PricewaterhouseCoopers
Staff Medical Plan

Effective: July 1, 2016
Group Number: 752713

Passport Connect

Provider Network:
If you reside in New Hampshire, Massachusetts and Maine, the provider network is established by HPHC Insurance Company.
If you reside outside of New Hampshire, Massachusetts and Maine, the provider network is established by United HealthCare Services, Inc.
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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (888) PwC-1545 (792-1545);
- PwC group number: 752713
- Claims submittal addresses:
  - Medical: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0809 or fax to (248) 733-6000
  - Mental health/substance use: UnitedHealthcare - Claims, P.O. Box 30760, Salt Lake City, UT 84130-0760 or fax to (248) 733-6079
- Online assistance: www.myuhc.com

PwC is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Staff Medical Plan (Plan), which is a part of the PricewaterhouseCoopers LLP Health & Welfare Benefits Plan. (As used in this SPD, “PwC” means PricewaterhouseCoopers LLP and its affiliated companies listed in Section 15, Important Administrative Information: ERISA, whose Employees participate in the Plan.) The SPD, which also serves as the Plan document, includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

To elect Plan coverage, you must select one of the following medical plan options:

- **Open Access plan.** This plan option allows you to choose Network or non-Network doctors or health care providers. You are not required to select a primary care physician and no referrals are required.

- **Middle Deductible plan.** This is an IRS-qualified high-deductible health plan offering both Network and non-Network Benefits. You are not required to select a primary care physician, and no referrals are required. Participants electing this option may be eligible to make voluntary contributions, or have contributions made on their behalf, to a tax-free Health Savings Account (HSA) to help pay for qualified medical expenses.

If you become Medicare eligible as a result of a disability, you can no longer make HSA contributions. If you become Medicare eligible as a result of age, but you have not elected Medicare participation, you may continue making HSA contributions. If you become Medicare eligible as a result of age and you elect Medicare participation, you cannot make HSA contributions.
- **High Deductible plan.** This is an IRS-qualified high-deductible health plan offering both Network and non-Network Benefits. You are not required to select a primary care physician, and no referrals are required. Participants electing this option may be eligible to make voluntary contributions, or have contributions made on their behalf, to a tax-free HSA to help pay for qualified medical expenses.

  If you become Medicare eligible as a result of a disability, the High Deductible plan is no longer available to you and your Dependents. You must make a new medical election in either the Middle Deductible or Open Access plan option. In addition, you cannot make HSA contributions and the firm will not contribute on your behalf. If you become Medicare eligible as a result of age, but you have not elected Medicare participation, you may remain in the High Deductible plan option and continue making HSA contributions. If you become Medicare eligible as a result of age and you elect Medicare participation, the High Deductible plan is no longer available to you and your Dependents. You must make a new medical election into either the Middle Deductible or the Open Access Plan. Further, you cannot make HSA contributions and the firm will not contribute on your behalf.

**Note:** If you participate in the High or Middle Deductible plan option and another health care plan, you are not eligible to make HSA contributions and PwC may not make contributions on your behalf. If you are covered by another health care plan (such as a Spouse's employer plan (if it is not a qualified high-deductible health plan)), a general purpose health care flexible spending account or medical reimbursement account or Medicare), and you are making HSA contributions, please contact Benefits Express immediately at (877) PwC-BenX (792-2369).

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

PricewaterhouseCoopers intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

Please read this SPD thoroughly to learn how the Staff Medical Plan works. If you have questions contact Benefits Express at (877) PwC-BenX (792-2369) or call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).
How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request printed copies of your SPD and any future amendments by contacting Benefits Express at (877) PwC-BenX (792-2369).
- Capitalized words in the SPD have special meanings and are defined in Section 14, Glossary.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, Glossary.
- PricewaterhouseCoopers LLP and its participating affiliates listed in Section 15, Important Administrative Information: ERISA, are referred to as PwC.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.
SECTION 2 - INTRODUCTION

Who is Eligible

Staff Eligibility

You are eligible to participate in the Plan if you are employed by PricewaterhouseCoopers LLP or another participating employer in the Plan (PwC), and PwC classifies you as a U.S. staff member scheduled to work a minimum of 20 hours per week. You are also eligible to participate in the Plan if you are an intern scheduled to work a minimum of 20 hours per week. Note: Interns may elect coverage only under the Middle Deductible plan.

Temporary employees, residents of Puerto Rico, PwC Mexico staff, and staff who are global mobility long-term assignees deployed to locations outside the U.S. are ineligible for the Plan. Also ineligible are individuals who are not on PwC’s payroll, such as persons classified by PwC as independent contractors and individuals whose services are provided through a staffing agency, even if they are retroactively reclassified as common law employees of PwC pursuant to applicable law or otherwise.

Dependent Eligibility

If you elect coverage for yourself, you may elect coverage for the following eligible Dependents:

Spouse/Domestic Partner: Your federally-defined Spouse or your Domestic Partner. A Domestic Partner is an individual of the same or opposite sex as you, who shares an intimate, committed and mutually dependent relationship with you, and has lived with you for at least six months. Your Domestic Partner must be:

- at least age 18;
- in an exclusive relationship with you;
- intending to reside with you permanently;
- mentally competent to consent to a contract;
- not related to you by blood to a degree of closeness that would prohibit legal marriage; and
- not married to or legally separated from another individual or in a civil union or a domestic partner relationship with anyone else.
In order to cover the child(ren) of your Domestic Partner, your Domestic Partner must meet the Plan's eligibility criteria.

Child: "Child" means your natural child, adopted child (and a child living with you who is in the process of being adopted), stepchild, and those of your Domestic Partner.

Children will be eligible through the last day of the month in which they reach age 26.

A child who is incapable of self-support due to a physical or mental disability may continue to be covered beyond age 26 as long as:

- the child was covered during the month of his or her 26th birthday and was disabled on or before that month;
- you provide more than one-half of the child’s support;
- the child is unmarried;
- your own coverage remains in force; and
- you submit proof of the child’s disability in accordance with the process established by the Plan and receive approval within 30 days of the child's 26th birthday. Contact UnitedHealthcare at (888) PwC-1545 (792-1545) for instructions.

Additional proof of such child’s continuing disability may be required periodically by the Plan. Note: If coverage for a disabled child ends at any time after age 26, re-enrollment in the Plan will not be permitted.

In the event your child attains age 26, Benefits Express will automatically discontinue coverage the last day of the month in which he/she attains age 26, at which time continuation of coverage under COBRA may be available. See Section 12, When Coverage Ends, for COBRA eligibility information.

Children listed as part of a qualified medical child support order (QMCSO) also may be enrolled in the Plan, provided they meet the Plan's eligibility requirements. A QMCSO is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement. A copy of the Plan’s procedures for handling QMCSOs and determining whether a medical child support order is qualified is available at no cost upon request from Benefits Express. Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Note: Coverage is no longer available for foster children (effective July 1, 2008) or children for whom you are the legal guardian (effective July 1, 2012). However, children who were already covered under the Plan immediately before these effective dates may continue their coverage while they meet all remaining eligibility requirements.
Additional Eligibility Rules

You will be required to provide documentation to support eligibility status upon enrollment and potentially at any time after enrollment. Misrepresentation of any details (e.g., regarding eligibility of a Dependent) is insurance fraud and could result in loss of coverage and termination from PwC.

Parents and grandparents of staff are never eligible for coverage under the Plan.

Active PwC partners are never eligible for coverage under the Staff Medical Plan. The only exceptions to this rule are for 1) partners of PwC member firms who are assigned to the U.S. and classified as Partners/Principals on Secondment and 2) partners who became disabled prior to July 1, 2010 and subsequently began receiving benefits under the Partner Long-Term Disability Plan.

Active partners must cover themselves and their children under the Partner Medical Plan. Active partners cannot be covered as Dependents under the Staff or Retiree Medical Plan.

No members of a family, whether partner, staff or retiree, or their children, can be covered under more than one PwC medical plan option.

To the extent permitted by law, if coverage was previously cancelled due to nonpayment of monthly payroll costs, PwC reserves the right to preclude you from enrolling for coverage, even if you would otherwise meet the eligibility requirements.

Required Information for Dependents Age One and Over

To comply with the Medicare Secondary Payer Mandatory Reporting provision contained in Section 111 of the Medicare, Medicaid and Children's Health Insurance Program (CHIP) Extension Act of 2007 and Internal Revenue Service (IRS) Code section 6055, Social Security Numbers (SSN)/Health Insurance Claims Numbers or Individual Taxpayer Identification Numbers (ITIN) for Covered Persons age one and over are required to be reported to the Centers for Medicare & Medicaid Services (CMS), the Department of the Treasury and the IRS. And because all medical plans must comply with the regulations, the SSN or ITIN of anyone age one or over needs to be provided in order to obtain and/or maintain medical coverage. In the event a Covered Person does not have an SSN or ITIN, contact Benefits Express for instructions.

Cost of Coverage

The cost of your coverage, which PwC shares, varies depending on the medical plan option you choose and the coverage level you elect (e.g., staff only, staff and family). Your share of the cost is deducted automatically from your pay, generally on a pre-tax basis. This means that the amount you contribute is deducted from your pay before federal income and Social Security taxes—and in most cases, state taxes—are withheld.

This pre-tax feature does not apply to staff on unpaid leaves of absence and those receiving long-term disability benefits under PwC's LTD Plan or to Domestic Partners, unless a tax-qualified relative (see below under Domestic Partner Tax Considerations).
As the cost of medical care rises, there will be periodic adjustments in your monthly cost, usually effective on the first day of the Plan Year (July 1). However, PwC reserves its right to change the level of required contributions for you and your Dependents at any time and without prior notice.

The table below outlines the monthly cost you pay for participation in the various medical plan options, based upon your coverage election:

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<tr>
<th>Coverage Classification</th>
<th>High Deductible Plan</th>
<th>Middle Deductible Plan</th>
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<td>Staff and Spouse/Domestic Partner</td>
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<td>$525</td>
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<td>Staff and Medicare-eligible Domestic Partner</td>
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<td>$407</td>
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<tr>
<td>Staff and Child(ren)</td>
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<tr>
<td>Staff and Family</td>
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<td>$780</td>
</tr>
<tr>
<td>Staff and Medicare-eligible Domestic Partner and Child(ren)</td>
<td>$213</td>
<td>$412</td>
<td>$665</td>
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If you or a Dependent enrolls in Medicare, please notify Benefits Express. Medicare enrollment may impact the amount you pay for medical coverage, your coverage options, and your eligibility to make HSA contributions.

**Domestic Partner Tax Considerations**

When you cover any Dependent under the Plan, you and PwC contribute toward the cost of that coverage. Generally, PwC makes contributions for your medical coverage on a pre-tax basis, and your contributions are withheld from your pay on a pre-tax basis.

Your contribution to cover a Domestic Partner and/or his or her children is the same amount as that to cover a Spouse and your own eligible children. The difference is that Domestic Partner benefits are generally taxable under current IRS regulations. Because IRS rules generally do not recognize your Domestic Partner as your “tax-qualified dependent” or “tax-qualified relative,” you are required to pay taxes on both the amount of PwC’s contribution toward health care coverage for your Domestic Partner and your own pre-tax contributions for that coverage. The value of this coverage paid by you and PwC must be reported (or imputed) as income in your pay and federal, state and local income taxes and FICA (Social Security taxes and Medicare) will be withheld on this amount. In addition, this imputed income will be included as income on your annual W-2 form. In other words, the law requires taxing the full cost of coverage for benefits provided to your Domestic Partner. Each December, PwC will provide a “gross up” allowance to active staff who were active
with PwC on the last business day of November and have a same-sex or opposite-sex Domestic Partner covered under the Plan. This allowance is to help offset your tax on the imputed income incurred when you and PwC pay for Domestic Partners’ medical benefits.

