered members also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 30 days after receipt.

Kaiser Permanente Vision Benefits

The Kaiser HMO medical plans only cover vision exams with a Kaiser Permanente network provider. You can find a Kaiser network doctor in your area at **kp.org**.

The plan covers vision exams at 100% with in-network providers, as described below.

Benefit	In-network	Out-of-network
Vision exam (every 12 months)	Covered 100% after applicable copay Preventive, routine vision screenings Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses	No coverage
Glasses and contacts	No coverage	No coverage

For more information on covered services, exclusions and claim procedures, view the evidence of coverage documents in the Reference Center at **the companyBenIQ.com**.

DENTAL

the company offers the following dental plans through Delta Dental:

- The **DHMO Plan** only covers care with Delta Dental network providers and facilities
- The **PPO plans** allow you to seek care from any provider
  - The Base PPO provides coverage for preventive, basic and major services
  - The Buy-up PPO has a higher level of coverage for basic and major services and includes coverage for orthodontia

Hawaii employees can only enroll in one of the PPO plans, which are administered by Delta Dental/Hawaii Dental Service in Hawaii. The DHMO Plan is not available in Hawaii.

Puerto Rico employees enrolled in the Triple-S health care plan receive dental benefits through Triple-S. See **What you pay** for coverage details. The dental plans described in this section are not available in Puerto Rico.

All of the dental benefits are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations. Specific coverage is outlined on the following pages.

To be covered under the plans, dental services and supplies must be dentally necessary and provided by a licensed dental provider practicing within the scope of their license. Services may also be provided by a dental hygienist under the supervision of and billed by a licensed dentist.

Delta Dental DHMO Plan

Where you can get care

The Delta Dental DHMO Plan covers care through Delta Dental's DHMO network providers. A primary care dentist (PCD) provides your basic and routine dental care, and will refer you to a participating specialist dentist in the network if necessary. If you don't select a PCD, Delta Dental will select a PCD for you and notify you of the selection.

You must use Delta Dental DHMO network providers to receive coverage under this plan. All services must be accessed through your primary care dentist (PCD), otherwise you could end up paying more.

To find Delta Dental DHMO network dentists, use the online provider search tool at **deltadentalins.com** or contact Delta Dental Member Services at **800-765-6003**.

What you pay

You pay nothing for preventive, diagnostic and basic services with network providers. For other care, you pay a share of the cost.

Note: Members must have a prior written or electronic referral from their PCD in order to receive the in-network care level of coverage for any services received from a specialist dentist (with the exception of orthodontic services).

If you receive services from a non-Delta Dental DHMO provider, you are responsible for the full costs of any services provided unless those services were arranged by your PCD and approved by Delta Dental or were required to treat a dental emergency.

Details on your benefits

You can find all the details – including a complete description of terms, conditions and limitations – in the Delta Dental DHMO Plan Document, which is incorporated by reference in this SPD. If there is a discrepancy between this document and the Plan Document, the Plan Document will govern. The Plan Document is available in the Reference Center at **the companyBenIQ.com**.

Delta Dental PPO Plans

Where you can get care

You have the flexibility to see any provider and receive benefits under the Delta Dental PPO plans. However, with Delta Dental dentists, you'll pay less for care and the dentist will submit claims on your behalf. See the **What you pay** section for more information about coverage levels for each plan.

You can find a Delta Dental network dentist in your area at **deltadentalins.com** or by contacting Delta Dental Member Services at **800-765-6003**. Members in Hawaii, visit **hawaiidentalservice.com**, or call Hawaii Dental Service from Oahu **808-521-1431** or from neighbor islands at **800-232-2533**.

During your first appointment, be sure to give your dentist the following information:

- Your Delta Dental group number
- the company employee's Delta Dental ID number (which must also be used by **dependents**)
- the company employee's date of birth
- Any other dental coverage you may have

If you receive services from a non-Delta Dental provider, you are responsible for paying the provider in full and then submitting the claim to Delta Dental. If you go to a non-Delta Dental dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered.

Predeterminations

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your plan at the time the treatment is completed.

In order to receive predetermination, your dentist must send a claim form listing the proposed treatment. Delta Dental will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the form to Delta Dental for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued. Payment will depend on the individual's eligibility and the remaining annual maximum benefit when completed services are submitted to Delta Dental.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

What you pay

You pay nothing for preventive and diagnostic care. For other care, you pay a share of the cost. See the **What's covered** section for more information about each type of service.

	DELTA DENTAL BASE PPO		DELTA DENTAL BUY-UP PPO	
PLAN FEATURE	Delta Dental PPO Dentist	Out-of-Network Dentist*	Delta Dental PPO Dentist	Out-of-Network Dentist*
Plan deductible	$50 per person	$75 per person	$50 per person	$75 per person
Plan year maximum benefit**	$1,500 per person		$2,000 per person	
Covered services	**Amount you pay after deductible (unless otherwise noted)**			
Preventive and diagnostic care – exams, cleanings and X-rays	$0, not subject to deductible	10%, not subject to deductible	$0, not subject to deductible	10%, not subject to deductible
Basic services – filings, root canals, endodontics (root canal), periodontics (gum treatment) and oral surgery	20%	30%	10%	30%
Major services – crowns and prosthodontics (bridges, dentures and implants)	50%	50%	40%	50%
Orthodontia (adults and children)	Not covered		50%, not subject to deductible ($3,000 lifetime maximum benefit)	

* Plan pays up to reasonable and customary charges (R&C) for out-of-network care; you are responsible for any charges over R&C.
** Plan year maximum benefit is the total amount the plan will pay for covered services during the plan year, January 1 through December 31.

If you use in-network providers, you'll receive the lower Delta Dental-negotiated rate, called the reasonable and customary charge (R&C). If you use out-of-network providers, only the R&C charge is applied to your **deductible**. You are responsible for the provider charge over the R&C charge.

The Base PPO Plan pays up to a maximum amount of $1,500 per member each plan year and the Buy-up PPO Plan pays up to a maximum amount of $2,000 per member each plan year. After the plan pays this annual limit, you are responsible for 100% of the cost when you seek care.

What's covered

This section provides details on the benefits of the dental plans:

- Preventive and diagnostic care
- Basic services
- Major services
- Orthodontics (only available on the Buy-up PPO Plan)

If you select a more expensive plan of treatment than is customarily provided or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee. For example, a crown where an amalgam filling would restore the tooth, or a precision denture where a standard denture would suffice.

Preventive and diagnostic care

Prophylaxis (cleaning)

The plans will pay for two cleanings or a dental procedure that includes cleaning each plan year under any Delta Dental plan. See note on additional benefits during pregnancy.

Routine prophylaxes are covered as a preventive and diagnostic benefit and periodontal prophylaxes are covered as a basic benefit.

Fluoride treatment

Fluoride treatments are covered once in a six-month period while under any Delta Dental plan.

Space maintainers

Space maintainers are a benefit once in a three-year period for children to age 15.

Oral examinations (including initial examinations, periodic examinations and emergency examinations)

The plans cover only the first two oral examinations in a plan year, including office visits for observation and specialist consultations. See note below on additional benefits during pregnancy.

X-rays

Full-mouth X-rays are a benefit once in a five-year period while you are eligible under any Delta Dental plan.

Delta Dental pays for a panoramic X-ray provided as an individual service only after five years have elapsed since any prior panoramic X-ray was provided under any Delta Dental plan.

Bitewing X-rays are provided on request by the dentist:

- Up to two times in any plan year for children to age 18
- Once in any plan year for adults age 18 and over

Diagnostic casts

Diagnostic casts are a benefit only when made in connection with subsequent orthodontic treatment covered under this plan.

Additional services

The preventive and diagnostic benefit also includes:

- Examination of biopsied tissues
- Palliative (emergency) treatment of dental pain
- Specialist consultation

Note: If you are pregnant and enrolled in a plan, Delta Dental will pay for additional services to help improve your oral health during pregnancy. The additional services each calendar year include one additional oral examination and either one additional routine cleaning or one additional periodontal scaling and root planing per quadrant. Written confirmation of your pregnancy must be provided by you or your dentist when the claim is submitted.

Basic services

Oral surgery

Includes extractions and certain other surgical procedures, including pre- and post-operative care.

Restorative services

Includes amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).

Direct composite (resin) restorations are benefits on anterior teeth and the facial surface of bicuspids. Any other posterior direct composite (resin) restorations are optional services and Delta Dental's payment is limited to the cost of the equivalent amalgam restorations.

Endodontic care

Includes treatment of the tooth pulp.

Periodontic care

Treatment of gums and bones that support the teeth.

Periodontal scaling and root planing is a benefit once for each quadrant each 24-month period. See note on additional benefits during pregnancy.

Sealants

Includes topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.

Sealant benefits include the application of sealants only to permanent first molars to age nine and second molars to age 15 if they are without caries (decay) or restorations on the occlusal surface. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

Adjunctive general services

Including:

- General anesthesia
- I.V. sedation
- Office visit for observation
- Office visit after regularly scheduled hours
- Therapeutic drug injection
- Treatment of post-surgical complications (unusual circumstances)
- Limited occlusal adjustment

Major services

Crowns, inlays, onlays and cast restorations

Covered if they are provided to treat cavities which cannot be restored with amalgam, silicate or direct composite (resin) restorations.

Crowns, inlays, onlays and cast restorations are benefits on the same tooth only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the restoration.

Prosthodontic care

Construction or repair of fixed bridges, partial dentures and complete dentures are only covered if provided to replace missing, natural teeth.

Prosthodontic appliances and implants are benefits only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactory. Delta Dental will replace an implant, a prosthodontic appliance or an implant supported prosthesis you received under another dental plan if we determine it is unsatisfactory and cannot be made satisfactory. We will pay for the removal of an implant once for each tooth during the member's lifetime.

A standard partial or complete denture is one made from accepted materials and by conventional methods.

Coverage is provided for implant surgical placement and removal, and for implant supported prosthetics, including implant repair and re-cementation.

Orthodontics (only available on the Buy-up PPO Plan)

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

If orthodontic treatment is begun before you become eligible for coverage, Delta Dental's payments will begin with the first payment due to the dentist following your eligibility date.

Delta Dental's orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.

Delta Dental will pay the applicable percentage of the dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If the member selects specialized orthodontic appliances or procedures chosen for aesthetic considerations, an allowance will be made for the cost of a standard orthodontic treatment plan and the member is responsible for the remainder of the dentist's fee.

X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits, but may be covered under **Preventive and diagnostic care** or **Basic services**.

What's not covered

Delta Dental does not provide benefits for:

- Services for injuries or conditions that are covered under workers' compensation or employer's liability laws
- Services which are provided to the member by any federal or state governmental agency or are provided without cost to the member by any municipality, county or other political subdivision, except Medi-Cal benefits
- Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel
- Services for restoring tooth structure lost from wear (abrasion, erosion, attrition and abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.
- Any single procedure, bridge, denture or other prosthodontic service which was started before the member was covered by this plan
- Prescribed drugs, or applied therapeutic drugs, premedication or analgesia
- Experimental procedures
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility
- Anesthesia, except for general anesthesia or I.V. sedation given by a licensed dentist for oral surgery services and select endodontic and periodontic procedures
- Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts")
- Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues
- Replacement of existing restoration for any purpose other than active tooth decay
- Occlusal guards and complete occlusal adjustment
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan
- Adult fluoride for Hawaii employees only

Filing a claim

Delta Dental will pay or deny any claims from Delta Dental network dentists. If there is a difference between what your dentist is charging you and what Delta Dental says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta Dental Member Services department at **800-765-6003**. Members in Hawaii, call Hawaii Dental Service from Oahu at **808-521-1431** or from neighbor islands at **800-232-2533**.

If you receive services from a non-Delta Dental provider, you are responsible for paying the provider in full and then submitting the claim to Delta Dental. If you go to a non-Delta Dental dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental dentists may be submitted to:

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330

Hawaii members, submit claims to:

Hawaii Dental Service
700 Bishop St., STE 700
Honolulu, HI 96813-4196

If your claim is denied

If any claims are not covered or if limitations or exclusions apply to services you have received from a Delta Dental dentist, you will be notified by an adjustment notice on the Notice of Payment or Action.

You may contact Delta Dental Member Services department at **800-765-6003** for more information regarding Delta Dental's processing policies.

Members in Hawaii, call Hawaii Dental Service from Oahu at **808-521-1431** or from neighbor islands at **800-232-2533**.

Complaints and grievances

If you have any questions about the services received from a Delta Dental dentist, first discuss the matter with your dentist. If you continue to have concerns, call or write to Delta Dental. Delta Dental will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of ineligibility should first be handled directly between you and your group. If you have a question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental or the quality of dental services performed by a Delta Dental dentist, call **800-765-6003**, contact Delta Dental through **deltadentalins.com** or write to:

Delta Dental
Attention: Customer Service Department
P.O. Box 997330
Sacramento, CA 95899-7330

Members in Hawaii, call Hawaii Dental Service from Oahu at **808-521-1431** or from neighbor islands at **800-232-2533**, contact Hawaii Dental Service through **hawaiidentalservice.com**, or write to:

Hawaii Dental Service
700 Bishop St., STE 700
Honolulu, HI 96813-4196

If your claim has been denied or modified, you may file a request for review with Delta Dental within 180 days after receipt of the denial or modification. Delta Dental will treat the request for review as a grievance. If in writing, the correspondence must include the group name and number, the primary member's name and ID number, the inquirer's telephone number and any additional information that would support the claim for benefits. The correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Delta Dental's review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of Delta Dental's regional consultants, to a review committee of the dental society or to the state dental association for evaluation. The review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual and we will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment or a clinical judgment in applying the terms of the contract terms, Delta Dental shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Delta Dental will provide a written acknowledgment within five days of receipt of the request for review. They will render a decision and respond to you within 60 days of receipt of the request for review. Delta Dental will respond within 72 hours to grievances involving severe pain and imminent and serious threat to a patient's health (urgent care grievance).

DISABILITY INSURANCE

Disability benefits replace a portion of your wages in the event of a qualified illness, injury or pregnancy. the company pays the full cost for these benefits, and you are automatically enrolled if you are eligible.

Plan	Eligibility	Coverage
Short-term disability	Full-time and eligible part-time active employees	After 7 days, replaces 60% of your pre-disability income, up to $1,000 a week, to a maximum of 26 weeks from your disability*
Long-term disability	Full-time active employees	After 180 days of disability, replaces 50% of your monthly pay, up to $5,000 per month (60%, up to $17,000 per month, for Senior VP and above and field support center and exempt distribution center employees), to a maximum age

* In locations that provide state-mandated disability coverage, the company pays the difference in cost between state-mandated disability benefits and Our short-term disability benefit.

New York Life administers disability claims for the disability insurance plans. You can find more information about your disability benefits or claims on **the companyBenIQ.com**.

For more information about conditions of coverage and payable benefits, see the Short-term Disability and Long-Term Disability Insurance Certificates available on **the companyBenIQ.com**. All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.

There are state-specific requirements that may change the provisions for this plan. If you live in a state that has such requirements, those requirements will apply to your coverage. For more information call New York Life at **888-842-4462** or **866-562-8241** (Español).

Short-term disability

Short-term disability (STD) weekly benefits provide income in the event of your illness, injury or pregnancy.

Your STD coverage will begin on the date you become an eligible employee.

Your effective date may be deferred if you are not in **active service** on the date your insurance, or increase in coverage, would otherwise have become effective. Your insurance or increase in coverage will become effective on the date you return to active service.

You are considered in active service on a regular scheduled the company work day if either of the following conditions are met:

- You are performing your regular occupation and are working at your usual place of business, at another the company location or a location where the company requires you to travel.
- The day is a the company scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.

All weekly disability benefits are subject to the plan's exclusions and limitations. More information on what is covered is provided on the following pages.

When benefits begin

Our STD plan pays weekly disability benefits after a seven-day waiting period. If you have paid time off (PTO) available, you may use it during the waiting period. Weekly disability benefits continue for a maximum of 26 weeks from your disability.

You are eligible for STD benefits if you become totally disabled, which means a disability prevents you from performing the **material duties** of your **regular occupation** and as a result you are unable to earn 80% or more of your pre-disability covered earnings. Your disability must be one of the following:

- **Injury**
- **Mental illness**
- **Sickness**
- **Substance abuse**
- Pregnancy

Please review the **Glossary** for additional information about these terms. If you are in an occupation that requires you to maintain a license, your failure to pass a physical examination required to maintain that license does not mean that you are disabled.

You must notify New York Life of your disability within 31 days of when your disability occurs, or as soon as reasonably possible. You can call New York Life at **888-842-4462** or **866-562-8241** (Español). Please review the **Filing a claim** section for more information on how to request STD benefits.

If your disability recurs

If you return to work for less than 14 days and then become unable to work due to the same or related cause as your first absence:

- Your weekly disability benefits will resume with no waiting period
- Your second absence will count against your previous 26-week maximum benefit period

If you return to work as an **active employee** for 14 days or more, any recurrence of a disability will be treated as a new disability.

What the plan pays

If you are eligible for an STD benefit, you will receive 60% of your pre-disability covered earnings, up to $1,000 per week. The plan will pay accrued benefits at the end of each week that you are disabled.

Your pre-disability covered earnings is your weekly rate of pay on the last day you were in active service before you became disabled, as defined in the table below.

Employee	Covered earnings
Salaried employees	Your regular weekly rate of pay, excluding bonuses, commissions, tips and tokens, overtime pay and any other fringe benefits or extra compensation.
Hourly employees	The average number of hours you worked per week, not including overtime, over the most recent 12-month period multiplied by your hourly wage.

Payments will be made to you. If you should die, payments owed at your death may be made to your following living relatives: your spouse, your mother, your father, your children, your brothers or sisters; or to the executors or administrators of your estate. Benefits are taxable and may be subject to interest payments as required by applicable law.

If you are disabled and working

In certain situations, you may be able to work in a reduced capacity or in a different job than you had when you became disabled. If you meet the disability criteria and are working, you may still be eligible for weekly disability benefits as long as your earnings are less than 80% of your pre-disability covered earnings.

Your weekly disability benefit may be reduced if the sum of your weekly disability benefit plus your **current weekly earnings** exceeds your pre-disability covered earnings.

Your current weekly earnings are the income you receive or could receive working while disabled. Your STD weekly benefit will not be reduced by your current weekly earnings if you meet the requirements for the "disabled and working" benefit. You qualify if you are prevented from performing some, but not all of the **material duties** of your **regular occupation**, are working on a part-time or limited duty basis, and as a result, your current weekly earnings are more than 20% but are less than 80% of your pre-disability earnings.

Reductions for other income benefits

Your weekly benefits from this plan will be reduced by other income benefits that you or your family receive or are eligible to receive as a result of your disability, including but not limited to state and Social Security disability benefits. Please review the definition of **other income benefits** for more information.

Note: You must apply for state and Social Security disability benefits, if eligible, and follow all established procedures in the event of a denial. If you work in California, Hawaii, New York, New Jersey, Rhode Island or Puerto Rico, you may be eligible to receive state disability benefits. Contact your state disability office to apply for state disability.

Assumed Receipt of Benefits

New York Life will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from other income benefits. New York Life will reduce your disability benefits by the amount from other income benefits they estimate are payable to you and your dependents.

New York Life will waive assumed receipt of benefits, except for **disability earnings** for work you perform while disability benefits are payable, if you:

- Provide satisfactory proof of application for other income benefits;
- Sign a reimbursement agreement;
- Provide satisfactory proof that all appeals for other income benefits have been made, unless New York Life determines that further appeals are not likely to succeed; and
- Submit satisfactory proof that other income benefits were denied.

New York Life will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

Social Security Assistance

New York Life may help you in applying for Social Security Disability Income (SSDI) benefits, and may require you to file an appeal if they believe a reversal of a prior decision is possible.

New York Life will reduce disability benefits by the amount they estimate you will receive, if you refuse to cooperate with or participate in the Social Security Assistance Program.

When weekly payments stop

STD weekly benefit payments will stop on the earliest of:

- The date you are no longer disabled
- The date you fail to furnish **proof of loss**
- The date you are no longer under the **appropriate care** of a physician
- The date you refuse New York Life's request that you submit to an examination by a physician or other qualified medical professional
- The date of your death
- The date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition
- The last day benefits are payable according to the maximum benefit period
- The date you earn, from any occupation, more than the percentage of covered earnings set forth in the definition of disability
- The date no further benefits are payable under any provision in the policy that limits benefit duration

Limitations and exclusions

The plan does not cover and will not pay a disability benefit for any disability:

- Unless you are under the appropriate care of a physician
- That is caused or contributed to by war or act of war, whether declared or not
- Caused by your active participation in a riot
- Caused by your commission of or attempt to commit a felony
- That results in the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless it is due solely to injury or sickness otherwise covered by the plan
- Caused or contributed to by any cosmetic surgery or surgical procedure that is not medically necessary (except if your disability is caused by your donating an organ in a non-experimental organ transplant procedure)
- Caused or contributed to by your being engaged in an illegal occupation
- Caused or contributed to by an intentionally self-inflicted injury
- For which workers' compensation benefits are paid, or may be paid, if duly claimed
- Sustained as a result of doing any work for pay or profit for another employer, including self-employment

No benefits will be payable for the disability if you are receiving or are eligible for benefits for a disability under a prior disability plan that was sponsored by the company and was terminated before the effective date of the policy.

Long-term disability

Long-term disability (LTD) benefits help to replace your income in the event of a prolonged illness or injury due to:

- **Injury**
- **Sickness**
- **Mental illness**
- **Substance abuse**
- Pregnancy

The LTD plan also offers additional benefits to support you and your family. Your LTD coverage will begin on the date you become an eligible employee.

Your effective date may be deferred if you are not in **active service** on the date your insurance, or increase in coverage, would otherwise have become effective. Your insurance or increase in coverage will become effective on the date you return to active service.

You are considered in active service on a regular scheduled the company work day if either of the following conditions are met:

- You are performing your regular occupation and are working at your usual place of business, at another the company location or a location where the company requires you to travel.
- The day is a the company scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.