Please note, if your Domestic Partner meets all the requirements for being your tax-qualified dependent/relative under the U.S. Tax Code, this tax consequence does not apply and the cost for the tax-qualified dependents'/relatives' coverage will not be reported (imputed) as income for federal tax purposes. In addition, certain states make benefits available tax-free on a state and local basis to qualifying same-sex couples. Please consult with your tax advisor to determine whether your Domestic Partner and/or his or her child(ren) meet the requirements to be considered your tax-qualified dependent/relative. Upon enrollment, you will be asked by Benefits Express to confirm whether or not your Domestic Partner is a tax-qualified dependent or relative. Should the tax-qualified status of your Domestic Partner change, it is your responsibility to notify Benefits Express within 30 days of the event in order to update your status and PwC's tax records.

**Electing Coverage**

**When to Enroll**

You must enroll in the Plan within 30 days of your date of hire or within 30 days of the date you first become eligible (e.g., because of an increase in your scheduled number of hours).

If you don't enroll by the above deadline, you and/or your eligible Dependents cannot enroll for coverage until the Annual Enrollment period held each year in May (for coverage effective July 1), unless you and/or an eligible Dependent experiences a life event that allows for a special enrollment period. See *Changing Your Elections* below for more information.

**How to Enroll**

You must enroll through Benefits Express using one of several tools.

1. **Online** at [www.benefitsweb.com/pwc.html](http://www.benefitsweb.com/pwc.html). You will need to enter your employee identification number and your 6-digit PIN.

2. **Via MY Rewards and Benefits on myKcurve using your firm-issued computer**—without using your employee ID or 6-digit PIN. To protect your personal information, PwC installs a unique certificate that cannot be duplicated, transferred or removed on each staff member's firm-issued computer. The certificate ensures that only you can access your own MY Rewards and Benefits information from your computer, using your GUID and password (which you should never disclose to anyone else).

3. **Via your iPhone or iPad using the Benefits Express mobile app or the Me@PwC mobile app.**

   - To download the Benefits Express app, from the PwC Apps@Work store, select Benefits Express from the list of available apps and then tap “Install.” Once installed, open the app, click “Health & Well-being,” then click the link to Benefits Express. Your GUID and password are required.
To download the Me@PwC app, from the PwC Apps@Works store, select the Me@PwC app from the list of available apps and then tap “Install.” Note, the Me@PwC app is not available to partners. Once installed, open the app, click “Health & Well-being,” then click the link to Benefits Express. Your GUID and password are required.

If you have any questions about installing the Me@PwC or Benefits Express apps, call 1-877-PwC-HELP (1-877-792-4357), and select option 2 for Technology Support, option 5 for Office Phone, Voicemail, Smartphone, Cellphone, Audio or Video Conferencing, and option 2 for Smartphone and Cellphone.

4. By phone at (877) PwC-BenX (792-2369). From an international location, call Benefits Express at (201) 363-3541. Hearing impaired callers can contact Benefits Express at (800) TDD-TDD4 (833-8334). Representatives are available Monday through Friday between the hours of 8 AM and 6 PM Eastern time. Your 6-digit PIN is required.

**Do You Know Your PIN?**
To request a PIN, go to Benefits Express Online via myKcurve, at [www.benefitsweb.com/pwc.html](http://www.benefitsweb.com/pwc.html), or call Benefits Express at (877) PwC-BenX (792-2369).

Enrollment tools and resources are available to help you make your decisions at MY Rewards and Benefits on myKcurve and Benefits Express Online.

**Certification**
When you initiate any transaction with Benefits Express, you are certifying that all of the information you provide is correct and you understand that misstatements, misrepresentations, or omissions may result in coverage being canceled as of its effective date. In addition, you are certifying that you understand intentionally providing false information may subject you to disciplinary procedures up to and including termination. Further, you are affirming your understanding that any person who knowingly provides false, incomplete, or misleading facts or information to any insurer or claims administrator may be found guilty of insurance fraud, which is a crime, and may be subject to both civil and criminal penalties. Finally, when you initiate a transaction with Benefits Express, you are authorizing PwC to deduct your voluntary contributions to the PwC-sponsored benefit program of your choosing.

**Coverage Levels**
When you enroll, you may choose from the following coverage levels:

- **Staff only** – entitles only the staff member to coverage;
- **Staff and Spouse/Domestic Partner** – entitles the staff member and Spouse or Domestic Partner to coverage;
- **Staff and Child(ren)** – entitles the staff member and one or more Dependent children to coverage; or
- **Staff and Family** – entitles the staff member and all eligible Dependents (including a Spouse or Domestic Partner) to coverage.
When Coverage Begins

**New Hires and Newly Eligible Staff**

Coverage starts on the first day you report to work, provided you complete your enrollment through Benefits Express within 30 days of your hire date. If you become initially eligible for coverage after your date of hire (e.g. increase in your scheduled number of hours to a minimum of 20 hours per week), your coverage will begin on the date you first became eligible to participate in the Plan provided you complete your enrollment through Benefits Express within 30 days following the eligibility date.

You must be actively at work on the day coverage is scheduled to begin; otherwise, coverage will become effective when you return to work. In the event that your absence is due to a health condition, this active-at-work requirement will be waived.

**New Coverage Because of a Life Event**

If you enroll for coverage within 30 days of a life event, as described under *Changing Your Elections* below, Plan coverage for you and/or your Dependents will begin on the date of the life event, provided that you enroll through Benefits Express within 30 days of the life event and you are actively at work on that day. If your absence is due to a health condition, this active-at-work requirement will be waived. Slightly different rules apply in the following situations:

- Coverage for a newborn child is effective on his or her date of birth, provided you enroll through Benefits Express within 30 days of the date of birth. Note that covered charges for a newborn child differ depending on whether the mother is covered under the same plan as the newborn child. If the mother is covered under this Plan, her newborn child is automatically covered under the Plan for the first 96 hours. A newborn child must be added to the Plan within 30 days of the date of birth in order to be eligible for coverage beyond the initial 96 hours.

- If enrolling a newly adopted child, the child must satisfy the Plan’s eligibility requirements. Coverage is effective as of the date of the court document granting adoption, placement or guardianship, provided you enroll through Benefits Express within 30 days of the adoption.

You will be required to provide documentation to support Dependent eligibility status upon enrollment and at any time in the future. Misrepresentation of any details (e.g., regarding eligibility of a Dependent) is insurance fraud and could result in termination of coverage.

**Special Enrollment**

If you and/or an eligible Dependent(s) enroll within 30 days after loss of other medical coverage, coverage under this Plan will be effective on the date the other coverage is lost.

If you and/or an eligible Dependent(s) enroll due to the acquisition of a new Dependent, coverage will be effective on the date of birth, adoption, placement for adoption or marriage provided you enroll within 30 days of the date of marriage, birth, adoption or placement for adoption.
You may be required to provide documentation to support Dependent eligibility status at any time. Misrepresentation of any details (e.g., regarding eligibility of a Dependent) is insurance fraud and could result in termination of coverage.

**Annual Enrollment**

If you enroll during the Annual Enrollment period in accordance with procedures established by PwC, medical coverage is effective July 1.

**If You Are Hospitalized When Your Coverage Begins**

If you enroll in the Plan and are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You or your provider should notify UnitedHealthcare as soon as is reasonably possible after your coverage begins. Network Benefits are available only if you receive Covered Health Services from Network providers.

**Medical Coverage During a Leave of Absence**

You may continue medical coverage for yourself and your eligible Dependents while you are on an authorized paid or unpaid leave of absence, up to six months. (For information on leaves of absence, including limits on how long you may remain on leave, please consult PwC’s Staff Leave of Absence policy.)

You are responsible for your contributions while on leave. During paid leaves, contributions continue in the same manner as prior to the leave. If your medical contributions can no longer be deducted by payroll (i.e., you are no longer receiving pay from PwC), you will be placed on a direct bill basis and you will be responsible for making payments to PwC in accordance with instructions provided on your direct bill statements. Failure to make the appropriate contribution payments could result in the cancellation of your coverage, unless prohibited by law, and you may be responsible for paying retroactive contributions upon return from your leave of absence. Re-enrollment in the Plan may be denied if past-due contributions have not been paid, unless prohibited by law.

If you wish to cancel your coverage during a leave, you must call Benefits Express within 30 days of the start of your leave. Be sure to confirm with Benefits Express whether coverage can be reinstated following the leave, since requirements vary.

For information on continuing, revoking or changing your coverage during a leave of absence, contact Benefits Express. If you do not return to work with PwC following your leave of absence, your employment will terminate and your coverage will end, except as may be available through COBRA, as described in Section 12, When Coverage Ends.

**Additional Rules During a Disability Leave of Absence**

See the prior section entitled Medical Coverage During a Leave of Absence. Medical coverage under the Plan for you and your eligible covered Dependents may continue while you are on an approved Short-Term Disability (STD) or Long-Term Disability (LTD) leave. Should
your disability benefits stop, even temporarily, your disability leave and employment may terminate, resulting in a loss of medical coverage (except as available through COBRA, as described in Section 12, *When Coverage Ends*). For information on disability leave, including when your leave terminates, please consult PwC’s *Staff Leave of Absence* policy, the Short Term Disability Plan SPD or the Long-Term Disability SPD.

If you become entitled to Medicare benefits typically after 29 months of disability (other than for eligibility as a result of end stage renal disease) you must enroll for Medicare coverage Parts A and B, which will become your primary coverage. If you are enrolled in the High Deductible plan option at that time, you must change to the Middle Deductible or Open Access plan option. Once you become Medicare eligible as a result of a disability, you can no longer make HSA contributions.

As soon as you become eligible as a result of disability, you must enroll in Medicare Parts A and B in order to maintain your eligibility for participation under this Plan. Your coverage under the Plan will integrate benefits with Medicare Parts A and B. See Section 10, *Coordination of Benefits* for further details.

See *Medicare Prescription Drug Benefit (Part D)* below for important details about this program.

**Changing Your Elections**

PwC’s contracts with the medical plan administrator and IRS regulations govern when you can change your elections under the Plan.

If any circumstances affecting eligibility for you or your Dependents changes, contact Benefits Express within 30 days to make a new benefits election.

**Annual Enrollment**

You may change from one available medical plan option to another during the Annual Enrollment period, in accordance with procedures established by PwC.

**Life Events**

Election changes during the Plan Year are permissible outside of Annual Enrollment in the case of certain IRS-defined “life events.”

Life events are limited to:

- addition of a Dependent due to birth or adoption (including placement of a child with you for adoption);
- change in your marital status, including marriage, divorce or legal separation;
- death of a Spouse, Domestic Partner or Dependent child;
- Domestic Partner or Dependent satisfies or ceases to satisfy the eligibility requirements;
- your start or completion of an unpaid leave of absence that lasts at least one month;
- change in your employment status from benefits-ineligible to benefits-eligible (e.g., scheduled to work a minimum of 20 hours per week);
- receipt of a QMCO as described above under Who is Eligible;
- your or your Dependent’s initial entitlement to Medicare or Medicaid;
- a significant change in coverage of your Spouse, Domestic Partner or Dependent child under another employer’s medical plan, including changes made in the other employer’s plan during their Annual Enrollment period;
- addition or elimination of a medical plan option; and
- a significant change in cost or coverage under the Plan or any of the Plan options.

If you have a life event, you must notify Benefits Express of the change within 30 days of the event—or you and/or your eligible Dependents must wait until the Annual Enrollment period held each year in May to apply for or change your level of coverage, effective July 1.

Election changes must be consistent with the life event. Life events generally do not provide the opportunity to transfer from one medical plan option to another. Further, you may not switch plans due to a long-term, out-of-town assignment except during Annual Enrollment periods held in May (for coverage effective July 1).

**Special Enrollment Rights**

You and your Dependents may qualify for a special enrollment right under HIPAA due to a loss of coverage or the acquisition of a new Dependent.

If you and/or your eligible Dependent(s) were covered under another group health plan (including COBRA continuation coverage) or had other medical insurance coverage at the time enrollment in this Plan was waived, you and/or your eligible Dependents may enroll in this Plan during the Plan Year if you and/or your eligible Dependent(s) experience a loss of the other coverage.

A loss of coverage is limited to:

- loss of eligibility for non-COBRA coverage (e.g., change in your Dependent’s employment status; death of your Spouse);
- cessation of the employer’s contributions toward non-COBRA coverage;
- exhaustion of COBRA continuation coverage; or
- reaching the lifetime limit on all benefits under the other coverage.

You must request enrollment in the Plan in accordance with firm-designated procedures within 30 days after the date the other coverage ends. In the case of reaching the lifetime limit, you must enroll within 30 days after the claim putting you or your eligible Dependent over the limit is denied. The Plan may request proof of the loss of the other coverage.

Additionally, if you acquire an eligible Dependent through marriage, birth, adoption (or placement for adoption), you (if you did not previously enroll) and your eligible Dependents may enroll in the Plan; however, you must enroll in accordance with firm-designated procedures within 30 days of the marriage, birth, adoption or placement for adoption. If you
do not enroll within the specified time period, enrollment is not permitted until the next Annual Enrollment period in May. You will be required to provide proof of the acquisition of the new Dependent upon enrollment and potentially at any time after enrollment.

**Special Enrollment Rights Under Medicaid and Children's Health Insurance Program (CHIP)**

Special enrollment periods under the Plan may be available to you or your Dependents if either of the following events occurs:

1. You are an eligible staff member who declined enrollment in the Plan for yourself or your Dependents (including a Spouse) because of coverage under Medicaid or a state Child Health Insurance Program, and you lose eligibility for the government-provided coverage; or

2. You are an eligible staff member who declined enrollment in the Plan for yourself or your Dependents, and you or your Dependent become eligible for a premium assistance subsidy under Medicaid or a state Child Health Insurance Program that provides help with paying for coverage under the Plan.

In either of the above situations, you or your Dependent has 60 days from the date of the triggering event described above (that is, either the loss of eligibility in item (1) above or the determination of eligibility in item (2) above) to exercise the special enrollment right.

If you and/or your eligible Dependent enroll within 60 days of a triggering event, as described above, coverage under this Plan will be effective on the date the other coverage is lost.

If you have any questions regarding the application of this provision to you, contact the Plan Administrator.

**Medical Coverage after Age 65 During Active Service**

If you continue working with PwC after age 65, you generally will become Medicare-eligible at that time. You have the option of enrolling in Medicare Parts A and B, or you can postpone Medicare enrollment until you terminate employment or retire.

If you choose to enroll in Medicare, Medicare is secondary coverage to PwC’s Plan.

If you enroll in Medicare, you can no longer participate in the High Deductible Plan. Further, you cannot make HSA contributions if you are in the Middle Deductible plan.

For more information about Medicare, call the Medicare Hotline at (800) MEDICARE (800-633-4227) or go to the Medicare information website at [www.medicare.gov](http://www.medicare.gov).

**Medicare Prescription Drug Benefit (Part D)**

Individuals who are Medicare eligible also may elect to purchase prescription drug coverage through Medicare Part D. Medicare Part D coverage is voluntary, and it is not included in Part A or Part B. However, there are several facts you should consider before you decide whether or not to enroll in Medicare Part D:
• the prescription drug Benefits included in PwC’s health care plan options provide greater value than the Medicare Part D pharmacy benefits. This means you would have lower out-of-pocket expense for prescription drugs under PwC's Plan than you would through Medicare Part D benefits;

• as long as you continue to participate in a medical plan with creditable coverage, such as this Plan, you will not be subject to the penalty imposed by Medicare if you decide to enroll in Medicare Part D at a later date;

• you cannot be covered under both PwC's Plan and Medicare Part D;

• if you enroll in Medicare Part D coverage, you and your covered Dependents will not be eligible for any health care coverage with PwC, and you will not be able to re-enroll in PwC's Plan as long as you maintain Medicare Part D coverage. You may not re-enroll in PwC’s Plan at any time; in general you must wait until the next Annual Enrollment period unless you have a life event as described under Life Events in this section; and

• if your coverage is terminated because you enroll in Medicare Part D, you are not eligible for COBRA coverage.

Every year that you are enrolled in both Medicare and the Plan, you will receive a Notice of Creditable Coverage from the Plan Administrator. This notice verifies your prescription drug coverage under the PwC plan is expected to pay out as much as the standard Medicare Part D prescription drug benefits.

Medical Coverage During Retirement

Eligibility requirements and details about the Retiree Medical Plan are contained in the Retiree Medical Plan SPD.
SECTION 3 - HOW THE PLAN WORKS

What this section includes:
- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.
Employees who live in Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive Network coverage through the Harvard Pilgrim Health Care Network when seeking covered health services in Massachusetts, Maine and New Hampshire or through the UnitedHealthcare Network when seeking covered health services outside Massachusetts, Maine and New Hampshire.

Employees who live outside Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive Network coverage through the UnitedHealthcare Network.

**Health Services from Non-Network Providers Paid as Network Benefits**

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. However, these services must be approved by UnitedHealthcare in advance. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services coordinated by a Network Physician in this manner, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, [www.myuhc.com](http://www.myuhc.com), UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, [www.myuhc.com](http://www.myuhc.com) has the most current source of Network information. Use [www.myuhc.com](http://www.myuhc.com) to search for Physicians available in your Plan.

**Network Providers**

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) or log onto [www.myuhc.com](http://www.myuhc.com).

Network providers are independent practitioners and are not employees of UnitedHealthcare.

UnitedHealthcare’s credentialing process confirms public information about the providers’ licenses and other credentials, but does not assure the quality of the services provided. For information on Premium designated providers, see UnitedHealth Premium Program in Section 7, Resources to Help You Stay Healthy or go to [www.myuhc.com](http://www.myuhc.com); within the Information Center, look for the UnitedHealth Premium® Designated Physicians link.
Don’t Forget Your ID Card

Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Coverage While Traveling Abroad

The Plan pays Benefits for Covered Persons while traveling outside the United States. Emergency services received outside the United States will be paid at the Network benefit level and are subject to the Annual Deductible. Eligible Expenses for non-Emergency services incurred while outside the United States are reimbursed at the non-Network benefit level and are subject to the Annual Deductible. Any care received must be a Covered Health Service. You must pay the provider at the time treatment is received and obtain appropriate documentation of services received including any bills, receipts and medical narrative. This information should be included when you submit your claim to UnitedHealthcare as described in Section 9, Claims Procedures. If you have any questions about Benefits while traveling abroad, or before you travel, please call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

Eligible Expenses

PwC has delegated to the Claims Administrator 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 the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator’s reimbursement policy guidelines, as described in this SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator’s contracted fee(s) with that provider.

- When Covered Health Services are received from a Non-Network provider as a result of an Emergency or as arranged by the Claims Administrator as described above under Health Services from Non-Network Providers Paid as Network Benefits, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
- Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator’s vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
- If rates have not been negotiated, then one of the following amounts:
  ♦ 300% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
  ♦ when a rate is not published by CMS for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:
    - For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Claims Administrator based on an internally developed pharmaceutical pricing resource.
    - For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by OptumInsight, Inc and/or a third party vendor. If the relative value scale(s) currently in use becomes no longer available, a comparable scale will be used. The Claims Administrator and OptumInsight, Inc. are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare’s website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - for facility claims, if one of the above methods does not apply, the Eligible Expense is based on 50% of the facility's billed charge. This method is used when the facility does not participate with Medicare, or because a CMS rate is not published, or when the claim has missing or incorrect information. Note: A relative value scale does not apply to facility charges so a gap methodology is not used;
  - for Physician claims, if one of the above methods does not apply, the Eligible Expense is based on 50% of the Physician's billed charge. This method is used if the service code submitted does not have a published CMS rate and if in addition a gap methodology does not apply to the service or if the provider does not submit sufficient information on the claim to pay it under a gap methodology.

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

**IMPORTANT NOTICE**
Non-Network Physicians and providers may bill you for any difference between the Physician's or provider's billed charges and the Eligible Expense described above.

**Annual Deductible**
The Annual Deductible is the amount of Eligible Expenses you must pay each Plan Year for Covered Health Services before the Plan begins to pay Benefits subject to the Deductible.
See Section 5, Plan Highlights under the applicable benefit category to determine if a Deductible applies. There is a combined Annual Deductible for Network and Non-Network Benefits. The amounts applied toward your Annual Deductible accumulate over the course of the Plan Year.

For the Middle Deductible and High Deductible plan options, the Annual Deductible also applies to items covered under your separate prescription drug coverage.

For Covered Health Services with visit limits (e.g., Manipulative (chiropractic) Treatment), services you receive both before and after you meet the Annual Deductible will be applied toward that visit limit.

**Copayment**

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not count toward the Annual Deductible. Copays under your medical Benefits count toward the Out-of-Pocket-Maximum; however Copays under your prescription drug Benefits do not count toward the medical Out-of-Pocket-Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

**Coinsurance**

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

**Coinsurance – Example**

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 90% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance.

**Out-of-Pocket Maximum**

The annual Out-of-Pocket Maximum is the most you pay each Plan Year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a Plan Year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the Plan Year.

For the Middle Deductible and High Deductible plan options, the Out-of-Pocket Maximum also applies to items covered under your separate prescription drug coverage. For the Middle Deductible and High Deductible plan options, Eligible Expenses charged by both Network and non-Network providers apply toward both the Network Out-of-Pocket Maximum and the non-Network Out-of-Pocket Maximum.
For the Open Access plan option, your Copays and Coinsurance apply to the Out-of-Pocket Maximum. This means that once the Out-of-Pocket Maximum is reached, you are no longer responsible for paying a Copay at the time of a visit to your provider.

For all plan options, amounts in excess of Eligible Expenses do not apply toward the Out-of-Pocket Maximum. You are responsible for charges in excess of Eligible Expenses.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Applies to the Network Out-of-Pocket Maximum?</th>
<th>Applies to the Non-Network Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays (Open Access Plan only)</td>
<td>Yes*</td>
<td>Yes*</td>
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<tr>
<td>Payments toward the Annual Deductible</td>
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<td>Yes</td>
</tr>
<tr>
<td>Coinsurance payments</td>
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<td>Yes</td>
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<tr>
<td>Charges for non-Covered Health Services</td>
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<td>No</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses</td>
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<td>No</td>
</tr>
</tbody>
</table>

*Medical Copays only. Prescription drug Copays do not apply to the medical Out-of-Pocket Maximum.
SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:
■ An overview of the Personal Health Support program; and
■ Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support Nurse program includes:

■ Admission counseling - Nurse advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.

■ Inpatient care management - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

■ Readmission management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

■ Risk management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss...
and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

Requirements for Notifying Personal Health Support

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

The Network services that require Personal Health Support notification are:

- ambulance – non-emergent air;
- Clinical Trials;
- Congenital Heart Disease surgeries;
- obesity surgery; and
- transplants.

For notification timeframes, see Section 6, Additional Coverage Details.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services.

The Non-Network services that require Personal Health Support notification are:

- ambulance – non-emergent air;
- Clinical Trials;
- Congenital Heart Disease surgeries;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic Testing – BRCA;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies;
- Lab, X-ray and Major Diagnostics - Outpatient - CT, PET Scans, MRI, MRA and Nuclear Medicine including breast MRIs, cardiac CT scans, diagnostic catheterization and electrophysiology implants;
- maternity care that exceeds the delivery timeframes as described in Section 6, Additional Coverage Details;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility). Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA).
- obesity surgery;
- prosthetic devices for items that will cost more than $1,000 to purchase or rent;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Surgery – Outpatient - cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, sleep apnea surgeries and orthognathic surgeries;
- therapeutic treatments as described in Section 6, Additional Coverage Details under Therapeutic Treatments - Outpatient;
- transplants; and
- treatment of gender dysphoria (Gender Identity Disorder) as described in Section 6, Additional Coverage Details under Gender Dysphoria (Gender Identity Disorder) Treatment.

For notification timeframes, see Section 6, Additional Coverage Details.

**Contacting Personal Health Support is easy.**

Simply call the toll-free number on your ID card: (888) PwC-1545 (792-1545).

**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 notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, Coordination of Benefits (COB).
SECTION 5 - PLAN HIGHLIGHTS

This section includes two tables that highlight features of the Plan. For a detailed description of Benefits and any limits or notification requirements that apply, see Section 6, Additional Coverage Details.