If you become disabled while covered by this plan, you may receive a monthly benefit and other LTD benefits after you reach the maximum period for STD benefits or 180 days, whichever occurs first. Your monthly benefits may be reduced by other sources of income or if you continue working while you are disabled. New York Life will send you a payment each month up to a maximum period.

All LTD monthly benefits are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations. More information on what is covered is provided on the following pages.

When benefits begin

Following the **elimination period**, you will be eligible for monthly benefits and other LTD benefits if you meet the eligibility criteria, as described below.

You must notify New York Life of your disability within 31 days of when your disability occurs, or as soon as reasonably possible. You can call New York Life at **888-842-4462** or **866-562-8241** (Español). Please review the **Filing a claim** section for more information on how to request LTD benefits.

Elimination period

The elimination period is 180 days, beginning from your injury or onset of your illness, or the expiration of the company STD benefits, whichever occurs first.

Eligibility criteria

You are eligible for LTD benefits if you become totally disabled, as summarized in the table below. Please review the **Glossary** for additional information about these terms.

You are eligible for LTD benefits if...	You are...	And you are...
Following the elimination period	Unable to perform the **material duties** of your **regular occupation** due to: • **Injury** • **Sickness** • **Mental illness** • **Substance abuse** • Pregnancy	Unable to earn 80% or more of your **covered earnings**.
After 24 months of receiving LTD benefits	Unable to perform **any occupation** for which you are or may, reasonably become, qualified based on education, training or experience.	

If you are in an occupation that requires you to maintain a license, your failure to pass a physical examination required to maintain that license does not mean that you are disabled.

If at the end of the elimination period, you are prevented from performing one or more of the essential duties of your occupation, but your **current monthly earnings** are equal to or greater than 80% of your pre-disability earnings, your elimination period will be extended for a total period of 12 months from the original date of disability, or until such time as your current monthly earnings are less than 80% of your pre-disability earnings, whichever occurs first. For the purposes of extending your elimination period, your current monthly earnings will not include the pay you could have received for another job or a modified job if such job was offered to you by your employer, or another employer, and you refused the offer.

If you are working while disabled

In certain situations, you may be able to work in a reduced capacity or work in a different job than you had when you became disabled. If you meet the above criteria and are working, you may be eligible for monthly benefits.

If your disability recurs

If, after the elimination period, you return to work for less than six months and then become unable to work due to the same or related cause as your first absence, and you earn less than the percentage of covered earnings that would still qualify you to meet the definition of **disability/disabled** during at least one month:

- Your monthly benefits will resume with no waiting period
- Your second absence will be considered a continuation of your first disability

If you return to work as an active employee for six months or longer, any recurrence of a disability will be treated as a new disability.

What the plan pays

If you are eligible, payments will be made to you on a monthly basis. Benefits will be prorated if payable for less than a month. The plan pays a minimum monthly benefit of $50 and a maximum monthly benefit of $5,000 ($17,000 for Senior VP and above and field support center and exempt distribution center employees).

If you die while any disability benefits remain unpaid, New York Life may pay any of your following living relatives: your spouse, your mother, your father, your children, your brothers or sisters; or to the executors or administrators of your estate.

Your level of LTD coverage depends on your job, as shown below.

Employee class	Coverage
Classes 1 & 7 (Senior VP and above and field support center and exempt distribution center employees)	Covers 60% of your pre-disability covered earnings, up to a maximum of $17,000 per month
All other full-time employees	Covers 50% of your pre-disability covered earnings, up to a maximum of $5,000 per month

Your pre-disability covered earnings is your monthly rate of pay on the last day you were in active service before you became disabled, as defined in the table below.

Employee	Covered earnings
Salaried employees	Your regular monthly rate of pay, excluding bonuses, commissions, tips and tokens, overtime pay and any other fringe benefits or extra compensation
Hourly employees	The average number of hours you worked per week, not including overtime, over the most recent 12-month period multiplied by your hourly wage

After 12 months of benefits, your pre-disability covered earnings will be indexed by adding the lesser of 10% or the annual percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers **(Consumer Price Index (CPI-W)** in the preceding calendar year. Please review **indexed pre-disability earnings** for more information on this calculation.

Payments will be made to you. If you should die, payments owed at your death will be made to your estate. Benefits are taxable and may be subject to interest payments as required by applicable law.

Calculating your LTD benefit

If you are not working while disabled, New York Life calculates your monthly benefit as described below.

Step	Calculation	Example
1.	Multiply the pre-disability covered earnings by the coverage level.	When Susan became disabled, her monthly pre-disability covered earnings were $2,500. Susan's coverage level is 50%. • $2,500 x 50% is $1,250
2.	Compare the result of this calculation to the maximum benefit level of $5,000 a month.	Susan's maximum benefit is $5,000, so she is eligible for a benefit level of $1,250.
3.	Deduct any other income benefits to calculate your monthly LTD payment.	Susan has no deductible sources of other income benefits, so her monthly payment is $1,250.

Incentive to work while disabled

If you return to work while you are disabled, your monthly benefit plus your job earnings, or **disability earnings**, can add up to 100% of your pre-disability covered earnings – more than you would get in monthly benefits from the plan alone.

For example, if Susan earns $1,000 in disability earnings from working while disabled and her monthly benefit is $1,250, her total income is $2,250.

This incentive will continue for 24 months, beginning with the first day you start working while disabled or the end of your **elimination period**, whichever is later. After 24 months, your monthly benefit will be reduced by 50% of your disability earnings.

Reductions for other income benefits

Your monthly benefit will be reduced by other income benefits that you or your family are eligible to receive as a result of your disability, including but not limited to state disability benefits and Social Security disability benefits. Please review the definition of **other income benefits** for full detail.

Note: You must apply for state and Social Security disability benefits, if eligible and follow all established procedures in the event of a denial. If you work in California, Hawaii, New York, New Jersey, Rhode Island or Puerto Rico, you may be eligible to receive state disability benefits. Contact your state disability office to apply for state disability.

Assumed Receipt of Benefits

New York Life will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from other income benefits. New York Life will reduce your disability benefits by the amount from other income benefits they estimate are payable to you and your dependents.

New York Life will waive assumed receipt of benefits, except for disability earnings for work you perform while disability benefits are payable, if you:

- Provide satisfactory proof of application for other income benefits;
- Sign a reimbursement agreement;
- Provide satisfactory proof that all appeals for other income benefits have been made unless we determine that further appeals are not likely to succeed; and
- Submit satisfactory proof that other income benefits were denied.

New York Life will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

Social Security Assistance

New York Life may help you in applying for Social Security Disability Income (SSDI) benefits, and may require you to file an appeal if they believe a reversal of a prior decision is possible.

New York Life will reduce disability benefits by the amount they estimate you will receive, if you refuse to cooperate with or participate in the Social Security Assistance Program.

When monthly benefits stop

Benefit payments will stop on the earliest of:

- The date you are no longer disabled
- The date you fail to furnish **proof of loss**
- The date you are no longer under the **appropriate care** of a physician
- The date you refuse New York Life's request that you submit to an examination by a physician or other qualified medical professional
- The date of your death
- The date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition
- The last day benefits are payable according to the maximum duration of benefits described below
- The date your **current monthly earnings** are equal to or greater than 80% of your **indexed pre-disability earnings**
- The date no further benefits are payable under any provision in the policy that limits benefit duration

Maximum period of payment

New York Life will provide you a monthly benefit each month up to the maximum period of payment, as listed below:

- If disabled prior to age 60, benefits are payable until age 65
- If disabled at age 60 or older, benefits are payable for the lesser of 60 months or until age 70

The LTD plan limits the maximum period of payment for mental and nervous disorders and **substance abuse**, including:

- **Mental illness** that results from any cause
- Any condition that may result from mental illness
- Anxiety disorders
- Eating disorders
- Depressive disorders
- Somatoform disorders (psychosomatic illness)
- Delusional (paranoid) disorders
- Alcoholism
- Drug addiction or abuse, including the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance

The maximum period of payment for mental and nervous disorders and substance abuse is:

- A total of 24 months for all such disabilities during your lifetime
- If, before reaching your lifetime maximum benefit, you are confined to a hospital for more than 14 consecutive days, your period of confinement will not count toward your lifetime maximum benefit

Additional benefits

In addition to the monthly benefits, this plan provides the following benefits in the event of your disability.

Rehabilitation plan

You may be eligible to participate in a rehabilitation plan, where New York Life agrees to provide, arrange or authorize vocational or physical rehabilitation services. The plan may, at New York Life's discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

If you desire to participate in a rehabilitation plan or to have a current program you are participating in approved by New York Life as a rehabilitation plan, you may contact New York Life for review and approval. New York Life has the sole discretion to approve your participation in a rehabilitation plan and to approve a program as a rehabilitation plan.

Survivor income benefit

If you were receiving a monthly benefit at the time of your death, New York Life will pay a survivor income benefit to your **surviving spouse**, or if there is no surviving spouse in equal shares to your **surviving children**. If there is no surviving spouse or surviving children, then no benefit will be paid.

The survivor income benefit is three times your monthly benefit.

Limitations and exclusions

The plan does not cover and will not pay a benefit for any disability:

- Unless you are under the **appropriate care** of a physician
- That is caused or contributed to by war or act of war, whether declared or not
- Caused by your active participation in a riot
- Caused by your commission of or attempt to commit a felony
- Caused or contributed to by your being engaged in an illegal occupation
- Caused or contributed to by an intentionally self-inflicted injury
- That results in the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless it is due solely to injury or sickness otherwise covered by the plan
- During which you are incarcerated in a penal or corrections institution

No benefits will be payable for the disability if you are receiving or are eligible for benefits for a disability under a prior disability plan that was sponsored by the company and was terminated before the effective date of the policy.

Pre-existing condition limitation

The plan will not pay a benefit or increase a benefit for any disability that results from or is contributed to by a pre-existing condition, unless at the time you become disabled you have been continuously covered by this plan for 12 consecutive months.

A pre-existing condition includes any of the following conditions for which you received medical care during the three consecutive months prior to your coverage under this plan:

- Any accidental bodily injury, sickness, mental illness, pregnancy, or episode of substance abuse
- Any manifestations, symptoms, findings, or aggravations related to or resulting from the above conditions

Filing a claim

You must report a disability claim to New York Life within 31 days of your disability, or as soon as reasonably possible. To report a disability claim do one of the following:

- Call New York Life toll-free at **888-842-4462** or **866-562-8421** (Español) between 7 a.m. and 7 p.m. Central time. A representative will walk you through the process.
- Fill out a claim form online at **myNYLGBS.com/customer-forms** using the following steps:
  - » Select the **Disability/Accident/Life/Critical Illness Forms**
  - » Click **Submit a Disability Claim**; this will bring you to the disclosure notice page
  - » Review and click **Continue** at the bottom of the page; a pop-up box will appear that says "Hit the continue button if you have read the above fraud language and wish to continue to file a claim"
  - » Click **Continue**
  - » Click **Submit a Disability Claim Online** to begin

New York Life may send forms to you to provide proof of loss. These forms must be returned within the following timeframes, or as soon as reasonably possible:

- For short-term disability, within 90 days of your loss
- For long-term disability, within 90 days of completing the **elimination period**

Proof of loss must be submitted within one year unless you are not legally competent. Please review **proof of loss** for more information.

New York Life may request additional information from you or your doctor certifying your total disability or continued total disability. New York Life may require that you be independently examined by a physician, other health professional or vocational expert of their choice and interviewed by an authorized New York Life representative (at New York Life's expense). New York Life may request proof of loss and/or independent examination throughout your disability, as often as reasonably necessary.

Payments

New York Life will make payments to you. New York Life has the right to recover any overpayments due to the following:

- Fraud
- Misstatement
- Any error New York Life makes in processing a claim
- Your receipt of **other income benefits**

New York Life may use any or all of the following to recover an overpayment:

- Request a lump sum payment of the overpaid amount
- Reduce any amounts payable under this policy
- Take any appropriate collection activity available

The minimum benefit amount will not apply when disability benefits are reduced in order to recover any overpayment. If an overpayment is due when you die, any benefits payable under the policy will be reduced to recover the overpayment. New York Life will not recover more money than the amount New York Life paid you.

If you provide New York Life with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive New York Life it is a crime. New York Life will use all means available to detect, investigate, deter and prosecute those who commit insurance fraud. New York Life will pursue all appropriate legal remedies in the event of insurance fraud.

Reimbursement or subrogation of third-party payments

If another party may be liable or legally responsible to replace lost income due to your disability, the plan may seek to recover or subrogate your benefits from that third party.

- The plan may request reimbursement for any benefit payments for which you recover payment from a third party.
- If you do not initiate legal action for the recovery of these benefits within a reasonable period of time, New York Life may subrogate – that is, take over – your right to receive payments from the other party. New York Life may bring legal action against the third party to recover any payments made in connection with the disability.

Denied claims and appeals

New York Life will notify you in writing if a claim or any part of a claim is denied. The denial letter will state:

- The specific reason(s) for the denial
- Specific reference to the policy provisions on which the denial is based
- A description of any additional information necessary to perfect a claim and an explanation of why it is necessary, and
- An explanation of the review procedure

If you are not satisfied with the reason(s) for the denial, you or your representative may ask to have the claim reviewed by New York Life. Your appeal must be in writing and must be sent to New York Life within 180 days of receipt of the claim denial if the claim requires New York Life to make a determination of disability, or within 60 day of receipt of the claim denial if the claim does not require New York Life to make a determination of disability.

New York Life will review your appeal and all new information submitted and notify you or your representative of its decision promptly. In some cases, New York Life may request that you provide additional information to assist in the review.

LIFE AND ACCIDENT INSURANCE

You have three plans that protect you and your family from the loss of income in the event of your death or injury:

- Life insurance pays benefits in the event of death
- Accidental death and dismemberment (AD&D) insurance pays benefits if you suffer injuries or die in a **covered accident**
- Business travel accident (BTA) insurance pays benefits in the event of injury while traveling for business

In the event of your death from a covered accident, your beneficiary will receive AD&D benefits in addition to life insurance benefits. If you should die or become injured on a covered **business trip**, BTA benefits will be paid in addition to AD&D and/or life insurance benefits.

All benefits under these plans are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations.

The following section is a summary of your benefits. You can find all the details — including a complete description of terms, conditions and limitations — in the New York Life booklets posted on **the companyBenIQ.com**. If there is a discrepancy between this document and the New York Life booklet, the New York Life booklet will govern.

How to enroll or change coverage

Enrolling in coverage

the company pays the full cost for basic life, AD&D and BTA insurance, and you are automatically enrolled if you are eligible. You may purchase supplemental employee and dependent life insurance.

You may be required to provide evidence of good health for supplemental life insurance coverage for yourself and your spouse or domestic partner, depending on the level and amount of insurance you select. Please review **evidence of good health (EOGH)** for more information.

Plan	Eligibility	Enrollment
Basic Life and AD&D insurance	Full-time and part-time **active employees**	Automatically enrolled as of your eligibility date
BTA insurance	Full-time active employees	Automatically enrolled as of your eligibility date
Supplemental and dependent life insurance	Full-time and part-time active employees	May be purchased when you first become eligible, during **open enrollment** or if you experience a qualified life event

You pay for the cost of supplemental and dependent life insurance through post-tax payroll deductions. You should verify that appropriate deductions are being taken from your pay a few weeks after you enroll. If deductions aren't being taken, please notify The company BenIQ Solution Center immediately. Your coverage may be jeopardized if deductions aren't being taken and your coverage is not considered paid by New York Life.

Changing your coverage

If you didn't enroll in supplemental or dependent life insurance when you were first eligible, you may apply to add or change this coverage during open enrollment or if you experience a qualified life event during the plan year. See the **How to Enroll** chapter for more information.

Note: You may be required to provide evidence of good health to New York Life if you make changes to your coverage. In addition to completing an evidence of good health form, you may be required to have a physical examination or to submit additional medical information. If you are requesting a reinstatement of previous coverage that has been terminated, you will need to provide evidence of good health to New York Life.

When coverage begins

Your basic life, AD&D and BTA insurance coverage will begin on the date you become an eligible employee.

Your effective date may be deferred if you are absent from work due to any of the following on the date your insurance, or increase in coverage, would otherwise have become effective. Your insurance or increase in coverage will not become effective until you return to **active service** one full day.

- Accidental bodily injury
- Sickness
- Mental illness
- Substance abuse
- Pregnancy

Employee life insurance

the company offers life insurance to all benefit eligible employees as described below through New York Life.

How the plan works

Life insurance pays a benefit to your beneficiary upon your death, provided you are covered under the plan when you die. Your coverage level is the amount that is paid to your beneficiary(ies) if you die.

When you become eligible, you are automatically enrolled for basic life insurance, which is 100% paid for by the company. The value of this coverage above $50,000 is considered taxable income to you.

Basic life insurance pays an amount based on your job type and **annual compensation**, up to the maximum coverage amounts in the table below. You may also purchase supplemental life insurance coverage with post-tax dollars at the levels listed below. **Evidence of good health (EOGH)** may be required before your coverage takes effect.

TYPE OF EMPLOYEE	COVERAGE LEVELS*	EVIDENCE OF GOOD HEALTH
Basic life insurance		
Executive (senior vice president or above)	4 times your annual compensation, up to $2.5 million	For coverage greater than $2 million
Field support center, distribution center and full-time store employees	2 times your annual compensation, up to $1 million	For coverage greater than $750,000
Supplemental life insurance		
All eligible employees	1 to 4 times your annual compensation, up to $1.2 million	• When you first enroll for coverage greater than $500,000 • For any increase in coverage after your initial enrollment period

* All coverage amounts are rounded to the next higher $1,000 if not already a multiple of $1,000. Supplemental life insurance payments will not be reduced by 33% if you are age 65 or older.

Evidence of good health

You may be required to provide evidence of good health when you enroll or request an increase in coverage amounts.

Complete the evidence of good health when you enroll online. New York Life will notify you when your application is approved and when your coverage becomes effective. If your evidence of good health is not approved or not submitted, your coverage will equal the amount for which you were eligible without evidence of good health.

Please review **evidence of good health (EOGH)** for more information.

Taxable life insurance

The IRS regulates the taxable value of life insurance coverage above $50,000. If you are enrolled for more than $50,000, the IRS taxable value will appear as taxable income on your annual W-2 form and will be reflected on your the company payroll check stubs as taxable benefits. How this impacts your federal income and Social Security taxes will depend on your age, tax situation, and the amount of life insurance over $50,000 you are enrolled in.

If you do not want basic life coverage of more than $50,000 you can opt to have your coverage capped at $50,000 at any time. To do so, log on to **the companyBenIQ.com**, or call The company BenIQ Solution Center at **877-737-2363** and select option 1 to talk with a BenIQ representative.

Annual compensation

Annual base compensation is defined as follows:

Employee type	Definition of annual base compensation
For salaried employees	Your regular annual rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day you were in active service.
For hourly employees	The average number of hours you worked per year, not including overtime, over the most recent one-year period immediately prior to the last day you were in active service, multiplied by your hourly wage in effect on the date immediately prior to the last day you were in active service.

Assignment of your life insurance rights

You may assign your life insurance to another person or entity (such as a trust), including any right you have to choose a beneficiary or to convert to another contract of insurance. If you wish to do this, you will need to alert New York Life of this assignment and the contract holder.

Active service provision

If you are ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until the date you return to **active service**. This rule also applies to any increases made to your coverage.

How the plan pays

Benefits are paid to your beneficiary upon your death from any cause, provided you are covered under the plan when you die. It is very important that you name a beneficiary and keep this information up to date throughout life changes (such as marriage or divorce). Payments for anything other than loss of life are made to you.

Be sure to designate a beneficiary on **the companyBenIQ.com** for your life insurance benefit. You are always the beneficiary for any dependent life insurance that you elect.

In the event of your death, benefits will be paid to your beneficiaries according to the following guidelines:

- Lump-sum for a benefit less than $5,000
- For benefits of $5,000 or more, a free interest-bearing account in the name of the beneficiary that is maintained with New York Life
- If there is no living named beneficiary or you do not name a beneficiary, New York Life will make payment at their option to:
  - Your surviving spouse/registered domestic partner
  - Your surviving child (children) in equal shares
  - Your surviving parents in equal shares
  - Your surviving siblings in equal shares, or
  - Your estate

Upon receipt of proof of loss, New York Life will make payment within 30 days. Please see the **Filing a claim** section for more information.

Reductions for basic life insurance

Basic life insurance payments for the employee will be reduced by 33% if you are age 65 or older. Age-related benefit reductions apply the first day of the month coinciding with or following your 65th birthday. Supplemental life insurance payments will not be reduced by 33% if you are age 65 or older.

Terminal illness benefit

If you are diagnosed with a terminal illness while covered by The company life insurance plans and are under 60, you may apply to cash out up to 80% of your life insurance coverage to a maximum of $500,000. This benefit is available only once. For this purpose, a terminal illness means that, due to an injury or sickness, the insured individual has a life expectancy of 12 months or less, without reasonable prospect of recovery.

To apply for this benefit, contact New York Life at **800-362-4462**. You may be required to submit proof of terminal illness on an ongoing basis that is satisfactory to New York Life. Any diagnosis submitted must be provided by a **physician**.

If you do not submit proof of terminal illness that is satisfactory to New York Life or if you refuse to be examined by a physician, as New York Life may require, a terminal illness benefit will not be paid.

Dependent life insurance

the company offers dependent life insurance to all eligible employees as described below through New York Life. Certain levels of life insurance coverage for your spouse or domestic partner may require evidence of good health before coverage takes effect.

The coverage level for your dependents is the amount that is paid to you if your dependent dies.

How the plan works

You may purchase dependent life insurance for your eligible dependents, including your spouse or domestic partner and children. The plan pays a benefit to you if a dependent dies while covered by the plan. You can only elect dependent life insurance if you are also electing supplemental life insurance for yourself.