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Open Access Plan</th>
<th>Middle Deductible Plan</th>
<th>High Deductible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
<td>Network</td>
</tr>
<tr>
<td>Copays(^1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Physician Office Services - Primary Physician</td>
<td>$20</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>■ Physician Office Services - Specialist Physician</td>
<td>$30</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>■ Urgent Care Center Services</td>
<td>$30</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Annual Deductible(^2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Staff-only coverage</td>
<td>$550</td>
<td>$1,675</td>
<td>$3,350</td>
</tr>
<tr>
<td>■ Other coverage levels (cumulative Annual Deductible(^3))</td>
<td>$1,100</td>
<td>$3,375</td>
<td>$6,750</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum(^2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Staff-only coverage</td>
<td>$2,550</td>
<td>$4,050</td>
<td>$3,675</td>
</tr>
<tr>
<td>■ Other coverage levels (cumulative Out-of-Pocket Maximum(^4))</td>
<td>$5,100</td>
<td>$8,100</td>
<td>$7,375(^5)</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit(^6)</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

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.
In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

Copays do not count toward the Annual Deductible. Copays under your medical Benefits count toward the Out-of-Pocket-Maximum; however Copays under your prescription drug Benefits do not count toward the medical Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. For the Middle and High Deductible plan options, the Annual Deductible and Out-of-Pocket Maximum apply to all Covered Health Services under the Plan and also apply to items covered under your separate prescription drug coverage.

If more than one member of a family unit is covered under the Plan, the Deductible for other coverage levels will apply and no one in the family is eligible to receive Benefits subject to the Deductible until this Deductible is satisfied.

If more than one member of a family unit is covered under the Plan, the Out-of-Pocket Maximum for other coverage levels will apply.

When enrolled for “other coverage levels,” there is an individual Network Out-of-Pocket Maximum of $6,850. If any one member of a family unit pays Network Eligible Expenses equal to $6,850, Network Eligible Expenses for that person will be paid at 100% for the rest of the Plan Year. (That person doesn’t have to reach the $7,375 Network family Out-of-Pocket Maximum in the Middle Deductible Plan/$10,750 in the High Deductible Plan.) The rest of the family will have to meet the remainder of the Network Annual Out-of-Pocket Maximum before the family’s Network Eligible Expenses are paid at 100%.

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 use disorder 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.

The table below provides an overview of the Plan’s coverage levels. For detailed descriptions of your Benefits, refer to Section 6, Additional Coverage Details.

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, Additional Coverage Details.

<table>
<thead>
<tr>
<th>Acupuncture Services</th>
<th>90% after you meet the Annual Deductible</th>
<th>60% after you meet the Annual Deductible</th>
<th>90% after you meet the Annual Deductible</th>
<th>70% after you meet the Annual Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Health Services</td>
<td>Open Access Plan</td>
<td>Middle and High Deductible Plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
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<td>----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td><strong>Ambulance Services (Emergency and Non-Emergency)</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>90% of billed charges after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>90% of billed charges after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services - Accident Only</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>70% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Diabetes Self-Management Items</td>
<td>Benefits for diabetes equipment will be the same as those stated under <em>Durable Medical Equipment</em> in this section.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>70% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Emergency Health Services - Outpatient</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>90% of billed charges after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>90% of billed charges after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*. 

---

1. Covered Health Services include Ambulance Services (Emergency and Non-Emergency), Clinical Trials, Dental Services (Accident Only), Diabetes Services, Durable Medical Equipment (DME), and Emergency Health Services - Outpatient.
<table>
<thead>
<tr>
<th>Covered Health Services(^1)</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td></td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*.

### Enteral Nutrition
Up to $5,000 per Plan Year

- **Open Access Plan**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible

- **Middle and High Deductible Plans**
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

### Gender Dysphoria (Gender Identity Disorder) Treatment
Depending upon where the Covered Health Service is provided, Benefits for Gender Identity Disorder treatment will be the same as those stated under each Covered Health Service category in this section.

### Habilitation and Rehabilitation Services - Outpatient Therapy and Manipulative Treatment
(Copay is per visit)
See Section 6, *Additional Coverage Details*, for visit limits

- **Open Access Plan**
  - 100% after you pay a $30 Copay
  - 60% after you meet the Annual Deductible

- **Middle and High Deductible Plans**
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

### Hearing Aids
Up to $5,000 every consecutive 36 months

- **Open Access Plan**
  - 90% after you meet the Annual Deductible
  - 90% of billed charges after you meet the Annual Deductible

- **Middle and High Deductible Plans**
  - 90% after you meet the Annual Deductible
  - 90% of billed charges after you meet the Annual Deductible

### Home Health Care

- **Open Access Plan**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible

- **Middle and High Deductible Plans**
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

### Hospice Care

- **Open Access Plan**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible

- **Middle and High Deductible Plans**
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

### Hospital - Inpatient Stay

- **Open Access Plan**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible

- **Middle and High Deductible Plans**
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible
<table>
<thead>
<tr>
<th>Covered Health Services(^1)</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*.

### Infertility Services

Special program notification requirements through the WIN Fertility Program apply to these Benefits. See Section 6, *Additional Coverage Details* and *Addendum – Prescription Drug Benefits*.

- **Physician Office Services (Copay is per visit)**
  - *Primary Physician*
    - 100% after you pay a $20 Copay
  - *Specialist Physician*
    - 100% after you pay a $30 Copay
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

- **Outpatient services received at a Hospital or Alternate Facility**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

$25,000 lifetime maximum for infertility services
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td></td>
</tr>
<tr>
<td>Injections Received in a Physician's Office</td>
<td><strong>Immunizations</strong>&lt;br&gt;100%&lt;br&gt;Annual Deductible does not apply&lt;br&gt;<strong>All other injections</strong>&lt;br&gt;90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Lab, X-Ray and Diagnostics – Outpatient</td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td><strong>Hospital - Inpatient Stay</strong>&lt;br&gt;90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Physician Office Services</strong>&lt;br&gt;90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*. 
## Covered Health Services

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[| Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td></td>
</tr>
</tbody>
</table>

### Neurobiological Disorders - Autism Spectrum Disorder Services
- **Hospital - Inpatient Stay**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

- **Physician Office Services**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

### Nutritional Counseling
(Copay is per visit)
- 100% after you pay a $30 Copay
- 60% after you meet the Annual Deductible
- 90% after you meet the Annual Deductible
- 70% after you meet the Annual Deductible

### Obesity Surgery
- **Physician Office Services**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

- **Physician Fees for Surgical and Medical Services**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

- **Hospital - Inpatient Stay**
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

---

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*. |
<table>
<thead>
<tr>
<th>Covered Health Services¹</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td></td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ostomy Supplies</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Pharmaceutical Products - Outpatient</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Physician Office Services - Sickness and Injury</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Primary Physician (Copay is per visit)</td>
<td>100% after you pay a $20 Copay</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Specialist Physician (Copay is per visit)</td>
<td>100% after you pay a $30 Copay</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

In addition to the Copay stated in this section, the Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician’s office:

■ lab, radiology/x-rays and other diagnostic services described

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*. 
<table>
<thead>
<tr>
<th>Covered Health Services¹</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td></td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td>under Lab, X-Ray and Diagnostics – Outpatient;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ outpatient surgery procedures described under Surgery – Outpatient; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ outpatient therapeutic procedures described under Therapeutic Treatments – Outpatient.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician Virtual Visits
(Copay is per visit)

<table>
<thead>
<tr>
<th></th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Designated Network</td>
<td>Designated Network</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $20 Copay Network</td>
<td>90% after you meet the Annual Deductible Network</td>
</tr>
<tr>
<td></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, Additional Coverage Details.
<table>
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<tr>
<th>Covered Health Services¹</th>
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<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td></td>
</tr>
<tr>
<td>Pregnancy – Maternity Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Routine Prenatal Care</td>
<td>100%</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Hospital, Lab, Anesthesia, Ancillary Charges and Obstetrician Delivery Fees</td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Physician Office Services</td>
<td>100%</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Mammogram, Colonoscopy or Other Preventive Tests</td>
<td>100%</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Breast Pumps</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>See Section 7, Resources to Help you Stay Healthy, for a description of the Nursing Moms' Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing - Outpatient</td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, Additional Coverage Details.
<table>
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<tr>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
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<td></td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, Additional Coverage Details.

### Prosthetic Devices
- 90% after you meet the Annual Deductible
- 60% after you meet the Annual Deductible
- 90% after you meet the Annual Deductible
- 70% after you meet the Annual Deductible

### Reconstructive Procedures

- **Physician Office Services (Copay is per visit)**
  - Primary Physician
    - 100% after you pay a $20 Copay
  - Specialist Physician
    - 100% after you pay a $30 Copay

- Hospital - Inpatient Stay
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

- Physician Fees for Surgical and Medical Services
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

- Prosthetic Devices
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible

- Surgery - Outpatient
  - 90% after you meet the Annual Deductible
  - 60% after you meet the Annual Deductible
  - 90% after you meet the Annual Deductible
  - 70% after you meet the Annual Deductible
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td><strong>Percentage of Eligible Expenses Payable by the Plan:</strong></td>
<td><strong>Percentage of Eligible Expenses Payable by the Plan:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Scopic Procedures - Outpatient Diagnostic and Therapeutic</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Substance Use Disorder Services</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>- Hospital - Inpatient Stay</td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>- Physician Office Services</td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Surgery - Outpatient</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint (TMJ) Services</strong></td>
<td>Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.</td>
<td></td>
</tr>
<tr>
<td><strong>Therapeutic Treatments - Outpatient</strong></td>
<td>90% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>
## Covered Health Services

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td><a href="#">Designated Facility</a> 100% after you meet the Annual Deductible</td>
<td><a href="#">Network Facility</a> 90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Travel and Lodging</td>
<td>For patient and companion(s) of patient undergoing transplant procedures</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>100% after you pay a $30 Copay</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*.

---

1. For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*.

1. **Transplantation Services**
   - Designated Facility: 100% after you meet the Annual Deductible
   - Network Facility: 90% after you meet the Annual Deductible
   - Not Covered

1. **Travel and Lodging**
   - For patient and companion(s) of patient undergoing transplant procedures

1. **Urgent Care Center Services**
   - 100% after you pay a $30 Copay
   - 90% after you meet the Annual Deductible
   - 90% after you meet the Annual Deductible
<table>
<thead>
<tr>
<th>Covered Health Services&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>For a description of Benefits and any limits or notification requirements that apply, see Section 6, Additional Coverage Details.</td>
<td>90% after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient;</td>
<td>90% of billed charges after you meet the Annual Deductible</td>
<td>90% of billed charges after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ outpatient surgery procedures described under Surgery - Outpatient; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wigs
One per Plan Year

---

<sup>1</sup>You should notify Personal Health Support, as described in Section 4, Personal Health Support before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Personal Health Support before you receive certain Covered Health Services. See Section 6, Additional Coverage Details for further information.
## Resource Services for Specific Conditions

The table below describes Covered Heath Services available under the Plan that include resource services for certain conditions when you seek care through UnitedHealthcare’s Network of Designated Facilities. For detailed descriptions of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*.