If you and your spouse or domestic partner are both the company employees, you cannot have both life insurance as an employee and also be covered by dependent life insurance through your spouse or domestic partner. In addition, no person may be covered as a dependent of more than one employee.

Note: If a dependent is confined for medical care or treatment, new or increased dependent life insurance coverage will be delayed until he or she is discharged or is no longer confined. This limitation does not apply to your dependent child who is age 6 months or less.

Spouse or domestic partner

You may purchase life insurance for your spouse or domestic partner at $50,000, $100,000 or $150,000 coverage levels. However, spouse or domestic partner coverage can never exceed the combined basic and supplemental life insurance amount in force for yourself.

You may be required to provide evidence of good health when you elect coverage over $50,000 for your spouse/domestic partner or increase coverage any time after your initial enrollment period. Complete the evidence of good health when you enroll online. New York Life will notify you when your application is approved and when your dependent's coverage becomes effective.

If your evidence of good health is not approved or not submitted, coverage will equal the amount for which your spouse/domestic partner was eligible without evidence of good health. Please review **evidence of good health (EOGH)** for more information.

Children

You may purchase life insurance coverage for your children (live birth up to age 26) at $5,000 or $10,000 coverage levels. If your dependent child becomes disabled before reaching age 26 and is primarily dependent upon you for financial support, coverage may be extended beyond age 26. You must submit proof of disability within 31 days of their 26th birthday.

Evidence of good health is not required for child dependent life insurance coverage.

Assignment of your life insurance rights

You may assign your dependent life insurance to another person or entity (such as a trust), including any right you have to choose a beneficiary or to convert to another contract of insurance. If you wish to do this, you will need to alert New York Life of this assignment and the contract holder.

How the plan pays

Benefits are paid to you if your covered dependent dies. Upon receipt of proof of loss, New York Life will make payment within 30 days. Please see the **Filing a claim** section for more information.

Terminal illness benefit

If your spouse or domestic partner is diagnosed with a terminal illness while covered by The company life insurance plan, you may apply to cash out up to 80% of their life insurance coverage. This benefit is available only once for your spouse or domestic partner. For this purpose, a terminal illness means that, due to an injury or sickness, the insured individual has a life expectancy of 12 months or less, without reasonable prospect of recovery.

To apply for this benefit, contact New York Life at **800-362-4462**. You may be required to submit proof of terminal illness on an ongoing basis that is satisfactory to New York Life. Any diagnosis submitted must be provided by a **physician**.

If you do not submit proof of terminal illness that is satisfactory to New York Life or if you refuse to be examined by a physician, as New York Life may require, a terminal illness benefit will not be paid.

Accidental death and dismemberment (AD&D) insurance

the company offers AD&D insurance to all benefit eligible employees through New York Life. AD&D coverage does not require **evidence of good health (EOGH)**. You are automatically enrolled and covered under the AD&D insurance on your eligibility date and the company pays 100% of the cost of this coverage.

How the plan works

AD&D insurance pays a benefit equal to your basic life insurance coverage level if you die in a **covered accident**. The plan pays a percentage of your basic life insurance coverage if you suffer certain injuries, as shown in the table on the following page. If your basic life insurance coverage is reduced because you are age 65 or older, your AD&D benefits will reflect this reduction.

The accident must occur while you are covered by this plan, and the related death or injury must occur within 365 days of the accident and while coverage is still in force. The maximum amount payable for any or all losses due to the same accident is the principal sum. Upon receipt of proof of loss, New York Life will make payment within 30 days. Please see the **Filing a claim** section for more information.

Be sure to designate a beneficiary on **the companyBenIQ.com** for your AD&D insurance benefit. Your beneficiary will receive the benefit payment in the event of your death. You will receive the benefit payment for all other losses.

Type of loss	**Benefit** (percent of basic life insurance coverage)
• Life • Both hands • Both feet • Sight of both eyes • One hand and one foot • Speech and hearing • Either hand or foot and sight of one eye • Movement of both upper and lower limbs (quadriplegia)	100%
• Movement of both lower limbs (paraplegia) • Movement of three limbs (triplegia)	75%
• Movement of the upper and lower limbs of one side of the body (hemiplegia) • Movement of one limb (uniplegia) • Either hand or foot • Sight of one eye • Speech or hearing in both ears	50%
• Four fingers on the same hand • Thumb and index finger on the same hand • All toes on the same foot	25%

A loss is defined as follows:

- Hands and feet, actual severance through or above wrist or ankle joints
- Sight, speech and hearing, entire and irrecoverable loss thereof
- Thumb and index finger, actual severance through or above the metacarpophalangeal joints
- Movement, complete and irreversible paralysis of such limbs

Additional AD&D benefits

Unless stated otherwise, additional benefits are payable to the same beneficiaries who receive the AD&D benefits, and are paid in addition to any AD&D benefits.

ELIGIBILITY	WHAT THE PLAN PAYS	LIMITATIONS
Seat belt benefit		
If your covered loss occurs while you are a passenger or licensed operator of a motor vehicle and you are wearing a **seat belt** during the **covered accident**, as verified on the police accident report.	10% of the principal amount up to $25,000 A minimum benefit will be paid if it cannot be determined that the covered person was wearing a seat belt at the time of accident	The vehicle must be a properly registered motor vehicle that is not being used as a **common carrier**. The **insured person** must not be **intoxicated** or taking drugs (unless administered under the advice of a **physician**).
Air bag benefit		
If you receive a seat belt benefit and a factory-installed **air bag** inflates.	5% of the principal amount up to $5,000	The vehicle must be a properly registered motor vehicle, driven by licensed operator who is not intoxicated or taking drugs.
Travel assistance services		
Travel services resulting from a covered medical emergency occurring unexpectedly, while traveling 100 or more miles from your home or out of the country.	Covered services may include: • Emergency medical evacuation • Return transportation • Immediate family member visit • Repatriation of remains	All services must be coordinated through and authorized by New York Life and/or their authorized representative.

Business travel accident (BTA) insurance

the company offers Business Travel Accident (BTA) insurance to active, full-time employees through New York Life. BTA coverage does not require **evidence of good health (EOGH)**. When you become eligible, you are automatically enrolled for BTA insurance, which is 100% paid for by the company.

What the plan covers

BTA insurance provides income protection in the event you are injured or die while traveling on a the company **business trip**. In certain cases, your spouse/domestic partner and dependent children are also covered, if they are traveling with you.

BTA coverage begins upon the actual start of a trip – whether at your home, place of work or elsewhere. This coverage will end when you arrive at your home or place of work, whichever happens first, or when you make a personal deviation, such as a personal trip or vacation, that exceeds seven days.

The plan will make a payment in the event of **injury** or death due to any of the following circumstances, anywhere in the world.

Circumstance	Coverage
Business trip	You, your spouse/domestic partner and children are covered while traveling on a business trip for the company, including an injury resulting from an accident while a passenger on a **civil aircraft** or **military transport aircraft** (including boarding and disembarking). Travel is not covered on a the company aircraft or an aircraft engaged in **extra-hazardous aviation activity**. This coverage also includes travel assistance services, which provides coverage for medical necessary services, emergency medical evacuation, return transportation and more.
Personal deviation from business trip	You are covered if you deviate from business travel for personal reasons of seven days or less from a business trip. Please see **personal deviation from a business trip**.
Alternative commuting	You are covered while commuting to work if you must use a different method of commuting than you normally do because of a strike, power failure, major breakdown or other similar event.
Hijacking and air piracy	If you are hijacked while traveling on business for the company, you are covered until you reach your residence or original destination. Please see **hijacking**.
Felonious assault and violent crime	You are covered if you suffer an injury during the course of business from a **felonious assault** or violent crime, such as a robbery, hold-up, kidnapping or criminal assault that is not inflicted by a family member or fellow employee.
Bomb scare, search or explosion	You are covered if a bomb scare, search or explosion occurs on the company premises. You are not covered if you accept known explosives as cargo. See the definition of **bomb** for more information.
Relocation	You, your spouse/domestic partner and children are covered while on a **relocation trip**. You are covered from when you leave your former place of residence until you begin your first full day of employment in your new location. You are not covered for any period of time in excess of 10 days from the start of the relocation trip.

Assignment of your BTA insurance rights

You may assign your BTA insurance to another person or entity (such as a trust), including any right you have to choose a beneficiary. If you wish to do this, you will need to alert New York Life of this assignment and the contract holder.

How the plan pays

Benefits will be paid to the employee or to the employee's beneficiary in the event of the employee's death. If no beneficiary has been designated, benefits will be paid to any survivors in the first of the following (in equal shares, if applicable):

- Spouse/domestic partner
- Children
- Parents
- Brothers and sisters

If there is no survivor, payment will be made to the employee's estate.

Payments will be made as soon as possible except for periodic payments, which will be paid on a monthly basis.

The plan pays BTA benefits for injuries or death within 365 days of a covered event, up to the following amounts. These amounts are reduced when the employee or spouse/domestic partner is age 70 or older.

Covered person	Coverage available (principal amount)
You	Up to 4 times salary to maximum of $2 million
Your spouse/domestic partner or child	$50,000 for your spouse/domestic partner $25,000 for each child

The actual amount paid will depend on the loss, as shown on the table below.

For the loss of:	The plan pays:
• Life • Both hands • Both feet • One hand and one foot • Sight of both eyes • Speech and hearing • Either hand or foot and sight of one eye • Movement of both upper and lower limbs (quadriplegia)	100% of the principal amount: • For employee: 4 times salary, up to a maximum of $2 million • For spouse/domestic partner: $50,000 • For each child: $25,000
• Movement of both lower limbs (paraplegia)	75% of the principal amount
• Movement of both upper and lower limbs on one side of body (hemiplegia) • One hand • One foot • Sight of one eye • Speech or hearing • Severance and reattachment of one hand or one foot	50% of the principal amount
• Movement of either upper or lower limbs on one side of body (uniplegia) • Thumb and index finger of either hand • All four fingers on same hand	25% of the principal amount
• All four toes on same foot	20% of the principal amount

Loss means:

- For hands and feet, actual severance through or above wrist or ankle joints
- For sight, speech or hearing, entire and irrecoverable loss
- For thumb and index finger, actual severance through or above the metacarpophalangeal joints
- For movement of limbs, complete and irreversible paralysis

Exposure

Exposure to the elements will be presumed to be an injury if it results from the forced landing, stranding, sinking or wrecking of a conveyance in which an insured person was an occupant at the time of the accident, and the plan would have covered an injury from the accident.

Disappearance

An insured person will be presumed to have suffered loss of life if all of the following requirements are met:

- His or her body has not been found within one year of disappearance
- The disappearance was due to an accidental forced landing, stranding, sinking or wrecking of the insured person's conveyance
- The plan would have covered an injury from the accident

Reduction of benefits on or after age 70

When you reach the following ages, the principal sum payable under the BTA benefit is reduced.

Employee's age	Percentage of principal sum
70 to 74	65%
75 to 79	45%
80 to 84	30%
85 or older	15%

Additional BTA benefits

If your **injury** or death results from a covered loss under the BTA benefit, you may be eligible for the following additional benefits. All benefits are subject to the exclusions and limitations of this plan.

ELIGIBILITY	WHO IS COVERED	WHAT THE PLAN PAYS	LIMITATIONS
Seat belt benefit			
If your covered loss occurs while you are a passenger or licensed operator of a motor vehicle and you are wearing a **seat belt** during the **covered accident**, as verified on the police accident report.	Employee Spouse/domestic partner Child(ren)	10% of the principal amount up to $25,000	The vehicle must be a properly registered motor vehicle that is not being used as a **common carrier**. The **insured person** must not be **intoxicated** or taking drugs (unless administered under the advice of a **physician**).
Air bag benefit			
If you receive a seat belt benefit and a factory-installed **air bag** inflates.	Employee Spouse/domestic partner Child(ren)	10% of the principal amount up to $25,000	The vehicle must be a properly registered motor vehicle, driven by licensed operator who is not intoxicated or taking drugs.
Rehabilitation benefit			
If you need rehabilitative services to assist in your physical recovery from a covered loss.	Employee Spouse/domestic partner Child(ren)	10% of the principal amount up to $25,000	Covered services must be for medical services, supplies or treatment that is essential for physical rehabilitation and to prepare an individual to return to his or her occupation.
Home alteration and vehicle modification benefit			
If you need to make one-time alterations to your principal residence and/or private car.	Employee Spouse/domestic partner Child(ren)	10% of the principal amount up to $25,000	The alterations must: • Make the residence or car more accessible to the insured person, as recommended by a recognized organization associated with the loss for a residence or as approved by the Motor Vehicle Department for car alterations • Be made within one year from the date of the accident • Be made by a person or persons with experience in such alterations

ELIGIBILITY	WHO IS COVERED	WHAT THE PLAN PAYS	LIMITATIONS
Coma benefit			
If as the result of the covered loss, you become comatose.	Employee Spouse/domestic partner Child(ren)	After 30 days, 1% of the principal amount for each month that the insured person remains in a **coma**, for up to 11 months.	The insured person must become comatose within 30 days of the accident and remain comatose for at least 60 consecutive days and must be diagnosed and treated regularly by a **physician**.
Bereavement and trauma counseling benefit			
If you require **bereavement and trauma counseling** as a result of the covered loss.	Employee and immediate family members, including spouse/domestic partner, child(ren), parents and siblings	Up to $100 per visit with a maximum of 5 visits or $500 per covered person per accident	Counseling must be: • Provided by a licensed therapist, counselor or psychiatrist registered or certified to provide psychological treatment or counseling • Incurred within one year from the date of loss

Exclusions and limitations

The plan does not pay basic life or AD&D insurance benefits for any loss caused or contributed to by any of the following:

- Intentionally self-inflicted injury
- Suicide or attempted suicide, whether sane or insane
- War or act of war, whether declared or not
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority
- Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a **physician**
- Injury sustained while committing or attempting to commit a felony
- Injury sustained while **intoxicated**
- Flight in, boarding or alighting from an aircraft, except as a **passenger** on a regularly scheduled commercial airline

If you or your dependent commits suicide, the plan will not make payments for supplemental life insurance in the first two years the coverage is in effect. This applies to initial coverage and elected increases in coverage. It does not apply to benefit increases that resulted solely due to an increase in earnings. Any premium paid by you during this two-year period for initial coverage or increases in coverage will be returned to your beneficiary.

The plan does not pay any basic AD&D insurance benefits for any loss caused or contributed to by any sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.

The plan does not pay BTA benefits for any loss resulting from:

- Intentionally self-inflicted injury
- War or act of war, whether declared or not
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority
- Injury sustained while on any aircraft, except as a fare-paying passenger on a regularly scheduled commercial or charter airline, and unless and only to the extent the plan specifically describes such coverage
- Injury sustained while committing or attempting to commit a felony
- Injury sustained while intoxicated

Aggregate limitation for BTA

The maximum amount that the BTA plan will pay for all benefits payable under this policy because of injury sustained due to any one accident is $10 million.

This aggregate amount will be proportionately reduced such that the total will equal the $10 million limit if both of the following occur:

- Two or more persons, in the same or different classes, are injured as the result of any one **covered accident**
- The total of all amounts payable for all persons, in the absence of this provision, exceeds $10 million

Filing a claim

You, or the person who has the right to claim benefits, must provide written notice of a claim within 31 days of the date of death or injury, or as soon as reasonably possible if notice cannot be given within that time. The notice must include the claimant's name, address, and the policy number. You can report a claim by fax, email, over the phone or by mail.

- Fax documents to **877-300-6770**
- Email scanned documents to **claims.pghlif2@myNYLGBS.com**
- Call toll-free **800-362-4462** between 7 a.m. and 7 p.m. Central time. A representative will walk you through the process.
- Mail documents to:
  New York Life
  P.O. Box 22328
  Pittsburgh, PA 15222-0328

Fill out a claim form online at **myNYLGBS.com/customer-forms** using the following steps:

- Select the **Disability/Accident/Life/Critical Illness Forms**
- Click **Submit a Life and Accidental Death & Dismemberment Claim**; this will bring you to the disclosure notice page
- Review and click **Continue** at the bottom of the page; a pop-up box will appear that says "Hit the continue button if you have read the above fraud language and wish to continue to file a claim"
- Click **Continue**
- Click **Submit a Life, Accidental Death and Dismemberment or Waiver Claim Online** to begin your claim

A completed claim form is needed to substantiate a proof of loss and must be returned to New York Life within 90 days of the date of loss, or as soon as reasonably possible. For periodic payments under the BTA plan, proof of loss must be returned within 90 days of the end of the period of New York Life's liability. Please review **proof of loss** for more information. For additional information, or to file a claim, contact New York Life at **800-362-4462**.

Claim review

After the completed claim form is received, New York Life will review your claim and notify you of approval or denial.

New York Life may, at their expense, request an examination for any person for whom a claim is pending or an autopsy in case of death (where it is not forbidden by law).

New York Life has the right to review and deny the claim if you fail to disclose important information about your health as described in **evidence of good health** or if payment of the claim is forbidden by law.

Claim denials and appeals

If a claim for benefits is wholly or partly denied, you or your beneficiary will be furnished with written notification of the decision. This written decision will include the following information:

- The specific reason or reasons for denial
- Specific reference to policy provisions on which the denial is based
- A description of any additional information necessary to prepare the claim and an explanation of why it is necessary
- An explanation of the review procedure

On any claim, the claimant or his or her representative may appeal to New York Life for a full and fair review. To do so, he or she must request a review upon written application within:

- 180 days of receiving a denial for claim that involves a determination of disability
- 60 days of receiving a denial for a claim that does not involve a determination of disability

The appeal may include a request for copies of all documents, records, and other information relevant to the claim. In addition, the appeal may submit written comments, documents, records and other information relating to the claim.

New York Life will respond in writing with their final decision on the claim within 60 days. In special circumstances, such as the need to hold a hearing, the final decision may be delayed no more than 120 days.

Limitation of action

You cannot take legal action against New York Life:

- Sooner than 60 days after the date written proof of loss is furnished
- After the date proof of loss is required to be furnished according to the terms of the plan:
  - For life and AD&D benefits, after three years
  - For BTA benefits, after three years (six years for residents of South Carolina)

Except for non-payment of premiums, your life insurance benefit cannot be contested after two years from its effective date. In the absence of fraud, no statement made by you relating to your **insurability requirement** will be used to contest your insurance for which the statement was made after your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by you.

There are state-specific requirements that may change the provisions for this plan. If you live in a state that has such requirements, those requirements will apply to your coverage. For more information, call The company BenIQ Solution Center at **877-737-2363** and select option 1 to talk with a BenIQ representative.

WELL-BEING

the company offers several resources to help you live a balanced life. This section provides information on programs offered to employees at no cost – Headspace, a confidential emotional support app, certain Wellness Program services like onsite flu shots available to eligible distribution center and field support center employees, and our Employee Assistance Program (EAP), which provides counseling, financial planning resources, legal support and more.

Headspace

Headspace offers guided meditations, sleep exercises, mindful workouts and daily inspiration to help with:

- Burnout
- Stress
- Anger
- Sleep
- Mindful parenting
- And much more

Visit **work.headspace.com/company/member-enroll** to get started.

Headspace Care

Headspace Care offers one-on-one support and coaching. Headspace Care can also coordinate with your medical plan for video-based therapy (costs may apply).

Download the Headspace Care app, then tap "Get Started" to verify your identity.

Wellness Program

the company encourages healthy and balanced living and offers distribution center and field support center employees access to certain Wellness Program services and activities at no cost, such as onsite flu shots and health fairs. Please contact your local HR department for more information.

Cigna Employee Assistance Program (U.S. Mainland and Hawaii)

In the United States, Our Employee Assistance Program (EAP) is provided through Cigna. This EAP can help you find after-school childcare, financial planning resources, confidential counseling and much more.

All employees and their family members are eligible for unlimited telephonic consultation at no cost.

To use the program or to learn more, call Cigna 24/7 at **877-622-4327** or visit **mycigna.com** (enter employer ID: **the company**, for initial registration).

Phone lines are staffed 24 hours a day, seven days a week. If you are calling in a crisis situation, you will be able to speak to a counselor immediately. If you are calling for non-emergency counseling, a licensed professional employee assistance consultant will listen to your concerns, get you the information you need and guide you toward the right solution.

EAP information, educational materials and self-help strategies are also available at **mycigna.com** (employer ID: **the company**).

Confidentiality

The EAP is a confidential program. When you call the EAP, your contact with the program will not be revealed to anyone – including the company – without your permission, except as required by law.

What the plan covers

Confidential counseling

Licensed EAP clinicians will listen to your concerns, get you the information you need and guide you toward the right solution on subjects like:

- Stress, anxiety and depression
- Job pressures
- Relationship/marital conflicts
- Grief and loss
- Parenting issues
- Substance abuse

Work-Life solutions

Work-Life specialists will do the research for you, providing referrals and customized resources for:

- Child and elder care
- College planning
- Moving and relocation
- Pet care
- Making major purchases
- Home repairs

Financial information and resources

Speak by phone with a Certified Public Accountant or Certified Financial Planner on a wide range of financial issues, including:

- Getting out of debt
- Retirement planning
- Credit card or loan problems
- Estate planning
- Tax questions
- Saving for college

Legal support and resources

Talk to an attorney by phone. If you require representation, we'll refer you to a qualified network attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Real estate transactions
- Debt and bankruptcy
- Civil and criminal actions
- Landlord/tenant issues
- Contracts
- Health and well-being resources

Online resources

Access to free online resources including:

- Monthly wellness seminars on topics that apply to real-life concerns. Watch live or on-demand from a computer, smartphone or tablet at **cigna.com/EAPWebCasts**.
- Monthly behavioral health awareness seminars on topics such as autism, eating disorders, substance use, children's behavioral health issues and more.
- Healthy Rewards discount program for savings on many health and wellness products and services.

Inspira Employee Assistance Program (Puerto Rico only)

In Puerto Rico, Our Employee Assistance Program (EAP) is provided through Inspira. This EAP offers a full range of assistance to employees and family members, at no cost.

Services include:

- Short-term counseling
- Crisis intervention and referral
- Educational and prevention activities (e.g. stress management, drug and alcohol abuse, anger management)
- Legal and financial orientation services

To get support or more information, call **800-284-9515** or **787-651-2384**, 24 hours a day, 7 days a week, or go to **inspirapr.com**.

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts (FSAs) are available to benefit-eligible employees in the United States. They can help you reduce your tax bill by letting you set aside before-tax dollars to pay for eligible health care and day care expenses. You don't pay federal income tax or Social Security and Medicare taxes on your contributions, and your reimbursements are also tax-free.

Optum Financial administers our flexible spending accounts.

Account type	Eligibility	Expenses covered	Contributions
Health care FSA	For employees who don't have a Health Savings Account	Out-of-pocket medical, prescription, dental, vision expenses	From $250 to $3,200
Day care FSA	For employees with eligible day care expenses	Child and elder care expenses	From $250 to $5,000 ($2,500 if married and filing separate tax returns)

Note: If you leave the company during the year, your participation in the FSAs will end. However, you can extend your health care FSA coverage through COBRA coverage. For more information, see the **If you leave the company** chapter.

How to enroll or change coverage

When you enroll

You must decide how much you would like to contribute to your FSA for the year, up to the maximum amount. Tools and tips for saving are available at optumfinancial.com.

You must re-enroll during the **open enrollment** period each year if you want to continue participating in the next calendar year.

The amount you elect will be deducted on a prorated basis each pay period throughout the year to fund your account. The following health care and day care FSA sections provide additional information about contributions.

Plan carefully! You cannot change your election amount during the calendar year unless you have a qualified family status change. In addition, money left over in an FSA at the end of each year may be forfeited by federal law.

- For the health care FSA, up to $640 will roll over to use the following year, as long as you participate in the health care FSA again
- Rollovers are not allowed for the day care FSA and any unused funds will be forfeited

Making changes

The annual open enrollment period is your only opportunity to make changes to your FSA elections unless you have a **qualified life event**.

Changes to your election due to a qualifying life event will be effective as of the date requested, except for changes to health care FSA contributions resulting from a birth, adoption, or placement for adoption. If you increase your contribution, you may not be reimbursed for **eligible expenses** beyond your prior contribution if they occurred before the change.

If you're on a leave of absence

Participation in the health care and day care FSA is suspended while on a leave of absence. If you wish to use the balance of your health care FSA while on leave, you must arrange to make after-tax contributions during your leave. The day care FSA can not be continued while on leave, as it is an IRS requirement that both spouses be working or full-time students to participate.

When you return to work in the same plan year, your participation and contributions to the health care and day care FSA will resume.

If you are on leave for the entire annual open enrollment period, you will receive information in the mail about how to enroll and continue FSA participation.

Eligible expenses

To be eligible for reimbursement, expenses must meet IRS criteria and be incurred during the same period of time in which amounts are credited to your FSA. Services and expenses incurred prior to your enrollment date are not eligible for reimbursement.

- If your contributions begin after January 1 (for example, if you are a new hire), expenses incurred on or after your enrollment date are eligible for reimbursement
- If your contributions end before December 31 (for example, due to termination of employment), expenses incurred after your last day of participation will not be eligible for reimbursement
- Otherwise, your expenses must be incurred from January 1 to December 31

Health care FSA

You may use your health care FSA to cover eligible out-of-pocket health care expenses for yourself and your dependents. You and your dependents do not need to be enrolled in a the company medical plan.

You may be reimbursed for eligible health care expenses up to the total amount you have elected to contribute for the year, regardless of the amount contributed to the account to date.

Expenses must meet the eligibility criteria defined under the Internal Revenue code. For a complete list of eligible expenses, visit **optumfinancial.com** or refer to IRS Publication 502. You may not use the health care FSA to cover premiums for health insurance. Expenses paid through your health care FSA cannot also be deducted on your tax return.

Day care FSA

Your day care expenses are eligible for reimbursement from your day care FSA if you and your spouse/domestic partner both work.

You may be reimbursed for eligible day care expenses for the following dependents:

- Your children age 12 and under that you claim as dependents for income tax purposes
- Older dependents, such as parents, who normally spend at least eight hours in your home each day, who are unable to care for themselves because of a disability, and whom you claim as dependents for income tax purposes

You may be reimbursed for eligible day care expenses up to the total amount you have contributed to the account to date.

Expenses must meet the eligibility criteria defined under the Internal Revenue code. For a complete list of eligible child and dependent care expenses, visit **optumfinancial.com** or refer to IRS Publication 503 and Form 2441 Instructions "Child and Dependent Care Expenses."

Note: Expenses reimbursed from your day care FSA cannot be used for the child and dependent care tax credit on your personal income tax return at the end of the year. You should seek the opinion of a tax advisor regarding your personal financial situation.

Using your FSAs

You can check your FSA balance or request reimbursement by logging in to your account at optumfinancial.com. You can also download the Optum Financial Mobile app to manage your account, submit claims and more. Search the Apple App Store or Google Play. Optum Financial representatives are available at **877-292-4040**.

Optum Financial makes it easy to use your FSA. You'll receive a debit card from Optum Financial so that you can pay for eligible health care expenses with funds directly from your health care FSA. You can also pay for health or day care expenses with your own funds, and then submit a claim for reimbursement on the Optum Financial website.

Note: You have 90 days following the end of the calendar year to submit claims for reimbursement of expenses that were incurred the previous calendar year. Claims that are submitted more than 90 days after the end of the calendar year are not eligible for reimbursement and any funds left in the account will be forfeited.

- For the health care FSA, up to $640 will roll over to use the following year, as long as you participate in the health care FSA the following year. Any remaining funds above $640 following 90 days after the end of the calendar year will be forfeited.
- Rollovers are not allowed for the day care FSA and any remaining funds in your day care FSA following 90 days after the end of the calendar year will be forfeited, as required by IRS rules.

Health Care Account Visa debit card

Avoid submitting a claim and get immediate reimbursement by using the Health Care Account Visa debit card. The card is used as a debit card on the worldwide VISA® network and is used at the point of service and/or sale to make payment. A PIN number is not required, however funds are limited, just like a bank debit card.

You may use your debit card:

- At your doctor's office to make a copayment
- At a store to buy a health-related item
- At your pharmacy to fill a prescription

Note: You may not use the debit card to purchase over-the-counter (OTC) medicines. Prescriptions are now required for OTC medications to be eligible for reimbursement. You will need to pay for the OTC medicine and then submit your prescription along with your claim form and receipt for reimbursement.

Claim reimbursements

To submit your claim:

- **Mobile:** Choose **upload claim documentation** from the app's main screen. You'll be prompted to take a photo of your documentation so that you can upload the image to your claim.
- **Online:** Log in to optumfinancial.com. After logging in, hover over **payments and reimbursements** and click on **create a new reimbursement**.
- **Fax:** Print a reimbursement form from the online portal, and fax the form along with your documentation to the number on the form. If you don't submit documentation, Optum Financial will mail you the form.

Receipts must accompany the claim form. Originals or copies of the receipts are acceptable, but be sure to keep copies for yourself. Credit card receipts, cancelled checks or balance forward statements are not accepted by the IRS.

Reimbursements are issued as either a check mailed to your home or, if you have direct deposit, an electronic funds transfer to your bank account.

IF YOU LEAVE THE COMPANY

Your eligibility for the company benefits ends when your employment at the company ends or when you no longer meet the eligibility requirements. Eligibility for your dependents ends when your eligibility ends, or earlier if your dependent no longer meets the requirements.

The following sections review when coverage ends and your options for continuing coverage, where available.

Health and FSA benefits

Your entitlement to benefits ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. the company will still pay for claims incurred before your coverage ended.

For employees

Health benefits

Your health benefit coverage ends when any one of the following occurs:

- The date the plan is terminated
- The last day of the month in which you no longer qualify as an eligible employee or in which you terminate employment
- The last day of the month in which you fail to make a required contribution
- The date of your death
- The first day following the maximum length of an applicable leave of absence, should you not return to work

Note: Under the Affordable Care Act you are required to have medical coverage. Please note some states also may require you to have medical coverage or pay a penalty. You may elect to purchase your medical coverage through your state's Marketplace or through COBRA, or through another employer-sponsored plan, for example.

You may be eligible to continue participation in your health and health care FSA benefits after you leave the company. See **Continuation of coverage for health and health care FSA benefits (COBRA)** for more information.

FSA benefits

Flexible spending account (FSA) coverage ends on the earliest of:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee
- The last date you made contributions
- The date of your death

Your final pre-tax contribution will be taken from your final paycheck (on your last day of work).

- For the health care FSA, you have 90 days from your last day to submit claims for expenses incurred before your last day.
- For the day care FSA, you have 90 days from the end of the **plan year** to submit claims for expenses incurred before your last day.

For dependents

Coverage for dependents will end on the earliest of the following dates:

- The date your coverage ends
- The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
  - Divorce or legal separation
  - The dissolution of a domestic partnership
  - The date a child no longer meets the age requirement for dependent status
  - The date your dependent becomes covered as an employee
  - The date coverage for all dependents under the plan is canceled
- The date the plan is terminated

Extension of medical coverage for disability

If you or your covered dependent are enrolled in a medical plan and have a **total disability** on the date coverage would otherwise end, coverage will be extended temporarily for treatment of the disability. Benefits will be paid until the earlier of the following:

- The date the total disability ends
- 12 months from the date coverage would have ended

Continuation of coverage for health and health care FSA benefits (COBRA)

Under a federal law called the **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**, the company employees and/or their dependents may be eligible to continue health plan coverage (called "COBRA coverage") at group rates. Health plan coverage available under COBRA includes the medical, dental, vision and health care flexible spending account (health care FSA) plans.

COBRA coverage is available in certain instances, called "qualifying events," where coverage under the plan would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the plan ends. COBRA coverage will allow you to access any unused health care FSA balance up through the end of the plan year, or until you stop remitting premiums, whichever occurs first. You cannot re-enroll for the health care FSA through COBRA.

The coverage described may change as permitted or required by changes in any applicable law.

A COBRA notice will be mailed to your home address on record a few weeks following the date your termination is recorded. You have 60 days to elect COBRA coverage, and 45 days to remit your initial premium.

Payments may be made online at **the companyBenIQ.com**. Checks are made payable to the company and mailed to the COBRA administrator, Businessolver, at the following address:

Businessolver, Inc.
Attn: COBRA Premium Payments
P.O. Box 310512
Des Moines, IA 50331-0512
877-547-6257

Once the COBRA administrator receives your premium, your coverage will go into effect retroactive to the date you lost coverage on the active plan. Ongoing, you must remit your premiums in a timely manner to continue your COBRA coverage. You must contact the COBRA administrator with any changes in your address.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers and HMOs offering benefits under the plan. For more information, contact the COBRA administrator listed under **claims administrators and funding information.**

You do not have to show that you are insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described on the following page. the company reserves the right to terminate your coverage retroactively if it's determined that you are ineligible under the terms of the plan.

Cost of COBRA coverage

You will be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you will be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level, or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of 30 days.

Contacting the COBRA administrator

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator listed under **claims administrators and funding information**.

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at **dol.gov/ebsa**.

Obligation to notify the COBRA administrator

You must notify the COBRA administrator in writing immediately if:

- Your marital status has changed
- You, your spouse or a dependent has changed addresses
- A dependent loses eligibility for dependent coverage under the terms of the plan

All notices and other communications regarding COBRA coverage and your health plans should be directed to the COBRA administrator.

Who is eligible for COBRA

If you are covered by the plan on the day before a qualifying event, you have the right to choose COBRA coverage if you lose coverage under the terms of the plan because of a reduction in your hours of employment or the termination of your employment (unless you are terminated because of your gross misconduct).

If you are enrolled in the plan and do not return to work following a leave of absence qualifying under the Family and Medical Leave Act (FMLA), the event that will trigger COBRA coverage is the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period, whichever is earlier.

If you are the spouse of an employee and you are covered by the plan on the day before the qualifying event, you are considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the terms of the plan for any of the following reasons:

- Your spouse dies
- Your spouse's employment is terminated (for reasons other than gross misconduct) or your spouse's hours of employment are reduced
- You divorce or legally separate from your spouse (this includes a divorce or legal separation that occurs after the employee drops you from coverage, if the employee acted in anticipation of the divorce or legal separation)
- Your spouse becomes entitled to Medicare (Part A, Part B, or both)

If you are a child of an employee and you are covered under the plan on the day before the qualifying event, you are also considered a qualified beneficiary. This means you have the right to COBRA coverage if you lose coverage under the terms of the plan for any of the following reasons:

- The employee dies
- The employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced
- The employee becomes entitled to Medicare (Part A, Part B, or both)
- You cease to be an "eligible child" under the plan

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of COBRA coverage, the new child is a qualified beneficiary. In accordance with the terms of the plan and the requirements of federal law, these qualified beneficiaries

can be added to COBRA coverage by providing a written notice to the COBRA administrator of the new child's birth, adoption or placement for adoption at the address listed under **claims administrators and funding information**. This written notice should include information about the new child who will be receiving COBRA coverage. The COBRA administrator may ask for documentation supporting the birth, adoption, or placement for adoption of the new child.

If a qualified beneficiary fails to notify the COBRA administrator about a new child within 30 days of the birth, adoption or placement for adoption, COBRA coverage cannot be elected for the new child. Newly acquired eligible dependents (such as a spouse) won't be considered qualified beneficiaries, but may be added as dependents. Notify the COBRA administrator within 30 days if you acquire a new spouse and want to enroll them in COBRA coverage.

COBRA-like continuation of coverage for partners

Although domestic partners and civil union partners are not qualified beneficiaries under COBRA, the company currently provides COBRA-like continuation coverage to partners and their children who were covered under the health plans when group coverage would otherwise have been lost.

In the description of federal COBRA above, whenever the term:

- "Spouse" is used and wherever "qualified beneficiary" when referring to a spouse is used, the term "partner" as defined by the plan also generally applies
- Wherever the terms "child" or "children" are used, or wherever "qualified beneficiary(ies)" when referring to a child or children is used, the child/children of a partner also generally applies
- Wherever the term "divorce" is used, termination of partnership also generally applies
- Wherever the term "COBRA continuation coverage" is used, COBRA-like continuation coverage also generally applies

However, be aware that certain HMOs may not allow continuation coverage for partners or the children of partners. Contact the HMO directly for specific information.

Your duties

You must, in writing, inform the COBRA administrator of a divorce, legal separation or child's loss of dependent status under the plan, if you wish to preserve your right to elect COBRA coverage. You must provide notice within 30 days from the latest of (1) the date of the divorce, legal separation, or loss of dependent status; or (2) the date coverage is lost because of the event.

Notice must be provided to the COBRA administrator on a form which can be obtained from the COBRA administrator. The notice should be completed and provided to the COBRA administrator at the address listed under **claims administrators and funding information**.

The notice must identify the employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, the employee or qualified beneficiary may be required to provide the COBRA administrator with documentation supporting the occurrence of the qualifying event.

If you fail to notify the COBRA administrator within this 30-day period, the right to elect COBRA coverage will be lost.

When the COBRA administrator is notified that one of these events has happened, the COBRA administrator will in turn notify you about your right to choose COBRA coverage.

The COBRA administrator's duties

Qualified beneficiaries will be notified of the right to elect COBRA coverage if they lose coverage under the terms of the plan because of any of the following events:

- The employee dies
- The employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced
- The employee becomes covered by Medicare (Part A, Part B, or both)

Electing COBRA

To elect or inquire about COBRA coverage, contact the COBRA administrator at the number listed under **claims administrators and funding information**.

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the events described earlier, or, if later, 60 days after you receive notice of your right to elect COBRA coverage. An employee or family member who doesn't choose COBRA coverage within the time period described above loses the right to elect COBRA coverage. The employee and family members will be required to reimburse the plan for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. "Similarly situated" generally refers to a current employee or dependent who hasn't had a qualifying event.

You will have the same opportunity to change coverage as similarly situated active employees have (e.g., at **open enrollment** or if you gain a new dependent). This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

Plan changes during COBRA

While you or your dependents have COBRA coverage, there may be changes to the health plans, such as new deductibles, covered expenses or changes to your premiums. All changes will also apply to your COBRA coverage.

Separate elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a spouse or eligible child can elect COBRA coverage even if the covered employee chooses not to. However, a covered employee or spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA coverage

If elected, COBRA coverage begins on the date your active employee coverage ends. For dependents that no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the first day of the month following the date of the qualifying event. However, coverage won't take effect unless COBRA coverage is elected as described previously and the required premium is received.

The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered spouse and dependents for up to 18 months.

However, if termination of employment or reduction of hours follows Medicare enrollment, the COBRA coverage period for your spouse and eligible children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

COBRA coverage for your covered spouse and dependents may continue for up to 36 months if coverage would otherwise end because:

- You die
- You divorce or legally separate, or
- Your child loses eligibility for coverage.

Note: COBRA coverage for the health care FSA ends at the end of the **plan year** in which the qualifying event occurs.

Disability extension

The 18 months of COBRA coverage may be extended to 29 months if an employee or covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. It also applies to family members who aren't disabled.

To benefit from the extension, the qualified beneficiary must provide the COBRA administrator with the disability determination within 60 days after the later of (1) the Social Security Administration's determination of disability; (2) the date on which a qualifying event occurs; or (3) the date coverage is lost because of the qualifying event. The notice of Social Security disability must also be furnished to the COBRA administrator before the end of the original 18-month COBRA coverage period.

During COBRA coverage, if the Social Security Administration determines that the qualified beneficiary is no longer disabled, the COBRA administrator must be

informed within 30 days. The notice can be made by providing to the COBRA administrator a copy of the notice from the Social Security Administration, or by other written means. The notice must properly identify the qualified beneficiary who is no longer disabled and the date the notice of redetermination was received. The 11-month COBRA extension will end at the end of the month in which the redetermination notice from the Social Security Administration is received by the qualified beneficiary.

Second qualifying event extensions

Your spouse and dependents may have additional qualifying events while they are covered by COBRA. These events can extend their 18- or 29-month continuation period to 36 months, but in no event will they have more than 36 months of COBRA measured from the first day of the month following the first qualifying event that originally allowed them to elect coverage. This extension may be available to the spouse and any eligible children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated or if the child stops being eligible under the plan. This only occurs if the additional event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.

The law requires a qualified beneficiary to notify the COBRA administrator if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event; or (2) the date coverage would have been lost because of the event.

Notice of the additional qualifying event must be provided to the COBRA administrator on the appropriate form, which may be obtained from the COBRA administrator. The form should be returned to the COBRA administrator at the address listed under **Claims administrators and funding information.**

The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage. In addition, the qualified beneficiary may be required to provide the COBRA administrator with documentation supporting the occurrence of the qualifying event.

If a qualified beneficiary (or his/her representative) fails to provide the appropriate notice and supporting documentation, if required, to the COBRA administrator during the 60-day notice period, the qualified beneficiary won't be entitled to extended COBRA coverage.

Early termination of COBRA coverage

COBRA coverage will terminate before the expiration of the 18-, 29-, or 36-month period for any of the following reasons:

- the company no longer provides group health coverage to any of its employees
- The premium for COBRA coverage isn't paid on time (within the applicable grace period)

You will be sent a termination notice to notify you of early termination of COBRA coverage due to the above events.

COBRA coverage will also terminate early if:

- The qualified beneficiary becomes covered – after the date COBRA coverage is elected – under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual
- The qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled

You are required to inform the COBRA administrator if you experience the above events.

Trade Act of 2002 – Second COBRA election

The Trade Act of 2002 created a second COBRA election for workers displaced by the impact of foreign trade and who are determined to be trade adjustment assistance (TAA)-eligible individuals. TAA-eligible individuals who declined COBRA when they were first eligible can elect COBRA within 60 days of the first day of the month in which they become TAA-eligible individuals. Nonetheless, this election may not be made more than six months after the date the TAA individual's group health plan coverage ended.

If you have questions about your extended ability to elect COBRA coverage, you may call the United States Department of Labor, Employment and Training Administration, Office of Trade Adjustment Assistance toll-free at **888-365-6822**. More information about the Trade Act of 2002 is also available at **doleta.gov**.

COBRA and FMLA

Taking an approved FMLA leave isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if both of the following are true:

- You, your spouse, or your dependent is covered by the plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave)
- You do not return to employment at the end of the FMLA leave or you terminate employment during your leave

COBRA coverage begins on the earlier of the following:

- When you inform the COBRA administrator that you are definitely not returning to work
- The end of the leave, if you do not return to work

HIPAA certificate of coverage

When your COBRA coverage ends, you will automatically receive a certificate of coverage that:

- Confirms that you had whatever medical coverage you continued through COBRA
- States how long you were covered

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit – against the new plan's pre-existing condition limit – for the time you were covered by the plan.

In addition to the certificate you receive automatically, you also may request an additional certificate from your medical plan by contacting them at the number listed under **claims administrators and funding information**.

State continuation of coverage rights

Many states require insured medical plans and HMOs to provide extended health coverage to participants after their group coverage ends. These rights generally supplement federal COBRA, or provide continuation coverage to those who are ineligible for federal COBRA coverage. Because the laws vary from state to state, you should review the benefit plan summaries on **the companyBenIQ.com** and/or contact your medical plan directly to learn about any rights you may have under state law. That way, you can meet any election and premium requirements necessary to take advantage of these state continuation coverage rights.

Even if you are not enrolled in an insured medical plan or HMO, please review the section below as it may impact your enrollment decisions when you initially enroll, or at open enrollment. For example, you may want to switch from a self-funded medical plan to an insured medical plan or HMO during open enrollment in order to take advantage of these rights.

Participants in California HMOs or insured medical plans

Cal-COBRA Extended Continuation Coverage: Insured medical plans and HMOs regulated in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA coverage an additional period of continuation coverage. Qualified beneficiaries must be offered up to a total of 36 months of combined federal and Cal-COBRA, starting from the date federal COBRA began. Note that Cal-COBRA does not apply to Our vision or dental plan.