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network (Designated Facility)</td>
<td>Non-Designated Facility</td>
</tr>
<tr>
<td><strong>Cancer Resource Services (CRS)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospital Inpatient Stay</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Physician Office Services (Copay is per visit)</td>
<td>Primary Physician 100% after you pay a $20 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Physician Fees for Surgical and Medical Services</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Lab, X-Ray and Diagnostics/Outpatient Scopic Procedures</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details*. 
<table>
<thead>
<tr>
<th>Covered Health Services(^1)</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network (Designated Facility)</td>
<td>Non-Designated Facility</td>
</tr>
<tr>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td></td>
</tr>
</tbody>
</table>

For a description of Benefits and any limits or notification requirements that apply, see Section 6, *Additional Coverage Details.*

<table>
<thead>
<tr>
<th>Congenital Heart Disease (CHD) Resource Services</th>
<th>90% after you meet the Annual Deductible</th>
<th>90% after you meet the Annual Deductible</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient Stay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Services (Copay is per visit)</td>
<td>Primary Physician 100% after you pay a $20 Copay</td>
<td>Specialist Physician 100% after you pay a $30 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician Fees for Surgical and Medical Services</td>
<td>90% after you meet the Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab, X-Ray and Diagnostics/Outpatient Scopic Procedures</td>
<td>90% after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Open Access Plan</td>
<td>Middle and High Deductible Plans</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
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<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network (Designated Facility)</td>
<td>Non-Designated Facility</td>
<td>Network (Designated Facility)</td>
</tr>
<tr>
<td>Neonatal Resource Services (NRS)</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td>Percentage of Eligible Expenses Payable by the Plan:</td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient Stay</td>
<td>90% after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician Office Services (Copay is per visit)</td>
<td>Primary Physician 100% after you pay a $20 Copay</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician Fees for Surgical and Medical Services</td>
<td>90% after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Lab, X-Ray and Diagnostics/Outpatient Scopic Procedures</td>
<td>90% after you meet the Annual Deductible</td>
<td>90% after you meet the Annual Deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

¹These Benefits are for Covered Health Services provided through the resource services program at a Designated Facility. For oncology services, CHD services or NICU services not provided through the resource services program, the Plan pays Benefits as described under Physician Office Services, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic, Lab, X-Ray and Diagnostics – Outpatient and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.
SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
■ Covered Health Services for which the Plan pays Benefits; and
■ Covered Health Services for which you should notify Personal Health Support before you receive them.

This section supplements the second table in Section 5, Plan Highlights.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. Services that are not covered are described in Section 8, Exclusions.

Acupuncture Services

The Plan pays for acupuncture services performed 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; or
■ Acupuncturist.

Acupressure, nutritional supplements or alternative treatments provided by an acupuncturist are not Covered Health Services under the Plan.

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, 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 a non-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; or
- from an acute facility to a sub-acute setting.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you should notify Personal Health Support as soon as possible prior to the transport.

Cancer Resource Services (CRS)
The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, Glossary.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).
Clinical Trials
The Plan pays 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; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, 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 qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services 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; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine 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 UnitedHealthcare'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; and
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 or the Department of Veterans Affairs;
- a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- 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; and
  ♦ 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; or

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.

Please remember that you should notify Personal Health Support as soon as the possibility of participation in a Clinical Trial arises.
**Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program facility. 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); and
- 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 (888) PwC-1545 (792-1545) for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Please remember for Non-Network Benefits, you should notify United Resource Networks or Personal Health Support as soon as CHD is suspected or diagnosed.

**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 sustained while the patient was participating in a PwC medical plan;
- 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; and
■ 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.)

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

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; and
■ replacement of lost teeth due to the Injury by implant, dentures or bridges.

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); and
■ direct treatment of acute traumatic Injury, cancer or cleft palate.

The Plan also pays Benefits for ancillary services, anesthesia and facility charges for extraction of impacted wisdom teeth.

**Diabetes Services**

The Plan pays Benefits for the Covered Health Services identified below.

<table>
<thead>
<tr>
<th>Covered Diabetes Services</th>
<th>Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</td>
<td></td>
</tr>
</tbody>
</table>
**Covered Diabetes Services**

<table>
<thead>
<tr>
<th>Diabetic Self-Management Items</th>
<th>Physician and provided by appropriately licensed or registered healthcare professionals.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.</td>
</tr>
<tr>
<td></td>
<td>Benefits are provided for insulin pumps, blood glucose monitors and related supplies for the management and treatment of diabetes. Insulin pumps, blood glucose monitors and related supplies are not subject to the Cost-Effective conditions of coverage stated under <em>Durable Medical Equipment</em> in this section.</td>
</tr>
<tr>
<td></td>
<td>Benefits for insulin and for diabetes supplies, including syringes and test strips, are provided under your separate prescription drug coverage.</td>
</tr>
</tbody>
</table>

Please remember for Non-Network Benefits, you should notify Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies.

**Durable Medical Equipment (DME)**

The Plan pays 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; and
- appropriate for use in the home.

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 and for repairs of that unit.

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;
- 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, Habilitation and Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section;
- custom molded cranial orthotics (helmets), when prescribed by a Physician;
- 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 Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage;
- rental of hospital-grade breast pumps (also called multi-user breast pumps) in conjunction with childbirth when the newborn child is hospitalized after the mother has been discharged, has extreme prematurity, a Congenital Anomaly, genetic abnormality, or another medical or surgical condition that impacts or delays breast feeding (e.g., cleft lip and palate, Down syndrome). Note: Purchase of a single-user breast pump in conjunction with Pregnancy is covered as described under Preventive Care Services in this section; and
- 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.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices – see Prosthetic Devices in this section.

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. 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.
Please remember for Non-Network Benefits, you should notify Personal Health Support if the retail purchase cost or cumulative rental cost of a single item of Durable Medical Equipment will exceed $1,000. To receive 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.

Emergency Health Services - Outpatient

The Plan’s Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

To ensure payment of Network Benefits, notify Personal Health Support as soon as possible after you are admitted to a non-Network Hospital as a result of an Emergency. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-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.

Enteral Nutrition

The Plan pays Benefits for enteral nutritional formulas for home use when determined by a Physician to be medically necessary due to one of the following:

- inherited diseases of amino acid or organic acid metabolism (e.g., PKU, branched chain ketonuria, galactosemia, homocystinuria);
- Crohn's disease;
- gastroesophageal reflux with failure to thrive;
- disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction;
- ulcerative colitis;
- multiple severe food allergies; or
- they are the Covered Person’s only source of nutrition.

Any combination of Network Benefits and Non-Network Benefits is limited to $5,000 per Plan Year.

Gender Dysphoria (Gender Identity Disorder) Treatment

The Plan pays Benefits for the treatment of gender dysphoria (Gender Identity Disorder) as described under non-surgical and surgical treatment for gender dysphoria.

Non-Surgical Treatment of Gender Dysphoria:

The Plan covers non-surgical treatment for gender dysphoria; the following non-surgical treatments are covered:
psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in Section 6, Additional Coverage Details;

continuous hormone replacement therapy with hormones of the desired gender injected by a medical provider;

*Note.* Coverage may be available for oral and self-injected hormones under your separate prescription drug coverage. Certain injections or topical hormone replacement products could be subject to prior authorization requirements. See *Addendum: Prescription Drug Benefits* for details.

laboratory testing to monitor the safety of continuous hormone therapy.

**Surgical Treatment of Gender Dysphoria:**
The Plan covers surgical treatment for gender dysphoria; the following are covered when the eligibility qualifications for surgery are met below:

- 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 the most recent edition of the World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People; and
  - For irreversible surgical interventions, the Covered Person must be age 18 years or older; and
  - Prior to surgery, the Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender.

Important:
- Certain Covered Persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the Covered Person'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.

The Claims Administrator has specific guidelines regarding Benefits for treatment of gender dysphoria (Gender Identity Disorder). Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Please remember for Non-Network Benefits for treatment of Gender Identity Disorder, you should notify Personal Health Support five business days before scheduled services are received or for non-scheduled services, within two business days or as soon as is reasonably possible.
Habilitation and Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient Habilitation Services and rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- speech therapy;
- Manipulative Treatment;
- post-cochlear implant aural therapy;
- vision therapy;
- cognitive rehabilitation therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

Benefits provided under this section include Habilitation Services as defined in Section 14, Glossary, for Covered Persons with a disabling condition.

For all outpatient therapy 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 therapy services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, or in the Covered Person's home. For Habilitation Services, the therapy provider may include a licensed audiologist, licensed nutritionist or licensed social worker.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitation services, are described under Durable Medical Equipment and Prosthetic Devices in this section.

In addition, the Plan provides Benefits for speech therapy when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, developmental delay, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits for physical and occupational therapy also include services provided to address developmental delay. Benefits for cognitive rehabilitation therapy are provided following a post-traumatic brain Injury or cerebral vascular accident or to address developmental delay.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if therapy goals have previously been met. (This requirement does not apply to Manipulative Treatment.)

Benefits for Habilitation Services and rehabilitation services combined are limited to:
■ 90 visits per Plan Year for physical, occupational, speech and cognitive rehabilitation therapy combined; and

■ 30 visits per Plan Year for Manipulative Treatment.

These visit limits apply to Network Benefits and Non-Network Benefits combined. Benefits for post-cochlear implant aural therapy, vision therapy, pulmonary rehabilitation and cardiac rehabilitation do not have visit limits.

**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.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only 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; or

■ hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $5,000 every consecutive 36 months. Hearing aid exams are not included in this maximum.

**Home Health Care**

Covered Health Services are services that a Home Health Agency or the Visiting Nurse Association provides if you need care in your home due to the nature of your condition. 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, as defined in Section 14, *Glossary*; and

■ provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.
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.

Covered Health Services include:

- physical, occupational and speech/language therapy;
- medical social work;
- nutritional counseling;
- medical supplies;
- enteral infusion therapy; and
- basic hydration therapy.

Covered Health Services also include home infusion therapy by a licensed home infusion therapy provider only, including the infusion solution and its preparation, equipment for administration and necessary part-time nursing (four hours or less per day).

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before receiving home health care services or as soon as reasonably possible.

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 for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when:

- the patient has a terminal illness and is expected to live six months or less (as certified by a Physician);
- the patient and attending Physician have agreed to a plan of care that stresses pain control and symptom relief rather than curative treatment; and
- hospice care is received from a licensed hospice agency, which can include a Hospital.

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before receiving inpatient hospice care.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- 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); and
Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

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 an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Benefits for Emergency admissions and admissions of less than 24 hours are described under Emergency Health Services and Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic, and Therapeutic Treatments - Outpatient, respectively.

Please remember that you should notify Personal Health Support five business days before an elective admission to a non-Network Hospital.

To ensure payment of Network Benefits, notify Personal Health Support as soon as possible after you are admitted to a non-Network Hospital as a result of an Emergency.

Infertility Services

Infertility services are available only for the Employee and his/her Spouse or Domestic Partner. The Plan pays Benefits for surgical and non-surgical treatment of infertility for:

- ovulation induction;
- insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI));
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and other embryo transfer. Note: A diagnosis of infertility is not required to receive these services;
- cryopreservation of embryos or other reproductive materials; and
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office or in a Covered Person's home.

The Plan pays Benefits for services for the reversal of sterilization only when required as an infertility treatment.

The Plan also pays Benefits for infertility services when planned cancer treatment is likely to produce infertility. Coverage is limited to:

- collection and cryopreservation of sperm;
- ovulation induction and retrieval of eggs;
- in vitro fertilization; and
- embryo cryopreservation.

Any combination of Network Benefits and Non-Network Benefits for infertility services is limited to a lifetime maximum of $25,000 per Covered Person.

Only charges for the following apply toward the infertility lifetime maximum:

- surgeon;
- assistant surgeon;
- anesthesia;
- lab tests;
- specific injections;
- charges for reversal of sterilization if not included in the above; and
- cryopreservation storage fees.

Benefits for prescription drugs for the treatment of infertility are provided under your prescription drug coverage and have a separate benefit maximum.

**WIN Fertility**

Contact WIN Fertility at (877) 528-0300. WIN Fertility provides consultative services regarding fertility treatment along with prior authorization for coverage of fertility medications. When you contact WIN, you have access to your own personal FertilityCoach NurseSM who will assist you in understanding your best treatment options. FertilityCoach Nurses are available for questions, concerns and clinical assistance 24 hours a day, seven days a week. Your personal treatment plan will be continually reviewed in collaboration with your reproductive endocrinologist.

Prior authorization by WIN Fertility is required for coverage of fertility medications. See *Addendum – Prescription Drug Benefits* for more information about medications covered under your prescription drug Benefits with Express Scripts.

**Injections Received in a Physician's Office**

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example travel immunizations or allergy immunotherapy.