Contact your California insured medical plan or HMO directly for further information on Cal-COBRA. The plan will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, deadlines for submitting premiums and how Cal-COBRA might be beneficial to you.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or denial of coverage.

Conversion privileges

When medical coverage ends for you or any dependent covered by an insured the company medical plan, you may be able to apply for an individual medical policy from that plan.

The coverage and benefits may not be the same as those provided by The company medical plans, and the rates will vary depending on your age, where you live, and other factors. For additional information on your conversion rights, you should check with your HMO or insurance carrier, or refer to the appropriate benefit summary.

Note: You may also be able to purchase an individual policy from a different HMO or insurance carrier, other than the carrier for a the company medical plan that provides the group coverage that you are losing.

Conversion coverage may be available for other benefits. Refer to your benefit summary for more information.

Right to individual health coverage

Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more
- Your most recent coverage was under a group health plan
- Your most recent coverage was not terminated because of fraud or non-payment of premiums
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision)
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage

Disability insurance

Your disability insurance coverage ends on the earliest of:

- The date the plan terminates
- The date the plan no longer insures your class
- The date premium payment is due but not paid
- The last day of the period for which you make any required premium contribution
- The date your employer terminates your employment
- The date you cease to be a full-time or part-time active employee in an eligible class for any reason, unless you are eligible to continue coverage while on an approved leave of absence

You may be eligible to continue coverage after you leave the company. See **Continuation of coverage for disability benefits** for more information.

Extension of STD and LTD coverage while you are disabled

If you are entitled to STD or LTD benefits while disabled and the policy terminates, benefits will continue as long as you remain disabled by the same disability. Benefits will not be provided beyond the date New York Life would have ceased to pay benefits had the insurance remained in force.

If you are disabled and no longer an active employee, your coverage will continue:

- If you are receiving STD weekly benefits, your STD coverage and STD payments will continue while you remain disabled, up to the limits of the plan
- During the **elimination period** for LTD benefits, your LTD coverage continues if you remain disabled by the same disability
- After the elimination period for LTD benefits, your LTD coverage and LTD payments will continue while you remain disabled, up to the limits of the plan

Continuation of coverage for disability benefits

Coverage can be continued when it would otherwise be terminated if your employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

- Is subject to any reductions in the policy and payment of premium by the company
- Terminates if the policy terminates or coverage for your class terminates

In any event, your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

If you are disabled: If you are considered disabled under these plans and you cease to be in active service, your insurance will be continued:

- During the elimination period for LTD benefits while you remain disabled by the same disability
- While you are receiving STD or LTD benefits while you remain disabled by the same disability, for as long as benefits are payable

If you are entitled to benefits while disabled and the plan terminates, benefits will continue as long as you remain disabled by the same disability, for as long as benefits would have been payable had the plan not been terminated.

Leave of absence: If you are on a documented leave of absence, other than family and medical leave or military leave of absence, your coverage may be continued until the last day of the month following 12 months from the date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

YOUR RIGHTS UNDER THE CALIFORNIA PAID FAMILY LEAVE PLAN

You may be eligible for the California Paid Family Leave partial wage replacement if your leave is to care for a qualified dependent or family member with a serious medical condition or to bond with a new child. To obtain a form, call **877-BE-THERE**. For more information, visit the California Employment Development Department's website at edd.ca.gov.

Military leave of absence: If you enter active full-time military service and are granted a military leave of absence in writing, your coverage may be continued until the last day of the month following 12 months from the date the leave of absence commenced. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family and medical leave: If you are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, your coverage will be continued for up to 12 weeks, or 26 weeks if you qualify for family military leave, or longer if required by other applicable law, following the date your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

You have the right to choose not to retain health coverage during FMLA leave. Upon return from FMLA leave, most employees must still be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as if you notify the employer of your intent not to return to work.

Life and accident insurance

Coverage for employees covered by life, Accidental death and dismemberment (AD&D) and business travel accident (BTA) insurance ends on the earliest of the following:

- The date the policy terminates
- The date you are no longer in a class that is eligible for coverage or the policy no longer insures your class
- The date the premium payment is due but not paid
- The date you are no longer in **active service** or your employment ends

Coverage for dependents covered by dependent life insurance or BTA insurance ends on the earliest of:

- The date your coverage ends
- The date the required premium is due but not paid
- The date you are no longer eligible for dependent coverage
- The date the company or the carrier terminates dependent coverage
- The date the dependent no longer meets the definition of dependent

You may be eligible to continue coverage after you leave the company. See **Continuation of coverage for life and accident insurance** for more information.

Life insurance in the event of employee disability

If you cease to be an active employee due to a disability, you may be eligible for the benefits described below.

A qualifying disability is an injury or sickness that prevents you from doing any work for which you are, or could become, qualified, by education, training or experience. In addition, you will be considered disabled if you have been diagnosed with a life expectancy of 12 months or less.

Extension of basic employee life insurance

Your basic life insurance coverage will be extended if you meet the following requirements:

- You become disabled and unable to work prior to age 65, or you have been diagnosed with a life expectancy of 12 months or less prior to age 65
- You provide proof of your disability or terminal illness

Coverage ends the earliest of the following:

- The policy terminates
- the company ceases to be a participating employer
- The required premium for coverage is due but not paid
- You attain 24 months of being disabled
- You are no longer in an eligible class, or the class is cancelled

If you qualify for disability extension, the amount of continued coverage:

- Will be the amount in force on the date you cease to be an active employee or the date you became insured under the policy if you were never an active employee under the policy
- Will be subject to any reductions provided by the policy
- Will not increase

If you return to work in an eligible class, as an active employee, then you may again be eligible for coverage as long as premiums are paid when due. If you do not return to work in an eligible class, coverage will end and you may be eligible to exercise the conversion right if you do so within the time limits described in such provision. The amount of life insurance that may be converted will be subject to the terms and conditions of the conversion right. Portability will not be available.

Waiver of premium for supplemental employee life insurance

After a six-month waiting period, your premium will be waived and your coverage will continue as long as you remain disabled and meet the following requirements:

- You pay premiums for six months
- You become disabled and unable to work prior to age 60 and you remain disabled for six consecutive months, starting on the date you were last actively at work, or you have been diagnosed with a life expectancy of 12 months or less prior to age 60
- You provide proof of your disability or terminal illness within one year of your last day of work as an active employee
- You are examined as required by New York Life

If you die within nine months of your last day of work but before you qualify for the waiver of premium, New York Life will pay the amount of life insurance in force provided you were continuously disabled and the disability did last or would have lasted six months or more, and premiums have been paid.

Your premium will be waived and your coverage will continue, as long as you remain disabled, until you reach **normal retirement age**.

If you return to work in an eligible class, as an active employee, then you may again be eligible for coverage as long as premiums are paid when due. If you do not return to work in an eligible class, coverage will end and you may be eligible to exercise the conversion right if you do so within the time limits described in such provision. The amount of life insurance that may be converted will be subject to the terms and conditions of the conversion right. Portability will not be available.

If the policy terminates before you qualify for a waiver of premium, you may be eligible to exercise the conversion right if you do so within the time limits described in such provision. You may still be approved for the waiver of premium if you qualify.

If the policy terminates after you qualify for a waiver of premium, your dependent coverage will terminate but your coverage under this policy will not be affected.

Continuation for dependent children with disabilities

If your dependent child becomes disabled before age 26, their life insurance may be extended if they are age 26 or older, disabled and primarily dependent upon you for financial support. Their coverage will not terminate solely due to age.

The dependent child must continue to meet the required conditions and premiums must be paid when due. No increase in the amount of life insurance will be available.

New York Life has the right to require proof, satisfactory to them, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. Proof will not be required more often than once a year after that.

Continuation of coverage for life and accident insurance

Coverage can be continued when it would otherwise be terminated if your employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

- Is subject to any reductions in the policy and payment of premium
- May be continued up to the maximum time shown provided for under the policy
- Terminates if the policy terminates

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The continuation provisions shown below may not be applied consecutively. In all other respects, your coverage and coverage for your dependents remains unchanged.

Leave of absence: If you are on a documented leave of absence, other than family and medical leave or military leave of absence, your coverage (including dependent life coverage) may be continued until the last day of the month following 12 months from the date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military leave of absence: If you enter active full-time military service and are granted a military leave of absence in writing, your coverage (including dependent

life coverage) may be continued until the last day of the month following 12 months from the date the leave of absence commenced. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family and medical leave: If you are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, your coverage (including dependent life coverage) may be continued for up to 12 weeks, or 26 weeks if you qualify for family military leave, or longer if required by other applicable law, following the date your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Portability

If your supplemental life insurance coverage ends prior to age 70, you may be eligible for the portability provision, which continues your current supplemental coverage. You are eligible for this provision if, prior to **normal retirement age**, you no longer meet the eligibility requirements of this plan for any of the following reasons:

- Your employment terminates for any reason
- Your or your covered dependent's membership in an eligible class under the policy ends
- Your covered dependent no longer meets the definition of dependent, however, a dependent child who reaches the limiting age under the policy is not eligible for portability

Portable life insurance is issued without evidence of good health. In order to port your life insurance, you must apply and pay the required premium within 31 days of your termination or change in employment status. If approved, coverage will be effective on the day after your qualifying event. New York Life will bill you directly for the policy and it is important to note that the premium rate on your ported policy will be higher than the rate you paid for coverage as an active employee.

Portability is not available under the following circumstances:

- If policy is no longer in force
- For any amount of life insurance for which you or your dependents were not eligible and covered
- If you were on a qualified disability extension or were having your premiums waived and do not actively return to work in an eligible class
- If you or your dependents are entering active military service

The minimum amount of supplemental insurance that can be continued is $5,000. You may elect to continue 50%, 75%, or 100% of the supplemental life insurance which is ending for you or your dependent (rounded to the next higher multiple of $1,000).

If you elect to continue 50% or 75% now, you may not continue any portion of the remaining amount under this portability provision at a later date.

Portability is not available for basic life insurance coverage.

Conversion

If your basic and supplemental life insurance coverage or any portion of it under the policy ends for any reason, except non-payment of premium, you and your dependents have the right to convert the full amount of coverage that terminated to an individual policy.

You may convert your insurance to any type of individual policy of life insurance customarily issued by New York Life for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits – such as any disability benefits, AD&D benefits, or accelerated benefits.

If the policy terminates or coverage for an eligible class is terminated, you must have been insured under the policy for three years or more in order to be eligible to convert coverage. Under this circumstance, the amount which may be converted is limited to the lesser of:

- $10,000
- The life insurance benefit under the policy less any amount of life insurance for which you may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage

You can convert your insurance by competing the application and paying the required premium within 31 days of termination of coverage. Evidence of good health will not be required. The individual policy takes effect on the 32nd day after your the company life insurance policy coverage ends.

LEGAL AND CLAIMS INFORMATION

This section provides administrative information and legal notices.

Claims administrators and funding information

Please direct all claims and claim appeals to the claims administrators for the benefit plan in which you are enrolled. Please also review the **Insured benefits/claims administrator authority** section for more information.

BENEFIT PLAN	CLAIMS ADMINISTRATOR	TYPE OF FUNDING
Medical		
Gold, Rose Gold and Silver HSA plans Group Number: 729751	UnitedHealthcare: **866-480-4988** UnitedHealthcare – Claims P.O. Box 30555 Salt Lake City, UT 84130-0555 **myuhc.com**	Self-funded
Kaiser HMO Plan (California) Northern California Policy Number: 48011-00 Southern California Policy Number: 226485	Kaiser Permanente: **800-464-4000** Northern California: Kaiser Claims Department P.O. Box 12923 Oakland, CA 94604-2923 Southern California: Kaiser Claims Department P.O. Box 7004 Downey, CA 90242-7004 **kp.org**	Insured
Kaiser HMO (Hawaii) Group Plan 220	Kaiser Permanente: **808-432-5955** (Oahu) or **800-966-5955** (Neighbor islands) Kaiser Permanente Membership Services 711 Kapiolani Blvd. Honolulu, HI 96813 **kp.org**	Insured

BENEFIT PLAN	CLAIMS ADMINISTRATOR	TYPE OF FUNDING
Medical		
HMSA Preferred Provider Plan Policy Number: 86678-18	HMSA: **800-776-4672** HMSA – Claims P.O. Box 860 Honolulu, HI 96808-0860 hmsa.com	Insured
Triple-S Plan Base ID: BENPLN16880 Sponsor Number: SP0002157	Salud Blue Cross Blue Shield: **787-774-6060** Salud Blue Cross Blue Shield – Claims P.O. Box 71548 San Juan, PR 00936-8648 ssspr.com	Insured
Prescription drugs (for UnitedHealthcare and HMSA participants)		
Prescription Drug Plan Group Number: RXDFSEP	Express Scripts: **800-903-8638** Express Scripts – Claims P.O. Box 2872 Clinton, IA 52733-2872 express-scripts.com	Self-funded
Dental		
DHMO Plan Policy Number: 78743	Delta Dental: **800-765-6003** Delta Dental – Claims P.O. Box 1810 Alpharetta, GA 30023 deltadentalins.com	Insured
Delta Dental PPO Policy Number: 2887	Delta Dental: **800-765-6003** Delta Dental – Claims P.O. Box 997330 Sacramento, CA 95899-7330 deltadentalins.com	Self-funded
Delta Dental/Hawaii Dental Service Policy Number: 2887	Oahu: **808-521-1431** Neighbor islands: **800-232-2533** Hawaii Dental Service 700 Bishop St., STE 700 Honolulu, HI 96813-4196 hawaiidentalservice.com	Insured

BENEFIT PLAN	CLAIMS ADMINISTRATOR	TYPE OF FUNDING
Vision (for UnitedHealthcare, HMSA and Triple-S participants)		
Vision Plan Policy Number: 30009284	Vision Service Plan: **800-877-7195** P.O. Box 997105 Sacramento, CA 95899-7105 vsp.com	Insured
Flexible spending accounts (FSAs) (for U.S. participants only)		
Health Care FSA Day Care FSA	Optum Financial: **877-292-4040** optumfinancial.com	Self-funded
Life and accident benefits		
Basic Life Plan Policy Number: FLX980458	New York Life: **800-362-4462** P.O. Box 22328 Pittsburgh, PA 15222-0328 myNYLGBS.com	Insured
Basic Accidental death and dismemberment (AD&D) Plan Policy Number: OK980467	New York Life: **800-362-4462** P.O. Box 22328 Pittsburgh, PA 15222-0328 myNYLGBS.com	Insured
Voluntary Life and Dependent Life Insurance Plan Policy Number: FLX-980452	New York Life: **800-362-4462** P.O. Box 22328 Pittsburgh, PA 15222-0328 myNYLGBS.com	Insured
Business Travel Accident (BTA) Plan Policy Number: ABL980112	New York Life: **800-362-4462** P.O. Box 22328 Pittsburgh, PA 15222-0328 myNYLGBS.com	Insured
Disability benefits		
Short-Term Disability (STD) Plan Policy Number: LK980351	New York Life: **888-842-4462** P.O. Box 22328 Pittsburgh, PA 15222-0328 myNYLGBS.com	Insured
Long-Term Disability (LTD) Plan Policy Number: LK980352	New York Life: **888-842-4462** P.O. Box 22328 Pittsburgh, PA 15222-0328 myNYLGBS.com	Insured

Additional resources

RESOURCE	CONTACT INFORMATION
the company Benefits Service Center	**877-737-2363**, option 1
COBRA Administrator	Businessolver, Inc. Attn: COBRA Premium Payments P.O. Box 310512 Des Moines, IA 50331-0512 **877-547-6257**

Administrative information

the company USA, Inc. (the company), as plan administrator, has the absolute discretionary authority to control and manage the operation and administration of this Plan, to correct errors, and to construe and interpret the provisions under the Plan, including but not limited to determinations regarding eligibility and benefits.

The plan administrator may delegate duties and responsibilities as it deems appropriate to facilitate the day-to-day administration of the Plan and, unless the plan administrator expressly provides to the contrary, any such delegation will carry with it the plan administrator's full discretionary authority to accomplish the delegation. The identity of service providers and the nature of their services may be changed from time to time at the sole discretion of the plan administrator. In order to receive benefits, you must cooperate with these service providers.

ERISA requires that certain information be furnished to each participant in an employee benefit plan.

Plan name	the company Welfare Benefits Plan
Plan number	501
Plan year	January 1 to December 31
Plan sponsor	the company USA, Inc. **415-284-3300** 350 Mission Street, Floor 7 San Francisco, CA 94105
Employer identification number	94-3322407
Type of plan	Welfare benefit plan providing health and welfare benefits
Type of administration	Sponsor administration
Plan administrator and named fiduciary	the company USA, Inc. Human Resources **415-284-3300** 350 Mission Street, Floor 7 San Francisco, CA 94105
Source of contributions	Pre-tax and after-tax employee contributions, and employer contributions
Plan funding	The insured arrangements are paid by insurance policies. The benefits and other plan costs (such as administrative costs) for the self-funded plans are paid from the general assets of the company. Please see the **Claims administrators and funding information** section for details on funding arrangements.
Type of administration	The benefit programs are provided under both self-funded and insured arrangements. The insured plans (which include HMOs) are provided under group contracts between the company and the carriers (including HMOs). The carriers, not the company, are responsible for determining eligibility for benefits, the amount of benefits payable and for prescribing the claims procedures for the plan.
Claims administrator	Please see the **Claims administrators and funding information** section.
Agent for legal process	the company USA, Inc. Attention: General Counsel **415-284-3300** 350 Mission Street, Floor 7 San Francisco, CA 94105

Additional information

Insured benefits/claims administrator authority

Certain benefits under this Plan are fully insured, as noted in the **Claims administrators and funding information** section. For insured benefits, claims for benefits are sent to the insurance company. In this case, the insurance company is responsible for paying claims, not the company.

The insurance company and the claims administrator are responsible for and have full discretionary authority for:

- Determining eligibility for and the amount of any benefits payable under the applicable benefit program and construe terms of the program
- Prescribing claims and appeal procedures to be followed and the claims and appeal forms to be used by program participants pursuant to the applicable program

The insurance company and claims administrator also have the authority to require program participants to furnish them with such information as they determine necessary for the proper administration of the applicable program.

With respect to insured benefits, you (or, in the case of your death, your beneficiary as that term is defined in the applicable insurance policy or contract) will be entitled to receive only the insured benefit for which provision is actually made under the insurance policy or contract.

the company does not assume liability or responsibility for any insured benefit and you will be able to look only to the insurance contracts for payment or any benefits. You will not have any claim for insured benefits against the company, the plan administrator or any employee, officer or director of the company.

Claims procedures

The claims administrator is responsible for paying claims and making benefits decisions for the self-funded benefits under the plan. These provisions, including procedures for presenting benefit claims and remedies for claims that are denied, in whole or in part, are described in the relevant sections of this SPD. the company is responsible for making decisions regarding eligibility to participate in the Plan.

Enrollment claims and appeals

If your request for enrollment in The company Welfare Benefits Plan is denied you will be notified in writing within 90 days after your application, which may be in electronic form, is received. In some cases, however, an additional 90 days may be necessary to process your application. When this additional time is needed, you will be notified of the special circumstances requiring the extension and the date you may expect a decision. Under law, the total period for responding to your application cannot exceed 180 days from the date you originally filed your application.

If additional information is necessary to process your application, you will be notified of the items needed for completion.

A notice of denial of your application for benefits will include:

- The specific reasons for denial
- Reference to the plan provisions on which the denial was based
- A description of any additional information needed to perfect your application for benefits and an explanation of why such information is necessary
- An explanation of the claims review procedure and the applicable time limits
- A statement of your right to bring a civil action under ERISA 502(a) following an adverse determination or review

Within 60 days after receiving a denial, you or your representative may appeal the decision by requesting a review by writing the plan administrator. If you fail to file your appeal within this timeframe, you will permanently lose your right to appeal the denied claim.

Submit your appeal requests to the plan administrator.

Your written request may (but is not required to) include issues, comments, documents and other records you want considered in the review. All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent

plan documents, records and other information relevant to your claim by asking the company.

A decision on your appeal will normally be given to you within 60 days of the receipt of your request for a review. If circumstances make an extension necessary, you will be notified in writing. In this case, the decision will be made no later than 120 days after your appeal was originally received.

The plan administrator has discretionary authority to grant or deny benefits under the plan. The plan administrator administers the plan in accordance with their terms and establishes policies, interpretations, practices, and procedures with respect to the plan. The plan administrator has discretionary authority to interpret the terms and provisions of the plan (including, but not limited to, to construe ambiguous plan terms), to make determinations regarding issues which relate to eligibility to participate in the plan, to decide disputes which may arise relative to a covered person's rights, and to decide questions of plan interpretation and those of fact relating to the plan.

Benefits under the plan are paid only if the plan administrator or claims administrator, as appropriate, determines in its discretion that you are entitled to benefits. The decisions of the plan administrator or claims administrator, as appropriate, as to the facts related to any claim for benefits or eligibility to participate and the meaning and intent of any provision of the plan, or the application of the plan provisions, to any claim, are final and binding on all interested parties.

Fraud or intentional misrepresentation

If the company covers an ineligible dependent as a result of fraud or intentional misrepresentation of fact, you will be subject to Our disciplinary actions, which may include the retroactive termination of your or your dependent's coverage. For example, if you intentionally misrepresent that a child meets Our definition of eligible child in order to obtain coverage, your and your child's benefits may be terminated or you may be required to reimburse the company for all expenses paid while the child was ineligible for coverage. Expenses may include but are not limited to premiums, claims, administrative fees, disciplinary action, civil action to recover any losses, and termination of your employment. This policy will be strictly enforced.

Right to amend or terminate plan

the company or its authorized delegate reserves the right in its sole discretion to amend in writing the Plan, or any benefit program, in whole or in part, and/or to completely discontinue the Plan or any benefit program at any time. Our decision to amend or terminate in writing is not a fiduciary decision. It is a business decision that can be made solely in Our interest.

the company or its authorized delegate may in writing terminate or partially terminate the Plan, or discontinue contributions at any time. In addition, the company reserves the right to amend or terminate in writing covered expenses, benefit copayments, lifetime maximums, and reserves the right to amend in writing the programs to require or increase participant contributions. the company also reserves the right to amend in writing the programs to implement any cost control measures that it may deem advisable.

Contributions and premiums

Our contributions

the company may fund benefits provided under the Plan in whole or part. Contributions made by the company will be made at the times and in the manner determined by the company. No assets will be set aside for the purpose of providing benefits under the Plan. the company will pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of the company. In no event shall the company have any obligation to fund self-funded benefits provided under the Plan in advance of the date that such benefits are payable or pre-pay the premiums or other fees required in order to provide insured benefits under the Plan. Our contributions, if any, may be paid directly to the insurance company or other provider under the Plan. Such payment shall constitute a complete discharge of the liability of the Plan.

Self-funded benefits

Our general assets are the sole source of self-funded benefits under the Plan. the company assumes no liability or responsibility for payment of such benefits beyond that which is provided in the self-funded benefit programs.

No right to assets

No participant, dependent, or beneficiary shall have any right to, interests in or claim for any particular assets of the company, the Plan, any benefit program or any underlying contract, trust or other funding vehicle.

No estoppel of plan

No person is entitled to any benefit under the Plan or any benefit program except and to the extent expressly provided under the Plan or the benefit program. The fact that payments have been made from the Plan or benefit program in connection with any claim for benefits under the Plan or benefit program does not (a) establish the validity of the claim, (b) provide any right to have such benefits continue for any period of time, or (c) prevent the Plan or benefit program from recovering the benefits paid to the extent that the plan administrator ultimately determines that there in fact was no right to payment of the benefits under the Plan or benefit program, to the extent permitted under applicable law.

Thus, if a benefit is paid to a person under the Plan or benefit program and it is thereafter determined by the plan administrator that such benefit should not have been paid (whether or not attributable to an error by such person, the plan administrator or any other person), then the plan administrator may take such action as it deems necessary or appropriate to remedy such situation, to the extent permitted under applicable law. Such actions could include, without limitation, deduction of the amount of any overpayment from any succeeding payments to or on behalf of such person under the Plan or benefit program or from any amounts due or owing to such person by a participating employer or under any other program, program or arrangement benefiting the employees or former employees of the company, or otherwise recovering such overpayment from whoever has benefited from it.

Responsibility for benefit programs

Please note that:

- All service providers are independent contractors of the applicable program; the company is not responsible for their actions.
- Neither the plan administrator nor the company is responsible for the fiscal viability of benefit providers or for the continuing participation of doctors, hospitals, and others in their networks.
- Neither the plan administrator nor the company can warrant or guarantee the quality or the length of service of providers.

No guarantee of employment

By adopting and maintaining the Plan and these benefit programs, the company has not entered into an employment contract with any person. Nothing in the Plan documents gives any employee the right to be employed by the company or to interfere with Our right to discharge any program participant at any time. Similarly, these programs do not give the company the right to require any program participant to remain employed by the company, or to interfere with an employee's right to terminate employment with the company at any time and for any reason.

Assignment of benefits

Except as otherwise may be required under a qualified medical child support order (QMCSO) which assigns benefits to a child who has been designated as an alternate recipient in accordance with the Plan's QMCSO procedures; by applicable law; or as otherwise specifically provided in the Plan or benefit program material; neither you nor your dependents nor your beneficiaries may assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse, dependents, or any beneficiaries at any time under the Plan. Any attempt to so assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If you, your spouse, dependent, or beneficiary attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, or if a person's bankruptcy or other event would cause amounts payable under the

Plan to be subject to the person's debts or liabilities, then the plan administrator may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your spouse (as defined under federal law) or your dependents, or any of them in such manner and proportion as the plan administrator may deem proper. Such payment shall constitute a complete discharge of the liability of the benefit program, the company, and the Plan.

However, you may request and authorize the plan administrator or the appropriate insurance company or service provider to pay benefits directly to the hospital, physician, dentist or other person furnishing services or supplies covered under the applicable benefit program and any such payment, if made, shall constitute a complete discharge of the liability of the benefit program, the company, and the Plan.

If the plan administrator determines that an underpayment of benefits has been made, the plan administrator shall take such action as it deems necessary or appropriate to remedy such situation. However, in no event shall interest be paid on the amount of any underpayment.

Our use of funds

the company shall be entitled to retain any policy dividend, refund or rebate, or portion thereof, it receives from any insurance company, administrative services organization, HMO, service program or any other organizations or individuals.

Plan's use of funds

All amounts paid to and held by the Plan (or any trust established in connection with the Plan), as well as any policy dividends and/or refunds not belonging to the company, shall be available to fund the benefits provided by any benefit program included in the Plan and to pay the benefit program's administrative expenses. To the maximum extent permitted by applicable law, the plan administrator, at its sole and unfettered discretion, may use funds accumulated under this Plan for any benefit program (whether funds accumulated from insurance contract reserves, insurance company refunds or dividends, participant or the company contributions, or administrative fees) to reduce the level of contributions that the company would otherwise make to the Plan for any benefit program.

Workers' compensation

The Plan is not in lieu of, and does not affect any requirement for coverage by, workers' compensation insurance.

Withholding of taxes

Withholding may be applied to amounts paid or payable pursuant to this Plan for all federal, state, local, or other taxes with respect to any amounts paid or payable under this Plan or any benefit program.

Participant rights under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The benefit plans maintained by the company that are governed by ERISA include those described in this SPD, except for the day care flexible spending account plan (a non-ERISA plan). ERISA provides that all plan participants have the right to the following:

- Receive information about your plan and benefits:
  - You can examine, without charge, at the plan administrator's office and at other specified locations (such as worksites) all documents governing the plan. This includes insurance contracts 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 (EBSA).
  - By submitting a written request to the plan administrator, you can obtain copies of documents governing the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. (The administrator can charge you a reasonable fee for the copies.)
  - You should receive a summary of the plan's annual financial report. The plan administrator is required by law to provide a copy of this summary annual report to each plan participant.

  To request the above information, send a written request to:

  the company Benefits Department
  350 Mission Street, Floor 7
  San Francisco, CA 94105

- Continue group health plan coverage: You can continue health care coverage (medical, vision, dental, and health care FSA) for yourself, spouse and/or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. For more details, review the **COBRA information** in this SPD, the relevant benefit summary, and the COBRA notice that was mailed to your home. If you need another copy of these documents, call **877-737-2363**.
- Reduce or eliminate exclusionary periods: If you have creditable coverage from another medical plan, you are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group medical plan. Your group medical plan or health insurance issuer should provide a Certificate of Creditable Coverage, free of charge, in the following instances:
  - When you lose coverage under the plan
  - When you become entitled to elect COBRA continuation coverage
  - When your COBRA continuation coverage ends
  - If you request it before losing coverage
  - If you request it up to 24 months after losing 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 plan. These people, called "fiduciaries" of the plan, have a duty to operate your plan prudently and in the interest of you and other plan participants and beneficiaries.

No one, including the company, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or 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 (within certain time schedules) to:

- Know why this was done
- Obtain copies of documents relating to the decision without charge
- Appeal any denial

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 your copies 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 administrator.

After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits which is denied or ignored, in whole or in part. After exhausting your appeal rights, you may file suit in a federal court if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court if:

- Plan fiduciaries misuse the plan's money
- You are discriminated against for asserting your rights

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 plan administrator. If you have any questions about this statement or about your rights under ERISA or 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, D.C. 20210 or **askebsa.dol.gov**. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **866-444-EBSA (3272)** or on the internet at **dol.gov/ebsa**.

Required notices

Please review this section for the following notices:

- Patient Protection and Affordable Care Act (PPACA)
- Special notice about Women's Health and Cancer Rights Act
- Special notice about Newborns' and Mothers' Health Protection Act
- Medicaid and the Children's Health Insurance Program (CHIP)
- Nondiscrimination and Accessibility Requirements
- Getting Help in Other Languages or Formats
- Your Rights and Protections Against Surprise Medical Bills

Patient Protection and Affordable Care Act (PPACA)

The claims administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the claims administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the number on the back of your medical ID card.

You may designate a pediatrician as the primary care provider for children.

You do not need prior authorization from your medical plan administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your medical plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the number on the back of your medical ID card.

Special notice about Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the plan provides benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment for complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following **covered health services**, as you determine appropriate with your attending physician:

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

The amount you must pay for such covered health services (including copayments and any deductible) are the same as are required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

Special notice about Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the claims administrator. For information on notification or prior authorization, contact your issuer.

Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **1-877-KIDS-NOW** or visit **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance to pay your health plan premiums. The following list of states is current as of January 31, 2024. You should contact your state for further information on eligibility.

ALABAMA – Medicaid

Website: **myalhipp.com**
Phone: **855-692-5447**

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: **myakhipp.com**
Phone: **866-251-4861**
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid

Website: **myarhipp.com**
Phone: 855-MyARHIPP **(855-692-7447)**

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: **dhcs.ca.gov/hipp**
Phone: **916-445-8322**
Fax: **916-440-5676**
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: **healthfirstcolorado.com**
Health First Colorado Member Contact Center: **800-221-3943**/State Relay 711
CHP+ Website: **hcpf.colorado.gov**
CHP+ Customer Service **800-359-1991**/State Relay 711

Health Insurance Buy-In Program (HIBI) Website: **mycohibi.com**
HIBI Customer Service: **855-692-6442**

FLORIDA – Medicaid

Website: **flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: **877-357-3268**

GEORGIA – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: **678-564-1162**, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: **678-564-1162**, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: in.gov/fssa/hip/
Phone: **877-438-4479**

All other Medicaid
Website: in.gov/medicaid/
Phone: **800-457-4584**

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: dhs.iowa.gov/ime/members
Phone: **800-338-8366**
Hawki Website: dhs.iowa.gov/Hawki
Phone: **800-257-8563**
HIPP website: hhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: **888-346-9562**

KANSAS – Medicaid

Website: kancare.ks.gov/
Phone: **800-792-4884**
HIPP Phone: **800-967-4660**

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: **855-459-6328**
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kynect.ky.gov
Phone: **877-524-4718**
Kentucky Medicaid Website: chfs.ky.gov

LOUISIANA – Medicaid

Website: medicaid.la.gov or ldh.la.gov/lahipp
Phone: **888-342-6207** (Medicaid hotline) or **855-618-5488** (LaHIPP)

MAINE – Medicaid

Enrollment Website: mymaineconnection.gov/benefits/s/?language=en_US
Phone: : **800-442-6003**
TTY: Maine relay 711
Private Health Insurance Premium Webpage: maine.gov/dhhs/ofi/applications-forms
Phone: **800-977-6740**
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: **800-862-4840**
TTY: 711
Email: masspremassistnace@accenture.com

MINNESOTA – Medicaid

Website: mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: **800-657-3739**

MISSOURI – Medicaid

Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: **573-751-2005**

MONTANA – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: **800-694-3084**
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: ACCESSNebraska.ne.gov
Phone: **855-632-7633**
Lincoln: **402-473-7000**
Omaha: **402-595-1178**

NEVADA – Medicaid
Medicaid Website: dhcfp.nv.gov
Medicaid Phone: **800-992-0900**

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: **603-271-5218**
Toll free number for the HIPP program: **800-852-3345**, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: **609-631-2392**
CHIP Website: njfamilycare.org/index.html
CHIP Phone: **800-701-0710**

NEW YORK – Medicaid
Website: health.ny.gov/health_care/medicaid/
Phone: **800-541-2831**

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov/
Phone: **919-855-4100**

NORTH DAKOTA – Medicaid
Website: www.hhs.nd.gov/applyforhelp
Phone: **844-854-4825**

OKLAHOMA – Medicaid and CHIP
Website: insureoklahoma.org
Phone: **888-365-3742**

OREGON – Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
oregonhealthcare.gov/index-es.html
Phone: **800-699-9075**

PENNSYLVANIA – Medicaid
Website: dhs.pa.gov/Services/Assistance/PAges/HIPP-Program.aspx
Phone: **800-692-7462**

RHODE ISLAND – Medicaid
Website: eohhs.ri.gov
Phone: **855-697-4347** or **401-462-0311** (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: scdhhs.gov
Phone: **888-549-0820**

SOUTH DAKOTA – Medicaid
Website: dss.sd.gov
Phone: **888-828-0059**

TEXAS – Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: **800-440-0493**

UTAH – Medicaid and CHIP
Medicaid Website: medicaid.utah.gov
CHIP Website: health.utah.gov/chip
Phone: **877-543-7669**

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: **800-250-8427**

VIRGINIA – Medicaid and CHIP
Medicaid Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
CHIP Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid and CHIP Phone: **800-432-5924**

WASHINGTON – Medicaid

Website: **hca.wa.gov/**
Phone: **800-562-3022**

WEST VIRGINIA – Medicaid

Website: **dhhr.wv.gov/bms/**
mywvhipp.com
Medicaid Phone: **304-558-1700**
CHIP Toll-free Phone: **855-MyWVHIPP (855-699-8447)**

WISCONSIN – Medicaid and CHIP

Website: **dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: **800-362-3002**

WYOMING – Medicaid

Website: **health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Phone: **800-251-1269**

To see if any more states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, ext. 61565

Nondiscrimination and Accessibility Requirements

When the Plan uses the words "claims administrator" in this section, it is a reference to UnitedHealthcare Services, Inc., on behalf of itself and its affiliated companies.

The claims administrator on behalf of itself and its affiliated companies complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the plan sponsor.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

UnitedHealthcare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711
UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human Services online, by phone or mail:

Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at:
hhs.gov/ocr/office/file/index.html
Phone: Toll-free **800-368-1019**, **800-537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

Getting Help In Other Languages or Formats

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This information is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Albanian

Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.

Amharic

ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711

Arabic

لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711

Armenian

Թարգմանիչ պահանջելու համար, զանգահարեք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմեք 0: TTY 711

Bantu-Kirundi

Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711

Bisayan-Visayan (Cebuano)

Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711

Bengali-Bangala

অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711

Burmese

ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Cambodian-Mon-Khmer

អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711

Cherokee

Ꮎ ᎠᏎᏯ ᎨᎵ ᏗᏟᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎪᏪᏔ ᎥᏋ ᏀᏤᎵ ᏙᏧ ᎨᏒ ᏗᎫᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏲᏍᏗᎢ, ᎭᏐᎽᏍᏓ ᴏ. TTY 711

Chinese

您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711

Choctaw

Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711

Cushite-Oromo

Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711

Dutch

U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711

French

Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.

French Creole-Haitian Creole

Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711

German

Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711

Greek

Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Gujarati

તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન 0 કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711

Hawaiian

He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono'ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.

Hindi

आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फोन करें, 0 दबाएं। TTY 711

Hmong

Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.

Igbo

Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.

Ilocano

Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711

Indonesian

Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711

Italian

Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Japanese

ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。

Karen

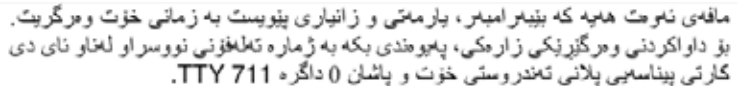
Korean

귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711

Kru- Bassa

Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711

Kurdish-Sorani



Laotian

Marathi

आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळिण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711

Marshallese

Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo emṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711

Micronesian-Pohnpeian

Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Navajo

T'áá jíík'eh doo bą́ ą́ h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yínízeedgo, ninaaltsoos nit['iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711

Nepali

तपाईंले आफ्नो भाषामा नःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711

Nilotic-Dinka

Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.

Norwegian

Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711

Pennsylvania Dutch

Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711

Persian-Farsi

شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711

Punjabi

ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦੱਤਿ ਗਏ ਦੱਲ ਫ਼ਰੀ ਮੈਂਬਰ ਫੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|

Polish

Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711

Portuguese

Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

Romanian

Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711

Russian

Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

Samoan- Fa'asamoa

E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.

Serbo-Croation

Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.

Spanish

Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711

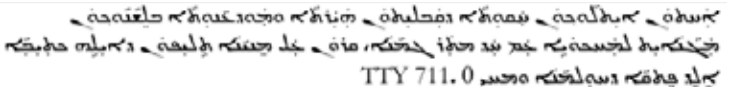
Sudanic-Fulfulde

Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo''u 0. TTY 711.

Swahili

Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711

Syriac-Assyrian



Tagalog

May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711

Telugu

ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషీకావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితాచేయబడ్డ టోల్ ఫ్రీ నంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేసి. TTY 711

Thai

คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711

Tongan- Fakatonga

'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711

Trukese (Chuukese)

Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.

Turkish

Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711

Ukrainian

У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711

Urdu

آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711

Vietnamese

Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711

Yiddish

איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט
דעם טאל פריי מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711

Yoruba

O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láisanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is balance billing (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your 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 plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You cannot be balance billed for these emergency services. This includes services you may get after you're 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 an in-network hospital or ambulatory surgical center**
  When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact your health plan or the CMS No Surprises Help Desk at **800-985-3059** for assistance.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Notice of Privacy Practices

This Notice of Privacy Practices (the "Notice") describes the legal obligations of The company Welfare Benefits Plan (the "Plan") and your legal rights regarding protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA requires health plans, which includes the Plan and the UHC Gold, UHC Rose Gold and UHC Silver HSA plans, Express Scripts Pharmacy, Delta Dental, VSP Vision and health care flexible spending account components, to notify Plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. Among other things, this notice describes how your protected health information may be used or disclosed by the Plan to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

Our pledge regarding health information privacy

The privacy policy and practices of the Plan protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("PHI"). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy obligations of the Plan

The Plan is required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect

How the Plan may use and disclose health information about you

The following are the different ways the Plan may use and disclose your PHI:

- **For treatment.** The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.
- **For payment.** The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- **For health care operations.** The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection and to implement and comply with HIPAA. The Plan may also

combine health information about many Plan participants and disclose it to the company in summary fashion so the company can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed to the company so it may be used without the company learning who the specific participants are.

- **To the company.** The Plan may disclose your PHI to designated the company personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the plan administrator and/or the members of Our Benefits Department who are specifically authorized to receive such PHI and have been trained in HIPAA compliance. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other the company employee or department and (2) will not be used by the company for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the company.
- **To a business associate.** Certain services are provided to the Plan by third party administrators and/or their subcontractors known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.
- **Treatment alternatives.** The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-related benefits and services.** The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- **Individual involved in your care or payment of your care.** The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.
- **As required by law.** The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.
- **Your authorization required.** The Plan may not use or disclose psychotherapy notes or use your PHI for marketing purposes or sell your PHI without your prior written authorization.

Special use & disclosure situations

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and disputes.** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.
- **Law enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- **Workers' compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.
- **Military and veterans.** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.
- **To avert serious threat to health or safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- **Public health risks.** The Plan may disclose your PHI about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- **Health oversight activities.** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

- **Research.** Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.
- **National security, intelligence activities, and protective services.** The Plan may release your PHI to authorized federal officials (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Organ and tissue donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, medical examiners, and funerals directors.** The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your rights regarding health information about you

Your rights regarding the health information the Plan maintains about you are as follows:

- **Right to inspect and copy.** You have the right to inspect and copy your PHI. This includes information about your Plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the Plan, submit your request in writing to The company Employee Benefits Plan Administrative Committee ("plan administrator"). The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to PHI information, you may request a review of the denial.
- **Right to amend.** If you feel that PHI information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, send a detailed request in writing to the plan administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend PHI information that was accurate and complete, not created by the Plan, not part of the PHI information kept by or for the Plan, or not information that you would be permitted to inspect and copy.
- **Right to an accounting of disclosures.** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the plan administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.
- **Right to request restrictions.** You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the plan administrator. You must advise us (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. Note: The Plan is not required to agree to your request.
- **Right to request confidential communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the plan administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a paper copy of this notice.** You have the right to a paper copy of this notice. You may write to the plan administrator to request a written copy of this notice at any time.

Changes to this notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post an electronic copy of the notice to The company BenIQ Solution Center at **the companyBenIQ.com**. You may also request a copy by calling or writing the Benefits Department.

Other uses and disclosures of health information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclosure your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the plan administrator (see **Administrative information**). Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred. Note: You will not be penalized or retaliated against for filing a complaint.

Contact information

If you have any questions about this notice, please contact Our Privacy Officer or the Benefits Department at:

the company
350 Mission Street, Floor 7
San Francisco, CA 94105

CONTACT INFORMATION

The company BenIQ Solution Center is your #1 benefit contact. Visit **the companyBenIQ.com** to chat live with a representative or find information about your benefits. Call **877-737-2363** (select 1 to talk with the BenIQ Solution Center). Hours of operation are weekdays from 8 a.m. to 5 p.m. Central time.

Medical	UnitedHealthcare (UHC)	**866-480-4988**, weekdays 8 a.m. to 10 p.m. Central time **myuhc.com**
	Kaiser California	**800-464-4000**, 7 days a week, 24 hours a day **kp.org**
	Kaiser Hawaii	Oahu: **808-432-5955** Neighbor islands: **800-966-5955** **kp.org**
	HMSA	**800-776-4672** **hmsa.com**
	Triple-S	**787-774-6060** **ssspr.com**
Prescription drugs for UHC plans	Express Scripts	**800-903-8638** **express-scripts.com**
Dental	Delta Dental DHMO	**800-422-4234** **deltadentalins.com**
	Delta Dental PPO	**800-765-6003** **deltadentalins.com**
	Hawaii Dental Service	Oahu: **808-521-1431** Neighbor islands: **800-232-2533** **hawaiidentalservice.com**
Vision	Vision Service Plan	**800-877-7195** **vsp.com**
Life insurance	New York Life	**800-362-4462** **myNYLGBS.com**
Disability	New York Life	**888-842-4462** or **866-562-8421** (Español) **myNYLGBS.com**
Leaves of absence	TRISTAR	**844-702-2352**

Well-being	Headspace and Headspace Care	Download the Headspace and Headspace Care apps work.headspace.com/company/member-enroll
	Cigna EAP (U.S. mainland and Hawaii)	**877-622-4327** mycigna.com (employer ID: **the company**)
	Inspira EAP (Puerto Rico)	**800-284-9515** or **787-651-2384** inspirapr.com
	Wellness Program	Please contact your local HR department
FSA and commuter accounts	Optum Financial	**877-292-4040** optumfinancial.com
HSA and the company 401(k) Savings Plan	Fidelity Investments	**800-835-5098** 401k.com

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

GLOSSARY

ACTIVE EMPLOYEE

For **disability insurance** and **life and accident insurance**, means an employee who works for the company on a regular basis in the usual course of business. This must be at least the minimum hours worked, as shown in the **Employees** section of the **Who's Eligible** chapter.