**Lab, X-Ray and Diagnostics - Outpatient**

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- lab and radiology/x-ray; and
- mammography, including 3D mammograms (breast tomosynthesis) for screening or diagnosis of breast cancer.
Benefits under this section include:

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

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services. Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient in this section.

Please remember for Non-Network Benefits for sleep studies, you should notify Personal Health Support five business days before scheduled services are received.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic 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; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before scheduled services are received, including diagnostic catheterization, electrophysiology implants, breast MRI or cardiac CT scan.

Medical Supplies

The Plan pays Benefits for medical or disposable supplies for use in the Covered Person’s home when the supplies are prescribed by a Physician. Covered Health Services include, but are not limited to, catheters and compression stockings.

Coverage also includes disposable supplies necessary for the effective use of Durable Medical Equipment and diabetic supplies for which Benefits are provided as described under Durable Medical Equipment and Diabetes Services in this section.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider’s office.
Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- therapeutic treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder (MH/SUD) Administrator determines coverage for inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

**Note:** Subject to all conditions of coverage described in this Mental Health Services section, Benefits are provided for outpatient Mental Health Services rendered by telephone.

**Special Mental Health Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you should notify the MH/SUD Administrator to receive inpatient mental health Benefits in advance of any treatment. Refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card: (888) PwC-1545 (792-1545).

**Neonatal Resource Services (NRS)**

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Facilities participating in the Neonatal Resource Services (NRS) program. NRS
provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Facility is defined in Section 14, Glossary.

In order to receive Benefits under this program, the Network provider must notify NRS or Personal Health Support if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

■ call Personal Health Support; or
■ call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

■ Physician Office Services - Sickness and Injury;
■ Physician Fees for Surgical and Medical Services;
■ Scopic Procedures - Outpatient Diagnostic and Therapeutic;
■ Therapeutic Treatments - Outpatient;
■ Hospital - Inpatient Stay; and
■ Surgery - Outpatient.

**Neurobiological Disorders - Autism Spectrum Disorder Services**

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; and
■ focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

Benefits include the following services:

■ diagnostic evaluations and assessment;
■ treatment planning;
■ therapeutic treatment and/or procedures;
■ referral services;
■ medication management;
■ individual, family, therapeutic group and provider-based case management services;
- crisis intervention.
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

**Note:** These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

The Mental Health/Substance Use Disorder (MH/SUD) Administrator determines coverage for inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you should notify the MH/SUD Administrator to receive inpatient Benefits for neurobiological disorders in advance of any treatment. Refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card: (888) PwC-1545 (792-1545).

### Enhanced Autism Spectrum Disorders Benefits

Covered Health Services also include early intensive behavior intervention programs and related interventions for Covered Persons with Autism Spectrum Disorder given by a Network provider when habilitative in nature and backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral programs (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)).

**Notification:** In order to receive these enhanced Autism Spectrum Disorders Benefits, a Network provider must be used and you must provide prior notification, which includes provider eligibility verification as determined by the MH/SUD Administrator. You or your provider should call the number on your ID card: (888) PwC-1545 (792-1545) to request services. A care advocate will take your information and have an Autism specialist call you or your provider within one business day. The specialist will discuss services being requested; explain Benefits and what services are covered under the Plan.

**Clinical Management:** In addition, clinical management of these enhanced Benefits is required. The Autism specialist will review detailed treatment plans from the treating provider for both initial and ongoing treatment. At a minimum, treatment plans are reviewed every six months by the autism specialist for progress and appropriateness of care.
Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional.

Covered Health Services under this section also include nutritional counseling when there is a diagnosis of an eating disorder.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under Preventive Care Services in this section.

Obesity Surgery

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

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria the following must also be true:

- you have completed a multi-disciplinary regimen to prepare for surgery, which includes a psychological evaluation;
- you have completed a six-month Physician supervised diet documented within the last two years; and
- 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.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, Glossary and are not Experimental or Investigational or Unproven Services.

Please remember that you should notify Personal Health Support as soon as the possibility of obesity surgery arises.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.
Pharmaceutical Products - Outpatient

The Plan pays 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. 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. Benefits under this section do not include medications for the treatment of infertility.

Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. See Addendum – Prescription Drug Benefits for a description of this coverage.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Physician Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office or in the 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 hearing exams in case of Injury or Sickness.

Benefits under this section include genetic testing and genetic counseling, when ordered by your Physician and approved by UnitedHealthcare. Not all genetic testing is a Covered Health Service. If you or your Physician have questions or would like additional information, please call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

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.

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before receiving Genetic Testing – BRCA.
Physician Virtual Visits

Benefits under this section include virtual visits for Covered Health Services, including the diagnosis and treatment of low-acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. To ensure that you are using a Designated Virtual Network Provider, access the virtual visits benefit through www.myuhc.com. Log in and click on the Physicians and Facilities tab at the top of the main page. You will then be able to choose the Designated Virtual Network Provider(s) that operates in your area. You can also access the benefit through the Health4Me app on your mobile phone. When you first utilize a Designated Virtual Network Provider, you will create an account on the provider’s website for registration and eligibility verification purposes.

Please Note:
Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary. At your virtual visit you can talk to a doctor about non-emergency conditions such as allergies, seasonal flu, bladder infection, rash, sinus problems or stomach ache.

In addition, use virtual visits when your doctor is not available, you become ill while traveling or you are considering visiting a hospital emergency room for a non-emergency health condition.

Benefits under this section do not include email, fax or standard telephone calls, or telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Note: Virtual visits may not be available in all states. In addition, in certain states a Designated Virtual Network Provider may not be able to prescribe drugs.

Pregnancy - Maternity Services

Healthy moms and babies
The Plan provides special programs to help moms and babies during and after Pregnancy. Participation is voluntary and free of charge. See Section 7, Resources to Help you Stay Healthy, for details on the Maternity Support Program and the Nursing Moms’ Program.

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Covered facilities for delivery include birthing centers.
Comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) require payment of certain routine services for prenatal care as preventive care services, with no cost sharing. These services include, but are not limited to:

- routine prenatal obstetrical office visits;
- gestational diabetes screening;
- lab services for screenings such as anemia screening, bacteriuria screening, Rh incompatibility screening and other tests specified under applicable guidelines;
- tobacco use cessation counseling specific to pregnant women; and
- immunizations recommended by the Advisory Committee on Immunization Practices.

Other maternity-related medical services not covered as preventive care services under the HRSA guidelines are Covered Health Services under the Plan, subject to any Copay, Coinsurance and/or Deductible. These services include, but are not limited to:

- radiology services including obstetrical ultrasounds;
- labor and delivery services; and
- prenatal services for a high-risk Pregnancy.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 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.

**Note:** If the mother is covered under the Plan, her newborn child is automatically covered under the Plan for the first 96 hours. The time frame will not change even if the mother and newborn child are discharged earlier, as described above. A newborn child must be added to the Plan within 30 days of the date of birth in order to be eligible for coverage beyond the initial 96 hours.

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.

Please remember for Non-Network Benefits, you should notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.
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 care and screenings required under applicable law. Determination of preventive care services may be subject to guidelines based on age, risk factors, dosage, and frequency. For details visit the UnitedHealthcare preventive care website at http://uhcpreventivecare.com/.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Breast pump purchases are available only through the Nursing Moms’ Program, described in Section 7, Resources to Help you Stay Healthy. Note: Rental of hospital-grade breast pumps may be available, subject to Deductible and Coinsurance, as described under Durable Medical Equipment (DME) in this section. Hospital-grade breast pump rental does not affect the mother’s coverage for a breast pump purchase for the same Pregnancy.

Resources for nursing moms
The Plan provides a special program to help nursing moms during and after Pregnancy. Participation is voluntary and free of charge. See Section 7, Resources to Help you Stay Healthy, for details on the Nursing Moms’ Program.

Preventive care services as defined by the Plan also include:

- breast ultrasound when billed as preventive following standard mammography screening; and
- preventive hearing screening at any age.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services may be paid under the preventive care benefit when billed by your provider with a wellness diagnosis, however determination of preventive care services may be subject to guidelines based on age, risk factors, and frequency. Call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) for additional information regarding coverage available for specific services.
For questions about your preventive care Benefits under this Plan call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

**Executive Health Exams International**

An active Employee and his or her Spouse may elect to receive a comprehensive annual preventive exam through Executive Health Exams International (EHE). Individuals at least 30 years of age may visit EHE once per Plan Year at no cost (10 months must elapse between EHE exams) while those under age 30 may take advantage of the no-cost visit once every three years.

You may schedule your appointment by calling (800) 362-8671; professional appointment counselors are available seven days per week: (all times Eastern) Monday through Friday, 7 AM through 11 PM; Saturday, 11 AM through 7 PM; and Sunday, 3 PM through 11 PM. Or, schedule your appointment online at [www.eheandme.com](http://www.eheandme.com).

For more information regarding the nearest EHE provider, please call (800) 362-8671.

**Private Duty Nursing - Outpatient**

The Plan covers 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.).

**Prosthetic Devices**

Benefits are paid by the Plan 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; and
- 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 under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

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 it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

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. 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 _Durable Medical Equipment (DME)_ in this section.

| Please remember for Non-Network Benefits, you should notify Personal Health Support before obtaining any prosthetic device that exceeds $1,000 in cost per device. |

**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.

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

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the 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 Health Service. You can contact UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. 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, as defined in Section 14, _Glossary_.

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.
Please remember that you should notify Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

**Scopic Procedures - Outpatient Diagnostic and Therapeutic**

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or 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; and
- 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*.

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, hysteroscopy.

**Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. 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); and
- Physician services for radiologists, anesthesiologists and pathologists.

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; and
- 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 dressing, feeding, bathing or transferring from a bed to a chair; and
- 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, as defined in Section 14, *Glossary.*

Please remember that you should notify Personal Health Support five business days before an elective admission to a non-Network Skilled Nursing or Inpatient Rehabilitation Facility.

**Substance Use Disorder Services**

Substance Use Disorder Services (also known as 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.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- therapeutic treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
■ services at a Residential Treatment Facility; and
■ Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder (MH/SUD) Administrator determines coverage for inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

**Note:** Subject to all conditions of coverage described in this Substance Use Disorder Services section, Benefits are provided for outpatient Substance Use Disorder Services rendered by telephone.

**Special Substance Use Disorder Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance-related and Addictive Disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you should notify the MH/SUD Administrator to receive inpatient substance use disorder Benefits in advance of any treatment. Refer to Section 4, Personal Health Support for the specific services that require notification. Please call the phone number that appears on your ID card: (888) PwC-1545 (792-1545).

**Surgery - Outpatient**

The Plan pays 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); and
■ Physician services for radiologists, anesthesiologists and pathologists.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.
Please remember for Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, sleep apnea surgeries and orthognathic surgeries, you should notify Personal Health Support five business days before scheduled services are received or for non-scheduled services, within two business days or as soon as is reasonably possible.

**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; and
- pain or dysfunction is moderate or severe.

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

*Note:* Refer to Section 8, *Exclusions* under the heading *Procedures and Treatments* for details on excluded TMJ appliances and services.

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 or Alternate Facility or in a Physician's office, including 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; and
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; and
- 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.

Benefits under this section also include reasonable rental cost of equipment and all necessary supplies required for physician-ordered home dialysis treatment. Charges for furniture, electrical, plumbing or other fixtures needed to perform home dialysis treatment are not Covered Health Services under the Plan.

Please remember for Non-Network Benefits, you should notify Personal Health Support five business days before scheduled services are received or, for non-scheduled services, within two business days or as soon as reasonably possible.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. 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; and
- 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.
Benefits are also available for cornea transplants. You are not required to notify United Resource Networks or Personal Health Support of 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 Health Services for which Benefits are payable 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 (888) PwC-1545 (792-1545) for information about these guidelines.

Please remember that you should notify 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).

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

■ transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;

■ Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion; or

■ if the patient is an enrolled Dependent minor child, the transportation and lodging expenses of two companions will be covered.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

■ airfare at coach rate;

■ taxi or ground transportation; or

■ mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

Benefits for travel and lodging expenses reimbursed under this Plan are limited to $10,000 per transplant.
Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with Designated Facilities around the country.