ACTIVE SERVICE

For **disability insurance** and **life insurance**, you are considered in active service on a regular scheduled the company work day if either of the following conditions are met:

- You are performing your regular occupation and are working at your usual place of business, at another the company location or a location where the company requires you to travel.
- The day is a the company scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.

ADDENDUM

Any attached written description of additional or revised provisions to the plan. The benefits and exclusions of this summary plan description (SPD) and the plan document and any amendments thereto shall apply to the addendum except that in the case of any conflict between the addendum and SPD, plan document and/or **amendment**, the addendum shall be controlling.

AIR AMBULANCE

For the **UnitedHealthcare medical plans**, medical transport by rotary wing air ambulance or fixed wing air ambulance, helicopter or airplane as defined in *42 CFR 414.605*.

AIR BAG

For the purpose of air bag benefits under **AD&D insurance** and **BTA insurance**, means an inflatable supplemental passive restraint system installed by the manufacturer of the motor vehicle or its proper replacement parts installed as required by the motor vehicle's manufacturer's specifications that inflates upon collision to protect an individual from injury and death. An air bag is not considered a seat belt.

ALTERNATE FACILITY

For the **UnitedHealthcare medical plans**, a health care facility that is not a hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services
- Emergency health services
- Rehabilitative, laboratory, diagnostic or therapeutic services

An alternate facility may also provide mental health or substance-related and addictive disorders services on an outpatient basis or inpatient basis (for example a residential treatment facility).

AMENDMENT

Any attached written description of additional or alternative provisions to the plan. Amendments are effective only when distributed by the plan sponsor or the plan administrator. Amendments are subject to all conditions, limitations and exclusions of the plan, except for those that the amendment is specifically changing.

ANCILLARY SERVICES

For the **UnitedHealthcare medical plans**, items and services provided by out-of-network physicians at a network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
- Provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary
- Provided by such other specialty practitioners as determined by the Secretary
- Provided by an out-of-network physician when no other network physician is available

ANNUAL COMPENSATION

Annual compensation for **life insurance benefits** means your annual wage or salary as reported by the employer for work performed for the employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation. Annual compensation is determined initially on the date you apply for coverage. A change in the amount of annual compensation is effective the date of the change, provided New York Life receives notification and premium adjustment is made.

ANNUAL DEDUCTIBLE (OR DEDUCTIBLE)

The amount you must pay for covered health services in a plan year before the plan will begin paying benefits in that plan year. The deductibles are shown in the What you pay sections of the **Medical** chapter and the What you pay sections of the **Dental** chapter.

ANY OCCUPATION

For **long-term disability benefits**, means any occupation for which you are qualified by education, training or experience, and that has an earnings potential greater than your monthly LTD payment.

APPROPRIATE CARE

For **disability benefits**, means that you:

- Are being treated by a physician who is qualified and experienced in the diagnosis and treatment of the conditions causing disability. If the condition is of a nature or severity that is customarily treated by a recognized medical specialty, the physician is a practitioner in that specialty.
- Continue to receive treatment, as often as is required, for the condition causing disability.
- Adhere to the treatment plan prescribed by the physician, including taking medication.

ASSISTED REPRODUCTIVE TECHNOLOGY (ART)

For the **UnitedHealthcare medical plans**, the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF)
- Gamete intrafallopian transfer (GIFT)
- Pronuclear stage tubal transfer (PROST)
- Tubal embryo transfer (TET)
- Zygote intrafallopian transfer (ZIFT)

AUTISM SPECTRUM DISORDERS

For the **UnitedHealthcare medical plans**, a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

BALANCE BILLING

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

When a provider or facility is "out-of-network" that means providers and facilities have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your 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 plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

BENEFITS

Plan payments for covered services, subject to the terms and conditions of the plan and any **addendum** and/or **amendment**.

BEREAVEMENT AND TRAUMA COUNSELING

For the purpose of bereavement and trauma counseling benefits under **BTA insurance**, means treatment or counseling provided by a licensed therapist or counselor registered or certified to provide psychological treatment or counseling for bereavement and trauma.

BODY MASS INDEX (BMI)

For the **UnitedHealthcare medical plans**, a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BOMB

For purpose of bomb scare, bomb search or bomb explosion coverage under **BTA insurance**, means any real or dummy explosive device placed with intent to damage, scare or cause injury.

- A bomb scare means any real or false report of the presence of a bomb on the premises of the company
- A bomb search means any organized search for a reported bomb
- A bomb explosion means any explosion of a bomb on the premises of the company whether or not the presence of a bomb was reported in advance

BUSINESS TRIP

For **BTA insurance**, means traveling:

- On assignment or at the direction of the company for the purpose of furthering the business of the company, and
- Is away from the individual's normal place of business and home residence, and
- Lasts no more than 60 days

CELLULAR THERAPY

For the **UnitedHealthcare medical plans,** administration of living whole cells into a patient for the treatment of disease.

CIVIL AIRCRAFT

For **BTA insurance**, means a civil or public aircraft that meets the following criteria:

- It has a valid Airworthiness Certificate
- It is piloted by a person who has a current pilot certificate, with the appropriate aircraft category rating for that aircraft, and a current medical certificate that is appropriate for the operation of that aircraft
- It is not operated by the militia, or armed forces of any state, national government or international authority

CLINICAL TRIAL

For the **UnitedHealthcare medical plans**, a scientific study designed to identify new health services that improve health outcomes. In a clinical trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA

See **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**.

COINSURANCE

The percentage of eligible expenses, or recognized amount when applicable, you are required to pay for certain covered health services.

COMA

For the purpose of the coma benefit under **BTA insurance**, means profound state of unconsciousness from which the covered person is not likely to be aroused through powerful stimulation. The coma must begin within 30 days of the covered

accident, continue for 60 consecutive days and must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally inflicted during the course of treatment of a **covered injury** unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in a covered accident.

COMMON CARRIER

For **AD&D insurance** and **BTA insurance**, means a conveyance operated by a concern other than the company, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

COMPANY

the company USA, Inc.

CONGENITAL ANOMALY

For the **UnitedHealthcare medical plans**, a physical developmental defect that is present at birth and is identified within the first 12 months of birth.

CONGENITAL HEART DISEASE (CHD)

For the **UnitedHealthcare medical plans**, any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited)
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her pregnancy
- Have no known cause

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

A federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

CONSUMER PRICE INDEX (CPI-W)

For the purpose of **long-term disability benefits**, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

COPAYMENT (COPAY)

A set dollar amount that you are required to pay for certain covered health services.

COSMETIC PROCEDURES

For the **UnitedHealthcare medical plans**, procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator. Reshaping a nose with a prominent bump is a good example of a cosmetic procedure because appearance would be improved, but there would be no improvement in function like breathing.

COST-EFFECTIVE

The least expensive equipment that performs the necessary function. This term applies to benefits for **durable medical equipment (DME)** and **prosthetic devices** in the UnitedHealthcare medical plans.

COVERED ACCIDENT

For **AD&D insurance** and **BTA insurance**, means a sudden, unforeseeable, external event that results directly or independently of all other causes, in a **covered injury** or covered loss and meets all of the following conditions:

- Occurs while the **covered person** is insured under the policy
- Occurs under one of the conditions of coverage specified in the schedule of benefits
- Is not contributed to by disease, sickness or mental or bodily infirmity
- Is not otherwise excluded under the terms of the policy

COVERED EARNINGS

For the purpose of **long-term disability benefits**, means the wage or salary you receive from the company for work performed just prior to the date of your disability. Covered earnings are determined initially on the date you apply for

benefits. A change in the amount of your covered earnings is effective on the date of the change, so long as the company has notified New York Life and the premium is paid.

However, if you were an hourly paid active employee before you became disabled, covered earnings means the product of:

- The average number of hours you worked per month, not including overtime, over the most recent 12-month period immediately prior to the last day you were actively at work before you became disabled, multiplied by
- Your hourly wage in effect immediately prior to the last day you were actively at work before you became disabled.

Covered earnings do not include any amounts you receive as bonuses, commissions, overtime pay or other extra compensation. Any increase in your covered earnings will not be effective while you are disabled.

COVERED HEALTH SERVICES

For the **UnitedHealthcare medical plans**, those health services, including services, supplies or pharmaceutical products, which UnitedHealthcare determines to be:

- **Medically necessary**
- Included in the **What's covered** section for the UnitedHealthcare plans and described as a covered health service
- Provided to a covered person who meets the plan's eligibility requirements, as described in the **Who's Eligible** chapter
- Not identified in the **What's not covered** section for the UnitedHealthcare plans

COVERED INJURY

See **injury**.

COVERED PERSON

Either the employee or an enrolled dependent only while enrolled and eligible for benefits under the plan. References to "you" and "your" throughout this SPD are references to a covered person.

CURRENT MONTHLY EARNINGS

For the purpose of **long-term disability benefits**, means the monthly earnings you receive from the company or another employer while you are disabled.

However, if the other employment is a job you held in addition to your job with the company, then during any period that you are entitled to benefits for being disabled from your occupation, only the portion of your earnings that exceeds your average earnings from the other employer over the six-month period just before you became disabled will count as current monthly earnings.

Current monthly earnings also includes the pay you could have received for another job or a modified job if both of the following are true:

- Such job was offered to you by the company or another employer, and you refused the offer
- The requirements of the position were consistent with your education, training and experience, and your capabilities as medically substantiated by your physician

CURRENT WEEKLY EARNINGS

For the purpose of **short-term disability benefits**, means weekly earnings you earn while you are disabled and eligible for the disabled and working benefit. These earnings may be received from the company or other employment.

However, if the other employment is a job you held in addition to your job with the company, then during any period that you are entitled to benefits for being disabled, only the portion of your earnings that exceeds your average earnings from the other employer over the six-month period just before you became disabled will count as current weekly earnings.

Current weekly earnings also include pay you could have received for another job or a modified job if both of the following are true:

- Such job was offered to you by the company, or another employer, and you refused the offer
- The requirements of the position were consistent with your education, training and experience, and your capabilities as medically substantiated by your physician

CUSTODIAL CARE

For the **UnitedHealthcare medical plans**, services that do not require special skills or training and that:

- Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating)
- Are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively

DEDUCTIBLE

See **annual deductible**.

DEPENDENT

An individual who meets the eligibility requirements specified in the plan, as described in the **Who's Eligible** chapter. A dependent does not include anyone who is also enrolled as an employee. No one can be a dependent of more than one employee.

DESIGNATED FACILITY

For the **UnitedHealthcare medical plans**, a facility that has entered into an agreement with the claims administrator or with an organization contracting on behalf of the plan, to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. To be considered a designated facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

DESIGNATED DISPENSING ENTITY

For the **UnitedHealthcare medical plans**, a pharmacy, provider, or facility that has entered into an agreement with the claims administrator, or with an organization contracting on the claims administrator's behalf, to provide pharmaceutical products for the treatment of specified diseases or conditions. Not all network pharmacies, providers, or facilities are designated dispensing entities.

DESIGNATED NETWORK BENEFITS

For the **UnitedHealthcare medical plans** that have a designated network benefit level, this is the description of how benefits are paid for the covered health services provided by a physician or other provider that has been identified as a designated provider.

DME

See **durable medical equipment (DME)**.

DISABILITY/DISABLED

For purposes of **disability benefits** you are considered disabled if solely because of injury or sickness (including mental illness, substance abuse and pregnancy) you are:

- Unable to perform the material duties of your regular occupation, and
- Unable to earn 80% or more of your pre-disability indexed earnings from working in your regular occupation.

After disability benefits have been paid for 24 months, you are considered disabled if, solely due to injury or sickness, you are:

- Unable to perform the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience, and
- Unable to earn 80% or more of your pre-disability indexed earnings.

New York Life will require proof of earnings and continued disability. If you are in an occupation that requires you to maintain a license, your failure to pass a physical examination required to maintain a license to perform the duties of your occupation alone does not mean that you are disabled from your occupation.

DISABILITY EARNINGS

For purposes of **disability benefits**, means any wage or salary for any work performed for any employer during your disability, including commissions, bonus, overtime pay or other extra compensation.

DOMESTIC PARTNER

An individual of the same or opposite sex with whom you have established a domestic partnership as described in this SPD.

DOMICILIARY CARE

For the **UnitedHealthcare medical plans**, living arrangements designed to meet the needs of people who cannot live independently but do not require skilled nursing facility services.

DURABLE MEDICAL EQUIPMENT (DME)

For the **UnitedHealthcare medical plans**, medical equipment that is all of the following:

- Ordered or provided by a physician for outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a sickness, injury or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home

EARNINGS

For **life insurance**, means your regular annual rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day you were actively at work.

However, if you are an hourly paid active employee, earnings means:

- The average number of hours you worked per year, not including overtime, over the most recent one-year period immediately prior to the last day you were actively at work, multiplied by
- Your hourly wage in effect on the date immediately prior to the last day you were actively at work

ELIGIBLE EXPENSES

For the **UnitedHealthcare medical plans**, the company USA, Inc. has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a covered health service and how the eligible expenses will be determined and otherwise covered under the plan.

Eligible expenses are the amount UnitedHealthcare determines that it will pay for benefits. Eligible expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For covered health services incurred while the plan is in effect, eligible expenses are determined as stated below.

For designated network benefits and network benefits, eligible expenses are the contracted fee(s) with that provider. For covered health services provided by a network provider, except for your cost sharing obligations, you are not responsible for any difference between eligible expenses and the amount the provider bills. When covered health services are received from an out-of-network provider as arranged by UnitedHealthcare, eligible expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact us 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.

For out-of-network benefits, eligible expenses are determined as follows:

1. When covered health services are received from an out-of-network provider as described below:
   - Non-emergency covered health services received at certain network facilities (hospital, hospital outpatient department, critical access hospital, ambulatory surgery center or any other facility specified by the Secretary) from out-of-network physicians when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary (including non-ancillary services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided)
   - Emergency health services provided by an out-of-network physician
   - Air ambulance transportation provided by an out-of-network provider

   The eligible expense is based on one of the following in the order listed below 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 UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UnitedHealthcare
   - The amount determined by *Independent Dispute Resolution (IDR)*

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You cannot be balance billed for these emergency services. This includes services you may get after you're 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 an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

If you think you've been wrongly billed, contact your health plan or the CMS No Surprises Help Desk at **800-985-3059** for assistance.

IMPORTANT NOTICE: For ancillary services, non-ancillary services provided without consent, non-ancillary services for unforeseen or urgent medical needs that arise at the time a service is provided for which consent has been satisfied, emergency health services provided by an out-of-network provider and air ambulance transportation provided by an out-of-network provider: You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by a network provider which is based on the recognized amount as defined in the SPD.

2. When emergency ground ambulance transportation is provided by an out-of-network provider, the eligible expense, which includes mileage, is a rate agreed upon by the out-of-network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here.

3. When covered health services are received from an out-of-network provider, except as described in sections 1 and 2, eligible expenses are determined based on one of the following:
   - An amount negotiated by UnitedHealthcare
   - A specific amount required by law (when required by law)
   - An amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same of similar service

   The plan will not pay excessive charges. You are responsible for paying directly to the out-of-network provider the appliable coinsurance, copayment or any deductible. Please contact UnitedHealthcare advocacy services if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. Following the conclusion of the advocacy services described below, any responsibility to pay more than the eligible expense (which includes your coinsurance, copayment and deductible) is yours.

Advocacy service

UnitedHealthcare provides advocacy services on your behalf with respect to out-of-network providers that have questions about eligible expenses and how UnitedHealthcare determines these amounts. Contact UnitedHealthcare at **866-480-4988** to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. If UnitedHealthcare or its designee reasonably conclude that the particular facts and circumstances related to a claim provide justification for reimbursement greater than what would result from the application of the eligible expense, and UnitedHealthcare or its designee determines that it would serve the best interests of the Plan and its employees (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare or its

designee may use its sole discretion to increase the eligible expense for a particular claim.

4. When covered health services are received from an out-of-network provider, except as described earlier, and you have Out-of-Area coverage:
   - » Eligible expenses are the amount UnitedHealthcare determines it will pay for benefits.
   - » You are responsible for paying, directly to the out-of-network provider, any difference between the amount the provider bills you and the amount the plan for will pay for eligible expenses.

ELIMINATION PERIOD

For **disability benefits**, means the number of consecutive days at the beginning of any one period of disability that must elapse before benefits are payable or the expiration of any employer sponsored short-term disability benefits or salary continuation program, excluding benefits required by state law. Review the **Elimination period** section under disability benefits for more information.

EMERGENCY

For the **UnitedHealthcare medical plans**, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 any of the following:

- Placing the health of the covered person (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

EMERGENCY HEALTH SERVICES

For the **UnitedHealthcare medical plans**, with respect to an emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or an independent freestanding emergency department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency health services include items and services otherwise covered under the plan when provided by an out-of-network provider or facility (regardless of the department of the hospital in which the items or services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an inpatient stay or outpatient stay that is connected to the original emergency unless the following conditions are met:
  - » The attending emergency physician or treating provider determines the patient is able to travel using non-medical transportation or non-emergency medical transportation to an available network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
    - a) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
    - b) The patient is in such a condition, as determined by the Secretary, to receive information as stated in a) above and to provide informed consent in accordance with applicable law.
    - c) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
    - d) Any other conditions as specified by the Secretary.

  The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

EMPLOYEE

A full-time employee of the company who meets the eligibility requirements specified in the plan, as in the **Who's Eligible** chapter. An employee must live and/or work in the United States.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

EMPLOYER

the company USA, Inc.

EOB

See **explanation of benefits (EOB)**.

ERISA

See **Employee Retirement Income Security Act of 1974 (ERISA)**.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES

For the **UnitedHealthcare medical plans**, medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not as appropriate for the proposed use in any of the following:
  - AHFS Drug Information (AHFS DI) under therapeutic uses section
  - Elsevier Gold Standard's Clinical Pharmacology under the indications section
  - DRUGDEX System by Micromedex under Therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb, or
  - National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B
- Subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight
- Only obtainable, with regard to outcomes for the given indication, within research settings

Exceptions:

- Clinical trials for which benefits are available as described in **clinical trials**
- If you are not a participant in a qualifying clinical trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, UnitedHealthcare may, at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

EXPLANATION OF BENEFITS (EOB)

For the **UnitedHealthcare medical plans**, a statement provided by UnitedHealthcare to you, your physician or another health care professional that explains:

- The benefits provided (if any)
- The allowable reimbursement amounts
- Deductibles
- Coinsurance
- Any other reductions taken
- The net amount paid by the plan
- The reason(s) why the service or supply was not covered by the plan

EVIDENCE OF GOOD HEALTH (EOGH)

May be required when applying for life insurance coverage amounts greater than the guaranteed issue amount. EOGH may include, but will not be limited to the following:

- A completed and signed application
- A medical examination
- An attending **physician's** statement
- Any additional information required

You will be notified in writing of any determination on an EOGH submission. If your EOGH is not satisfactory, the amount of life insurance you had in effect on the date immediately prior to the date you requested the increase will not change.

EXTRA-HAZARDOUS AVIATION ACTIVITY

For the purpose of **BTA insurance**, means an aircraft while it is being used for one or more of the following activities:

- Acrobatics or stunt flying
- Aerial photography or banner towing
- Any flight that requires a special permit or waiver from the FAA, even though granted
- Any form of hunting
- Any test or experiment
- Bird or fowl herding
- Crop dusting or seeding
- Exploration
- Firefighting
- Pipe or power line inspection
- Racing or any endurance test
- Spraying

FELONIOUS ASSAULT

For **BTA insurance**, means a violent or criminal act directed at the employee during the course of a robbery, hold-up, kidnapping or criminal assault or an attempt at these felonies.

FERTILITY SOLUTIONS PLUS

For the **UnitedHealthcare medical plans**, an inclusive, comprehensive fertility and family-building support solution designed to help covered persons 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.

GENDER IDENTITY DISORDER

For the **UnitedHealthcare medical plans**, a disorder characterized by the diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

GENE THERAPY

For the **UnitedHealthcare medical plans**, therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cell as a drug to treat disease.

GENETIC COUNSELING

For the **UnitedHealthcare medical plans**, counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders
- An individualized discussion about the benefits, risks and limitations of genetic testing to help you make informed decisions about genetic testing
- Interpretation of the genetic testing results in order to guide health decisions

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when covered health services for genetic testing require genetic counseling.

GENETIC TESTING

For the **UnitedHealthcare medical plans**, exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

GESTATIONAL CARRIER

For the **UnitedHealthcare medical plans**, a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

GOOD CAUSE

For **long-term disability** purposes, a medical reason preventing an individual from participating in a rehabilitation plan. Satisfactory proof of good cause must be provided to New York Life.

HEALTH STATEMENT(S)

A single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

HIJACKING

For **BTA insurance**, means unlawful seizure or wrongful exercise of control of an aircraft or other conveyance, or the crew thereof, in which the employee is traveling as a passenger.

HOME HEALTH AGENCY

For the **UnitedHealthcare medical plans**, a program or organization authorized by law to provide health care services in the home.

HOSPITAL

For the **UnitedHealthcare medical plans**, an institution, operated as required by law, which is:

- Primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals; care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of physicians
- Has 24-hour nursing services

A hospital is not primarily a place for rest, custodial care or care of the aged and is not a skilled nursing facility, convalescent home or similar institution.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

For the **UnitedHealthcare medical plans** a health care facility that:

- Is geographically separate and distinct and licensed separately from a hospital under applicable law, and
- Provides emergency health services

IATROGENIC INFERTILITY

For the **UnitedHealthcare medical plans**, an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

INDEXED PRE-DISABILITY EARNINGS

For **long-term disability benefits**, for the first 12 months monthly benefits are payable, your indexed pre-disability earnings are equal to your covered earnings. After 12 monthly benefits are paid, your indexed earnings are your covered earnings plus an increase applied on each anniversary of the date monthly benefits became payable. The amount of each increase will be the lesser of:

- 10% of your indexed earnings during your preceding year of disability, or
- The rate of increase on the Consumer Price Index (CPI-W) during the preceding calendar year

INFERTILITY

For the **UnitedHealthcare medical plans**, a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after six months for women age 35 years or older.

IN-NETWORK

When used to describe a provider of health care services for the **UnitedHealthcare medical plans**, this means a provider that has a participation agreement in effect (either directly or indirectly) with the claims administrator or with its affiliate to participate in the network; however, this does not include those

providers who have agreed to discount their charges for covered health services by way of their participation in the Shared Savings Program. The claims administrator's affiliates are those entities affiliated with the claims administrator through common ownership or control with the claims administrator or with the claims administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain covered health services, but not all covered health services, or to be an in-network provider for only some products. In this case, the provider will be an in-network provider for the covered health services and products included in the participation agreement and an out-of-network provider for other covered health services and products. The participation status of providers will change from time to time.

IN-NETWORK BENEFITS

Description of how benefits are paid for covered health services provided by an in-network provider.

INJURY

For the **UnitedHealthcare medical plans**, injury means bodily damage other than sickness, including all related conditions and recurrent symptoms.

For **disability insurance**, injury means any accidental loss or bodily harm that results directly or independently from an accident.

For **life insurance**, injury means bodily injury resulting directly from an accident and independently of all other causes, while you are covered under the plan. A loss resulting from the following is not considered as resulting from injury:

- Sickness or disease, except a pus-forming infection which occurs through an accidental wound
- Medical or surgical treatment of a sickness or disease

For **BTA insurance**, injury means any bodily harm that results, directly and independently of all other causes, from a covered accident.

INPATIENT REHABILITATION FACILITY

For the **UnitedHealthcare medical plans**, a hospital (or a special unit of a hospital that is designated as an inpatient rehabilitation facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

INPATIENT STAY

For the **UnitedHealthcare medical plans**, an uninterrupted confinement, following formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility.

INSURABILITY REQUIREMENT

For **life insurance**, you satisfy the insurability requirement for coverage on the day New York Life agrees in writing to accept you as insured, based on providing evidence of good health.

INSURED PERSON

For **disability**, **life and accident insurance**, means an eligible employee or dependent while he or she is covered by this plan.

INTENSIVE BEHAVIORAL THERAPY (IBT)

For the UnitedHealthcare medical plans, 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 disorders**. Examples include Applied Behavior Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI).

INTENSIVE OUTPATIENT TREATMENT

For the **UnitedHealthcare medical plans**, a structured outpatient treatment program.

- For mental health services, the program may be freestanding or hospital-based and provides services for at least three hours per day, two or more days per week.
- For substance-related and addictive disorders services, the program provides nine to 19 hours per week of structured programming for adults and six to 19 hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

INTERMITTENT SCHEDULE

For the **UnitedHealthcare medical plans**, skilled nursing care that is provided or needed either of the following:

- Fewer than seven days each week
- Fewer than eight hours each day for periods of 21 days or less

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

INTOXICATED

For **AD&D insurance** and **BTA insurance**, means the blood alcohol content, the results of other means of testing blood alcohol level, or the results of other means of testing other substances, that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

MANIPULATIVE TREATMENT

For the **UnitedHealthcare medical plans**, Therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

MATERIAL DUTIES OR MATERIAL DUTY

For the purpose of **disability benefits**, means a duty that meets all of the following requirements:

- Is substantial, not incidental
- Is fundamental or inherent to the occupation
- Cannot be reasonably omitted or changed

Your ability to work the number of hours in your regularly scheduled workweek is a material duty.

MEDICAID

A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

MEDICALLY NECESSARY

For the **UnitedHealthcare medical plans**, healthcare 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 UnitedHealthcare or its designee, within UnitedHealthcare'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 disorder 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 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.

UnitedHealthcare 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 UnitedHealthcare's sole discretion.

UnitedHealthcare 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 UnitedHealthcare and revised from time to time), are available to **covered persons** on **myuhc.com** or by calling **866-480-4988** and to physicians and other health care professionals on **UnitedHealthcareOnline.com**.

MEDICARE

Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

MENTAL HEALTH SERVICES

For the **UnitedHealthcare medical plans**, covered health services for the diagnosis and treatment of mental illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a covered health service.

MENTAL HEALTH/SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES ADMINISTRATOR

The organization or individual designated by the company who provides or arranges mental health and substance-related and addictive disorders services under the **UnitedHealthcare medical plans**.

MENTAL ILLNESS

For the **UnitedHealthcare medical plans**, mental illness means mental health or psychiatric diagnostic categories listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless they are listed in the **What's not covered** section for the UnitedHealthcare plans.

For **disability benefits**, mental illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A mental illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of the disability plans, mental illness does not include the following mental disorders outlined in the diagnostic and statistical manual of mental disorders:

- Mental retardation
- Pervasive developmental disorders
- Motor skills disorder
- Substance-related disorders
- Delirium, dementia, and amnesic and other cognitive disorders
- Narcolepsy and sleep disorders related to a general medical condition

MILITARY TRANSPORT AIRCRAFT

For the purpose of **BTA benefits** only, means a transport aircraft operated by the United States Air Mobility Command (AMC) or a national military air transport service of any country.

NON-MEDICAL 24-HOUR WITHDRAWAL MANAGEMENT

For the UnitedHealthcare medical plans, an organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

NORMAL RETIREMENT AGE

The Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act.

OPEN ENROLLMENT

The period of time, determined by the company, during which eligible employees may enroll themselves and their dependents under the plan. the company determines the period of time that is the open enrollment period.

OTHER INCOME BENEFITS

For **disability benefits**, means the amount of any benefit for loss of income, provided to you or your family, as a result of the period of disability for which you are claiming benefits under the plan. This includes any such benefits for which you or your family are eligible or that are paid to you or your family, or to a third party on your behalf, and may include:

- Any amounts received (or assumed to be received) by you or your dependents under:
  - The Canada and Quebec Pension Plans
  - The Railroad Retirement Act
- Any local, state, provincial or federal government disability or retirement plan or law payable for injury or sickness provided as a result of employment with the employer
- Any work loss provisions in mandatory "no-fault" auto insurance

- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf or for your dependents to such benefits
- Any retirement plan benefits funded by the employer. Retirement plan means any defined benefit or defined contribution plan sponsored or funded by the employer. It does not include an individual deferred compensation agreement, a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
- Any proceeds payable under any franchise or group similar plan. If other insurance applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, we will pay for our pro rata share of the total claim. Pro rata share means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
- Any amounts paid because of loss of earnings capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined
- Any increase in your other income benefits during a period of disability due to a cost of living adjustment will not be considered in calculating your disability benefits after the first reduction is made for any other income benefits. This section does not apply to any cost of living adjustment for disability earnings.
- Other income benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years. If no specific allocation of a lump sum payment is made, then the total payment will be an other income benefit.

OUT-OF-NETWORK BENEFITS

Description of how benefits are paid for covered health services provided by out-of-network providers.

OUT-OF-POCKET MAXIMUM

The maximum amount you pay every plan year.

PARTIAL HOSPITALIZATION/DAY TREATMENT

For the **UnitedHealthcare medical plans**, a structured ambulatory program that may be a free-standing or hospital-based program and that provides services for at least 20 hours per week.

PASSENGER

For **BTA insurance**, means a person who is not:

- The operator or driver
- The pilot, student pilot or a crewmember

PERSONAL DEVIATION FROM A BUSINESS TRIP

For **BTA insurance**, means personal trips that do not exceed seven days that are taken by the employee before, during or after a covered business trip that is not assigned or at the direction of the company for business.

PERSONAL HEALTH SUPPORT

For the **UnitedHealthcare medical plans**, programs provided by the claims administrator that focus on prevention, education and closing the gaps in care designed to encourage an efficient system of care for you and your covered dependents.

PERSONAL HEALTH SUPPORT NURSE

The primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

PHARMACEUTICAL PRODUCTS

For the **UnitedHealthcare medical plans**, FDA-approved prescription pharmaceutical products administered in connection with a covered health service by a physician or other health care provider within the scope of the provider's license and not otherwise excluded under the plan.

PHYSICIAN

For the **UnitedHealthcare medical plans**, physician means any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law. Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a physician. The fact that a provider is described as a physician does not mean that benefits for services from that provider are available to you under the plan.

For **disability**, **life and accident insurance**, physician means a person who is a licensed doctor practicing within the scope of his or her license and rendering care and treatment that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

PLAN YEAR

January 1 – December 31.

PREGNANCY

For the **UnitedHealthcare medical plans**, includes prenatal care, postnatal care, childbirth and any complications associated with pregnancy.

PRE-EXISTING CONDITION

For **disability benefits**, means any of the following conditions for which you received medical care during the three consecutive months prior to your coverage under this plan:

- Any accidental bodily injury, sickness, mental illness, pregnancy, or episode of substance abuse
- Any manifestations, symptoms, findings, or aggravations related to or resulting from the above conditions

PRE-IMPLANTATION GENETIC TESTING (PGT)

For the **UnitedHealthcare medical plans**, a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-A – for aneuploidy (formerly PGS)
- PGT-M – for monogenic disorder (formerly single-gene PGD)
- PGT-SR – for structural rearrangements (formerly chromosomal PGD)

PRESUMPTIVE DRUG TEST

For the **UnitedHealthcare medical plans**, a test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

PRIOR AUTHORIZATION

For the **UnitedHealthcare medical plans**, a review by UnitedHealthcare prior to coverage. Prior authorization monitors use or evaluates clinical necessity, appropriateness, efficacy or efficiency of proposed services. The process may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

PRIVATE DUTY NURSING

For the **UnitedHealthcare medical plans**, nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- Services exceed the scope of intermittent care in the home
- Skilled nursing resources are available in the facility
- The skilled care can be provided by a **home health agency** on a per visit basis for a specific purpose
- The service is provided to a covered person by an independent nurse who is hired directly by the covered person or his/her family; this includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing

PRIVATE PASSENGER AUTOMOBILE

For **AD&D insurance** and **BTA insurance**, means a validly registered, four wheel private passenger car, including policy-holder owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other public conveyance will not be considered a private passenger automobile.

PROOF OF LOSS

For **disability benefits**, proof of loss may include but is not limited to the following:

- Documentation of:
  - The date your disability began
  - The cause of your disability
  - The prognosis of your disability
  - Your pre-disability earnings, current weekly earnings or any income, including but not limited to copies of your filed and signed federal and state tax returns
  - Evidence that you are under the **appropriate care** of a physician
- Any and all medical information, including X-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes
- The names and addresses of all:
  - Physicians or other qualified medical professionals you have consulted
  - Hospitals or other medical facilities in which you have been treated
  - Pharmacies that have filled your prescriptions within the past three years
- Your signed authorization for New York Life to obtain and release:
  - Medical, employment and financial information
  - Any other information New York Life may reasonably require
- Your signed statement identifying all other income benefits
- Proof that you and your dependents have applied for all other income benefits that are available

You will not be required to claim any retirement benefits that you may only get on a reduced basis. All proof submitted must be satisfactory to New York Life. New York Life may require additional proof of loss to determine if you are disabled, or to determine if you meet any other term or condition. They may request that you (at New York Life's expense):

- Meet and interview with a New York Life representative
- Be examined by a physician, vocational expert, functional expert, or other medical or vocational professional of New York Life's choice

Your additional proof of loss must be satisfactory to New York Life. Unless they determine you have a valid reason for refusal, they may deny, suspend or terminate your benefits if you refuse to be examined or meet to be interviewed by their representative.

For **life and accident insurance**, proof of loss may include, but is not limited to, the following:

- A completed claim form
- A certified copy of the death certificate (if applicable)
- Your enrollment form
- Your beneficiary designation (if applicable)
- Documentation of:
  - The date your disability began
  - The cause of your disability
  - The prognosis of your disability
- Any and all medical information, including X-ray films and photocopies of medical records, including histories
- Physical, mental or diagnostic examinations and treatment notes
- The names and addresses of all:
  - Physicians or other qualified medical professionals you have consulted
  - Hospitals or other medical facilities in which you have been treated
  - Pharmacies that have filled your prescriptions within the past three years
- Your signed authorization for New York Life to obtain and release medical, employment and financial information (if applicable)
- Any additional information required by New York Life

RECOGNIZED AMOUNT

For the **UnitedHealthcare medical plans**, the amount which copayment, coinsurance and applicable deductible, is based on for the below covered health services when provided by out-of-network providers.

- Out-of-network emergency health services
- Non-emergency covered health services received at certain network facilities by out-of-network physicians, when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical

access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

- An *All Payer Model Agreement* if adopted,
- State law, or
- The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the recognized amount to determine your cost sharing may be higher or lower than if cost sharing for these covered health services were determined based upon an eligible expense.

RECONSTRUCTIVE PROCEDURE

For the **UnitedHealthcare medical plans**, a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a reconstructive procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or congenital anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a reconstructive procedure.

RECOVER OR RECOVERY

For **long-term disability benefits**, means that you are no longer disabled and have returned to work with the company and premiums are being paid for you.

REGULAR OCCUPATION

For **disability benefits**, means your occupation as it is recognized in the general workplace. Your occupation does not mean the specific job you are performing for a specific employer or at a specific location.

REHABILITATION PROGRAM

For **long-term disability benefits**, means a process of working with New York Life to plan, adapt, and put into use options and services to meet your return to work needs. A rehabilitation program may include, when New York Life considers to be appropriate, any necessary and feasible:

- Vocational testing
- Vocational training
- Alternative treatment plans such as:
  - Support groups
  - Physical therapy
  - Occupational therapy
  - Speech therapy
- Work-place modification to the extent not otherwise provided
- Job placement
- Transitional work
- Similar services

REHABILITATION

For the purpose of the rehabilitation benefit under **BTA insurance**, means medical services, supplies, or treatment, or hospital confinement (or part of a hospital confinement) that satisfies all of the following conditions:

- Are essential for physical rehabilitation required due to the covered person's covered loss
- Meet generally accepted standards or medical practice
- Are performed under the care, supervision or order of a physician
- Prepare the covered person to return to their or any other occupation

RELOCATION TRIP

For **BTA insurance**, means a trip that:

- Begins when the covered person leave his or her former place of residence for the purpose of relocating to a new residence
- Ends when the covered person begins his or her first full day of employment at his or her new location, or 10 days from the date the covered trip began

REMOTE PHYSIOLOGIC MONITORING

For the **UnitedHealthcare medical plans**, the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more remote physiologic monitoring devices. Remote physiologic monitoring must be ordered by a licensed physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote physiologic monitoring may not be used while the patient is inpatient at a hospital or other facility. Use of multiple devices must be coordinated by one physician.

RESIDENTIAL TREATMENT

For the **UnitedHealthcare medical plans**, treatment in a facility which provides mental health services or substance-related and addictive disorders services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs
- It provides a program of treatment under the active participation and direction of a physician
- It offers organized treatment services that feature a planned and structured regimen of care on a 24-hour setting and provides at least the following basic services:
  - Room and board
  - Evaluation and diagnosis
  - Counseling
  - Referral and orientation to specialized community resources

A residential treatment facility that qualifies as a hospital is considered a hospital.

RETIREMENT PLAN

For **disability benefits**, means a defined benefit or defined contribution plan that provides benefits for your retirement and that is not funded wholly by your contributions. It does not include:

- A profit sharing plan
- Thrift, savings or stock ownership plans
- A non-qualified deferred compensation plan
- An individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement

SEAT BELT

For the purpose **AD&D insurance** and **BTA insurance**, means:

- An unaltered belt, lap restraint or lap and shoulder restraint installed by the manufacturer of the automobile or proper replacement parts as required by the automobile manufacturer's specifications
- A child restraint device that meets the standards of the National Safety Council and is properly secured and utilized in accordance with applicable state law and the recommendations of its manufacturer for children of like age and weight

SECRETARY

For the **UnitedHealthcare medical plans**, as that term is applied in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*.

SEMI-PRIVATE ROOM

For the **UnitedHealthcare medical plans**, a room with two or more beds. When an inpatient stay in a semi-private room is a covered health service, the difference in cost between a semi-private room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice or when a semi-private room is not available.

SHARED SAVINGS PROGRAM

For the **UnitedHealthcare medical plans**, 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 and a third party vendor. When this program applies, the non-network provider's

billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the plan may pay the lesser of the Shared Savings Program discount or an amount determined by UnitedHealthcare, such as:

- A percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market
- An amount determined based on available data resources of competitive fees in that geographic area
- A fee schedule established by a third party vendor
- A negotiated rate with the provider

In this case the non-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID card. Shared Savings Program providers are not network providers and are not credentialed by UnitedHealthcare.

SICKNESS

For the **UnitedHealthcare medical plans**, physical illness, disease or pregnancy. The term sickness as used in this benefits booklet includes mental illness or substance-related and addictive disorders, regardless of the cause or origin of the mental illness or substance-related and addictive disorders.

For **disability benefits**, means a disability that is:

- Caused or contributed to by:
  - Any condition, illness, disease or disorder of the body
  - Any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance
  - Hernia of any type unless it is the immediate result of an accidental injury covered by the policy
  - Pregnancy
- Caused or contributed to by any medical or surgical treatment for a condition listed above

SKILLED CARE

For the **UnitedHealthcare medical plans**, skilled nursing, teaching and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient
- A physician orders them
- They are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair
- They require clinical training in order to be delivered safely and effectively
- They are not **custodial care**, as defined by the UnitedHealthcare medical plans

SKILLED NURSING FACILITY

For the **UnitedHealthcare medical plans**, a nursing facility that is licensed and operated as required by law. A skilled nursing facility that is part of a hospital is considered a skilled nursing facility for purposes of the plan.

SPECIALTY PHARMACEUTICAL PRODUCT

For the **UnitedHealthcare medical plans**, pharmaceutical products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

SPOUSE

For the **UnitedHealthcare medical plans**, an individual to whom you are legally married or your domestic partner, as defined in this SPD.

SUBSTANCE ABUSE

For **disability benefits**, means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by any of the following:

- Impairments in social and/or occupational functioning
- Debilitating physical condition
- Inability to abstain from or reduce consumption of the substance
- The need for daily substance use to maintain adequate functioning

Substance abuse includes alcohol and drugs but excludes tobacco and caffeine.

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES

For the **UnitedHealthcare medical plans**, covered health services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a covered health service.

SURROGATE

For the **UnitedHealthcare medical plans**, a female who becomes pregnant, usually by artificial insemination or transfer of a fertilized egg (embryo), for the purpose of carrying the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child.

SURVIVING CHILDREN

For **long-term disability benefits**, means your unmarried children, stepchildren, legally adopted children who, on the date you die, are primarily dependent on you for support and maintenance and who are under age 26.

The term surviving children will also include any other children related to you by blood or marriage or domestic partnership and who meets both of the following requirements:

- Lived with you in a regular parent-child relationship
- Were eligible to be claimed as dependents on your federal income tax return for the last tax year prior to your death

SURVIVING SPOUSE

For **long-term disability benefits**, means your wife or husband who was not legally separated or divorced from you when you died.

Spouse will include your domestic partner provided you have met one of the following requirements:

- Have executed a domestic partner affidavit satisfactory to New York Life establishing that you and your partner are domestic partners for purposes of the policy
- Have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law

You will continue to be considered domestic partners provided you continue to meet the requirements described in the domestic partner affidavit or required by law.

TELEHEALTH/TELEMEDICINE

For the **UnitedHealthcare medical plans**, live, interactive audio with visual transmissions of a physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a covered person's home or place of work. Telehealth/telemedicine does not include virtual care services provided by a designated virtual network provider.

THERAPEUTIC DONOR INSEMINATION (TDI)

For the **UnitedHealthcare medical plans**, insemination with a donor sperm sample for the purpose of conceiving a child.

TOTAL DISABILITY

For the **UnitedHealthcare medical plans**, an employee's inability to perform all substantial job duties because of physical or mental impairment or a dependent's inability to perform the normal activities of a person of like age and gender.

TRANSITIONAL LIVING

For the **UnitedHealthcare medical plans**, mental health/substance-related and addictive disorders services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in American Society of Addiction Medicine (ASAM) criteria, that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery.
- Supervised living arrangements, which are residences such as facilities, group homes and supervised apartments that provide members with stable and

safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery.

UNITEDHEALTH PREMIUM PROGRAM

A program that identifies network physicians or facilities that have been designated as a UnitedHealth Premium Program physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, physicians and facilities must meet program criteria. The fact that a physician or facility is an in-network physician or facility does not mean that it is a UnitedHealth Premium Program physician or facility.

UNPROVEN SERVICES

For the **UnitedHealthcare medical plans**, health services, including medications and devices, regardless of U.S. Food and Drug Administration (FDA) approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy; the comparison group must be nearly identical to the study treatment group

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **myuhc.com**.

Note: If you have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

URGENT CARE

For the **UnitedHealthcare medical plans**, care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

URGENT CARE CENTER

For the **UnitedHealthcare medical plans**, covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

WORKPLACE MODIFICATION

For **disability benefits**, means change in your work environment, or in the way a job is performed, to allow you to perform, while disabled, the essential duties of your job. Payment of this benefit will not reduce or deny any benefit you are eligible to receive under the terms of the plan.