Urgent Care Center Services
The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, Glossary. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under Physician Office Services - Sickness and Injury earlier in this section.

Wigs
The Plan pays Benefits for wigs and other scalp hair prosthesis when loss of hair is due to Sickness or injury.

Any combination of Network Benefits and Non-Network Benefits is limited to purchase of one wig or other scalp hair prosthesis per Plan Year.
SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:
- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

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

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

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and PwC are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey
You, your Spouse and Dependent children over age 18 are invited to learn more about your health and wellness at www.myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to www.myuhc.com. After logging in, access your personalized Health & Wellness page. If you need any assistance with the online survey, please call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

Health Improvement Plan
You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:
■ nutrition;
■ exercise;
■ weight management;
■ stress;
■ smoking cessation;
■ diabetes; and
■ heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – PwC's way of helping you meet your health and wellness goals.

**myNurseLine**

myNurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that PwC has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

■ a recent diagnosis;
■ a minor Sickness or Injury;
■ men's, women's, and children's wellness;
■ how to take prescription drugs safely;
■ self-care tips and treatment options;
■ healthy living habits; or
■ any other health related topic.

myNurseLine gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

myNurseLine is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card: (888) PwC-1545 (792-1545).

**Note:** If you have a medical emergency, call 911 instead of calling myNurseLine.

**Your child is running a fever and it's 1:00 AM. What do you do?**

Call myNurseLine toll-free, any time, 24 hours a day, seven days a week. You can count on myNurseLine to help answer your health questions.
With myNurseLine, you also have access to nurses online. To use this service, log onto www.myuhc.com and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

**Note:** If you have a medical emergency, call 911 instead of logging onto www.myuhc.com.

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

- mammograms for women;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations.

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

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

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

**UnitedHealth PremiumSM Program**

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto [www.myuhc.com](http://www.myuhc.com) or call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

**www.myuhc.com**

UnitedHealthcare's member website, [www.myuhc.com](http://www.myuhc.com), provides information at your fingertips anywhere and anytime you have access to the Internet. [www.myuhc.com](http://www.myuhc.com) opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With [www.myuhc.com](http://www.myuhc.com) you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.
Registering on www.myuhc.com

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

Visit www.myuhc.com and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

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

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) or call the program directly at (866) 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, Additional Coverage Details under the heading Cancer Resource Services (CRS).

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠ to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of
evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

**Wellness Programs**

**Maternity Support Program**

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the toll-free number on your ID card: (888) PwC-1545 (792-1545). Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- enrollment by an OB nurse;
- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;
- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card: (888) PwC-1545 (792-1545).

As a program participant, you can always call your nurse with any questions or concerns you might have.
Nursing Moms’ Program

The Nursing Moms’ Program is designed to assist new mothers. The program, delivered by a team of experts in the field of lactation, offers relevant prenatal and postnatal breastfeeding counseling in addition to breastfeeding equipment. Studies have long linked significant health benefits to breastfeeding, and the program empowers a family to make the most informed decisions when it comes to feeding their new baby. The program is available at no cost to participants.

To enroll in the Nursing Moms’ Program, please complete and submit the Lactation Program Enrollment Form after your fifth month of pregnancy. The form is available via MY Rewards and Benefits on myKcurve. You can fax, email, or mail the form to MCH Services, Inc. (contact numbers are listed on the form). For more information, please contact MCH Services, Inc. at:

email: PWClacpro@AOL.com  
Phone: Rona Cohen or Pat Briody at (800) 822-6688  
Fax: Rona or Pat at (310) 552-2100

Upon enrollment, participants in the Nursing Moms’ Program will receive an educational packet (including a breastfeeding book and breastfeeding tip sheets). Program participants may use any or all of the following services:

**Prenatal Education** – a 30-minute prenatal education telephone call with a board-certified lactation consultant during the last trimester of pregnancy, which helps prepare a new mother on how to establish a successful nursing pattern immediately after the baby’s birth.

**Maternity Leave Support** – six weekly outreach telephone calls beginning three to five days after birth. (Participants are also able to place an unlimited number of calls to the lactation consultant’s toll free number during maternity leave.)

**Return-to-Work or Transition Consultation** – a one-on-one telephone discussion with the lactation consultant focusing on transitioning back to work or being outside the home.

**Continued Access (home and/or office) to Lactation Consultant** – during the first four months back at work or of continued breastfeeding, ongoing telephone access to the lactation consultant is available.

**Pump in Style Advanced Electric Breast Pumps by Medela** – several models of Medela brand breast pumps are available to program participants at no cost. The breast pump must be ordered through the program coordinators at MCH Services, Inc. by either calling or submitting a Pump Order Form for the program. (See contact information above.)
SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, Additional Coverage Details.

The Plan does not pay Benefits for the services, treatments and supplies listed in this Section 8 even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, Additional Coverage Details, those limits are stated in the corresponding Covered Health Service category in Section 5, Plan Highlights. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, Plan Highlights. Please review all limits carefully, as the Plan 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 the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments
1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, Additional Coverage Details.

Dental
1. dental care and consultations by a dentist, except as identified under Dental Services - Accident Only in Section 6, Additional Coverage Details.

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 are excluded;

2. routine dental services; 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; and
   - services to improve dental clinical outcomes.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details;

3. 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 in Section 6, Additional Coverage Details;

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

   This exclusion does not apply to accident-related dental services, to dental care required for the direct treatment of a medical condition or to certain charges related to extraction of impacted wisdom teeth as described under Dental Services – Accident Only in Section 6, Additional Coverage Details; and

6. 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**

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME) in Section 6, Additional Coverage Details.

   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 foot orthotics when there is a diagnosis of diabetic foot disease;

3. the following items are excluded, even if prescribed by a Physician:
- blood pressure cuff/monitor;
- enuresis alarm;
- non-wearable external defibrillator;
- trusses; and
- ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 6, Additional Coverage Details; and

7. oral appliances for snoring.

Drugs
1. prescription drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable 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);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services
1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, Glossary.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details.

Foot Care
1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details. Routine foot care services that are not covered include:

   - cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

- cleaning and soaking the feet; and
- applying skin creams in order to maintain skin tone; and 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 for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes;

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. shoe inserts;

6. arch supports; and

7. shoes (standard or custom), lifts, wedges and shoe orthotics.

This exclusion does not include shoe orthotics or diabetic footwear which are covered when there is a diagnosis of diabetic foot disease.

**Gender Dysphoria (Gender Identity Disorder) Treatment**

1. reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;

2. sperm preservation in advance of hormone treatment or gender surgery;

3. cryopreservation of fertilized embryos;

4. voice modification surgery;

5. facial feminization surgery, including but not limited to: facial bone reduction, face “lift,” facial hair removal, and certain facial plastic procedures; and

6. treatment received outside of the United States.

**Medical Supplies and Equipment**

1. non-prescribed medical or non-prescribed disposable supplies.

This exclusion does not apply to:

- medical supplies when prescribed by a Physician, including catheters and compression stockings;
- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 6, Additional Coverage Details; or
- diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details;

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect; and

4. the replacement of lost or stolen Durable Medical Equipment.

**Mental Health/Substance Use Disorder**

In addition to all other exclusions listed in this Section 8, Exclusions, the exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance Use Disorder Services in Section 6, Additional Coverage Details.

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or Substance-related and Addictive Disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
   - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
   - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
   - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
   - not clinically appropriate for the patient's Mental Illness, Substance-related and Addictive Disorder or condition based on generally accepted standards of medical practice and benchmarks.

3. 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;

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, sexual dysfunctions, feeding disorders, communication disorders, motor disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
5. mental health treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to enhanced Autism Spectrum Disorders Benefits as described under *Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* in Section 6, *Additional Coverage Details*;

7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;

8. tuition for or services that are school-based for children and adolescents with Autism Spectrum Disorder;

9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

10. 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;

11. all unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;

13. gambling disorders;

14. substance-induced sexual dysfunction disorders and substance-induced sleep disorder; and

15. any treatments or other specialized services designed for Autism Spectrum Disorder that are provided by non-Network and/or non-eligible providers or 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 or Unproven Services.

**Nutrition**

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, except as described under *Enteral Nutrition* in Section
6. Additional Coverage Details. Infant formula available over the counter is always excluded;
- foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
- oral vitamins and minerals;
- meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- other dietary and electrolyte supplements; and

3. 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**

1. television;

2. telephone;

3. beauty/barber service;

4. guest service; and

5. 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 except as described under Preventive Care Services in Section 6, Additional Coverage Details;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- electric scooters;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).
Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, Glossary, are excluded from coverage. Examples include:
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - 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; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; and

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

2. 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);

3. rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except as identified under Habilitation and Rehabilitation Services – Outpatient Therapy and Manipulative Treatment in Section 6, Additional Coverage Details;

6. Habilitation Services or rehabilitation services that are solely educational in nature or otherwise paid under state or federal law for purely educational services;
7. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

8. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

9. psychosurgery (lobotomy);

10. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

11. chelation therapy, except to treat heavy metal poisoning;

12. 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;

13. the following treatments for obesity:
   - non-surgical treatment, even if for morbid obesity; and
   - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in Section 6, Additional Coverage Details;

14. medical and surgical treatment of hyperhidrosis (excessive sweating);

15. the following services for the diagnosis and treatment of TMJ:
   - surface electromyography;
   - Doppler analysis;
   - vibration analysis;
   - computerized mandibular scan or jaw tracking;
   - craniosacral therapy;
   - TMJ appliances (orthotic splints) and TMJ appliance-related therapies. This exclusion does not apply to appliances when prescribed by a Physician as part of a medical treatment plan;
   - orthodontic treatment;
   - occlusal adjustment; and
   - dental restorations; and

16. 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 Rights Act of 1998 for which
Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

**Providers**

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

5. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

6. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

7. 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**

1. the following infertility treatment-related services:
   - cryopreservation and other forms of preservation of reproductive materials except as described under *Infertility Services* in Section 6, *Additional Coverage Details*; and
   - donor services, including donor surgical or Hospital expenses or related charges;

2. surrogate parenting, donor eggs, donor sperm and host uterus;

3. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

4. services provided by a doula (labor aide); and

5. parenting, pre-natal or birthing classes.

**Services Provided under Another Plan**

Services for which coverage is available:
1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

**Transplants**

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. 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); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

**Travel**

1. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

**Types of Care**

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary*;

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures; and
7. services of personal care attendants.

**Vision and Hearing**

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses.
   
   This exclusion does not apply to the first pair of contact lenses following cataract surgery;

4. hearing aid batteries;

5. 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; or
   - 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; and

6. 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**

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:
   
   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:
   
   - delivered in other than a Physician's office or health care facility; and
- self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

- that do not meet the definition of a Covered Health Service in Section 14, Glossary;
- 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 SPD; or
- for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products. This exclusion does not apply to cryopreservation of reproductive materials;

8. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization; and

9. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

- required solely for purposes of education, sports or camp, 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 in Section 6, Additional Coverage Details;
- related to judicial or administrative proceedings or orders; or
- required to obtain or maintain a license of any type.
SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits
In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits
If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

How To File Your Claim
You can obtain a claim form by visiting www.myuhc.com or calling UnitedHealthcare toll-free at (888) PwC-1545 (792-1545). If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- PwC group number – 752713;
- the ID 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:
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
- a statement indicating either that you are, or you are not, 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).

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

The above information should be filed with UnitedHealthcare at the address on your ID card.

**Claim Payment and Assignment**

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. If you have utilized a non-Network provider, it is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

In certain circumstances, UnitedHealthcare will pay a non-Network provider directly. For example, you may authorize payment to the provider on your claim form or otherwise request in writing at the time you submit your claim that your benefit payment should be made directly to the non-Network provider. If direction to pay the provider directly does not constitute a “valid assignment of Benefits” as described below, UnitedHealthcare may in its discretion make payment of the Benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person’s agreement that the non-Network provider will be entitled to all the Covered Person’s rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person’s Benefits, and that the Covered Person will no longer be entitled to those rights.

When Benefits are paid to a non-Network provider, with or without an assignment of Benefits, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate. In addition, PwC reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes PwC pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

**Note:** UnitedHealthcare will only pay Benefits to you or your Provider, as described above, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

**International Claims**

If you receive health care services outside the U.S., you must pay the provider at the time of treatment and obtain appropriate documentation of services received including any bills, receipts and medical narrative*. Be sure to:

- retrieve an original or copy of all medical records from your provider before you leave the foreign country;
ensure records are clear and legible;
ask the provider to write the bill in English if possible; and
confirm with your provider that the bill includes patient name, date of service, description of the services provided and the charge for each service provided.

**Note:** Proof of payment is required. Cancelled checks, cash receipts, charge receipts or handwritten receipts from the provider are all acceptable forms of proof of payment.

You do not need to submit your claim prior to returning to the U.S. However, be aware of the timely filing requirements described in the box below titled *Important - Timely Filing of Non-Network Claims.*

Claims for services received outside the U.S. should be filed on an International Claim Form, which you can obtain by visiting [www.myuhc.com](http://www.myuhc.com) or calling UnitedHealthcare toll-free at (888) PwC-1545 (792-1545). The International Claim Form includes helpful tips and details on how to submit your claim by mail or fax.

All monetary conversions and rates of exchange are calculated based on the date of service.

See *Coverage While Traveling Abroad* in Section 3, *How the Plan Works* for a description of how services provided outside the U.S. are covered.

*If you permanently live in or are traveling to Mexico, you are required to provide medical notes for charges over U.S. $1,000.

**Health Statements**

When UnitedHealthcare processes at least one claim that includes member payment responsibility (other than a Copay) for you or a covered Dependent, you will receive a Health Statement in the mail within 30 days of claim receipt. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

**Note:** If UnitedHealthcare processes claims that do not include member payment responsibility, a Health Statement will be sent within 90 days of claim receipt. In addition, if you elect to have Explanations of Benefits (EOBs) mailed to you, Health Statements will be sent within the 90-day time frame.

If you would like to track claims for yourself and your covered Dependents online, you may do so at [www.myuhc.com](http://www.myuhc.com). You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

**Explanation of Benefits (EOB)**

Explanations of Benefits (EOBs) will be generated and available at [www.myuhc.com](http://www.myuhc.com) within 14 days of claim receipt. 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.
If you would like paper copies of the EOBs, you may call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) to request them. You can also view and print all of your EOBs online at [www.myuhc.com](http://www.myuhc.com) or elect to receive by mail EOBs which include member payment responsibility (other than a Copay) by making the appropriate selection on this site. See Section 14, *Glossary* for the definition of Explanation of Benefits.

**Note:** If you do not register on [www.myuhc.com](http://www.myuhc.com), you will automatically receive an EOB in the mail any time there is a payment to you when a claim is processed.

**Important - Timely Filing of Non-Network Claims**

All claim forms for non-Network services must be submitted within 12 months after the end of the Plan Year in which you received services. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. 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.

**Claim Denials and Appeals**

**If Your Claim is Denied**

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) 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.

The notice of denial will include the information necessary to identify the claim involved (including, if applicable, the date of service, the health care provider, the claim amount and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning); the specific reasons for the decision; the plan provisions on which the decision is based; a description of applicable internal and external review processes (and how to initiate an appeal) and a statement of your right to bring a civil action under Section 502(a) of ERISA; information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge; information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment or about your right to request this explanation free of charge; contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim and an explanation of why such material or information is necessary.

See the section titled *Timing of Claim and Appeals Determinations* for the timeframes applicable to claim and appeal determinations.

**How to Appeal a Denied Claim**

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described above, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination.
You do not need to submit Urgent Care appeals in writing. This communication should include:

- 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; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) to request an appeal.

<table>
<thead>
<tr>
<th>Types of claims</th>
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<tbody>
<tr>
<td>The timing of the claims appeal process is based on the type of claim you are appealing.</td>
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<tr>
<td>If you wish to appeal a claim, it helps to understand whether it is an:</td>
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<tr>
<td>■ urgent care request for Benefits;</td>
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<td>■ pre-service request for Benefits;</td>
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<td>■ post-service claim; or</td>
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<td>■ concurrent claim.</td>
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<tr>
<th>Review of an Appeal</th>
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<tr>
<td>UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:</td>
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<td>■ an appropriate individual(s) who did not make the initial benefit determination; and</td>
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<tr>
<td>■ a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.</td>
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Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The notice will include the information necessary to identify the claim involved (including, if applicable, the date of service, the health care provider, the claim amount and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), the specific reasons for the decision, new or additional evidence, if any, considered and relied upon by the Plan in reviewing your appeal, the Plan provisions on which the decision is based, a description of applicable internal and external review processes (and how to initiate an appeal) and a statement of your right to
bring a civil action under Section 502(a) of ERISA, information about any internal rule,
guideline, protocol, or other similar criterion relied upon in making the claim determination
and about your right to request a copy of it free of charge, information about the scientific
or clinical judgment for any determination based on medical necessity or experimental
treatment, or about your right to request this explanation free of charge and contact
information for an office of consumer assistance or ombudsman (if any) that might be
available to assist you with the claims and appeals processes and any additional information
needed to perfect your claim and a statement that the plan may have other voluntary
alternative dispute resolution options, such as mediation and that more information may be
obtained from your local U.S. Department of Labor office.

Filing a Second Appeal
Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal
decision, you have the right to request a second level appeal from UnitedHealthcare within
60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine
documents relevant to their 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.

Federal External Review Program
If, after exhausting your internal appeals, you are not satisfied with the determination made
by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance
with applicable regulations regarding timing, you may be entitled to request an external
review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit
determinations 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); or
■ as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written
request to the address set out in the determination letter. You or your representative may
request an expedited external review, in urgent situations as detailed below, by calling
UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) or by sending a written request
to the address set out in the determination letter. 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; and
any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

**Standard External Review**

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the 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. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
■ all other documents relied upon by UnitedHealthcare; and

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

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 the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare’s determination, 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 is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

**Expedited External Review**

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

■ an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function and you have filed a request for an expedited internal appeal; or

■ a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

■ is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) for more information regarding external review rights, or if making a verbal request for an expedited external review.

**Timing of Claim and Appeals Determinations**

Separate schedules apply to the timing of claims and appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, Glossary;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.
### Urgent Care Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>24 hours</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits to UnitedHealthcare within:</td>
<td>48 hours after receiving notice of additional information required</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination within:</td>
<td>72 hours</td>
</tr>
<tr>
<td>If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the appeal decision within:</td>
<td>72 hours after receiving the appeal</td>
</tr>
</tbody>
</table>

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.*

### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:</td>
<td>5 days</td>
</tr>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial request for Benefits is complete, within:</td>
<td>15 days</td>
</tr>
<tr>
<td>■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>15 days after receiving the first level appeal</td>
</tr>
</tbody>
</table>
Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>15 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>■ after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>30 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

**Concurrent Care Claims**

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.
If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

**Limitation of Action**

You cannot bring any legal action against PwC 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 PwC 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 PwC or the Claims Administrator.

You cannot bring any legal action against PwC 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 PwC or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against PwC or the Claims Administrator.
SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

■ How your Benefits under this Plan coordinate with other medical plans;
■ How coverage is affected if you become eligible for Medicare; and
■ Procedures in the event the Plan overpays Benefits.

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

■ another employer sponsored health benefits plan;
■ a medical component of a group long-term care plan, such as skilled nursing care;
■ no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
■ medical payment benefits under any premises liability or other types of liability coverage; or
■ Medicare or other governmental health benefit.

Note: This Plan does not coordinate benefits with any benefits plan provided by a foreign government or other entity outside the U.S.

If coverage is provided under two or more plans, 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.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545) to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary
If you are covered by two or more plans, the benefit payment follows the rules below in this order:

■ this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
■ when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
■ a plan that covers a person as an employee pays benefits before a plan that covers the person as a Dependent;

■ if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

■ your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

■ if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child;

■ plans for active employees pay before plans covering laid-off or retired employees;

■ the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and

■ finally, if none of the above rules determines which plan is primary or secondary, 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.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

**Determining Primary and Secondary Plan – Examples**

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.
When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the Eligible Expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference between what it would have paid and what the primary plan paid.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total Eligible Expense.

Determining the Eligible Expense If This Plan is Secondary

If this Plan is secondary, the Eligible Expense is this Plan's allowed amount had it been the only plan involved.

When a Covered Person Qualifies for Medicare

This section applies to you if you are receiving Long-Term Disability benefits and you become eligible for Medicare as a result of your disability or if you have end-stage renal disease.

Determining Which Plan is Primary

To the extent permitted by law, this Plan will be secondary to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the 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.

Note: For Domestic Partners age 65 or older, Medicare will always remain primary, even if the Employee has active current employment status.

Determining the Eligible Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Eligible Expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the Eligible Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Eligible Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.
**When This Plan is Secondary to Medicare**

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the Eligible Expense.
- if this Plan would have paid less than Medicare paid, the Plan pays no Benefits.
- if this Plan would have paid more than Medicare paid, the Plan will pay the difference between what it would have paid and what Medicare paid.

The maximum combined payment you can receive from all plans may be less than 100% of the total Eligible Expense.

**Medicare Cross-Over Program**

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Spouse will also have this automated cross-over, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan. You can verify that the automated cross-over took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call UnitedHealthcare toll-free at (888) PwC-1545 (792-1545).

**Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

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

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan may recover the amount in the form of salary, wages, or benefits payable under any firm-sponsored benefit plans, including this Plan. The Plan also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan’s obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan 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 Plan. The 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.
 SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:
■ How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

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; or
■ 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 are also subject to recovery.

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

■ require that the overpayment be returned when requested, or
■ reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the 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; and
■ conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation/Third Party Recovery
You shall cooperate with PwC and its agents in a timely manner in order to protect its legal and equitable rights to subrogation and reimbursement. Cooperation includes, but is not limited to:
■ providing any relevant information requested;
■ 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;
■ appearing at medical examinations and legal proceedings, such as depositions or hearings; and
■ obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

If a third party may be liable for a covered medical expense that you or your Dependent have incurred, the Plan has the right of subrogation to any claim that you or your Dependent have against the third party. The Plan will then be entitled to be paid back from any amount that you or your Dependent recover against the third party for any expenses that the Plan has had, and the recipient of any such recovered amounts shall hold the funds in constructive trust for the Plan.

The Plan has a right of reimbursement against any recovery by you or your Dependents from a third party. No court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you or your Dependents to pursue damages or personal injury claims. No so-called "fund doctrine" or "common fund doctrine" right shall defeat the Plan's rights. Regardless of whether you or your Dependents have been fully compensated or made whole, the Plan may collect from you or your Dependents the proceeds of any full or partial recovery that you or your Dependents or legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection by PWC shall include, but not be limited to, any and all amounts whether designated in any settlement or judgment as economic damages, non-economic damage, punitive damages, attorneys’ fees or otherwise. You shall not, without PwC’s written consent, settle any claim for an amount less than the amount that PwC has paid or advanced on your behalf.

Upon request of PwC, you will assign to PwC all rights to recovery from third parties of the Benefits paid or advanced on your behalf by PwC. PwC may, as its option, take necessary and appropriate action to assert its rights, including but not limited to filing suit in your name. However, doing so shall not obligate PwC to pay you part of any recovery PwC may obtain.

Third Parties
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;
■ PwC and/or its Workers' Compensation carrier, as appropriate; or
any person or entity who is or may be obligated to provide you with benefits or payments under:
- underinsured or uninsured motorist insurance;
- medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
- workers’ compensation coverage; or
- any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions
As a Covered Person, you agree to the following:

- the Plan's rights will not be reduced due to your own negligence.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- no allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- your failure to cooperate with the Plan or its agents 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 caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.
SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

When Coverage Ends

Your coverage under the Plan will end on the earliest of the following dates, even if you are hospitalized:

- the last day of the month in which your last day of employment occurs for any reason, including retirement;
- the date of your death;
- the last day of the month in which you no longer satisfy the eligibility requirements as specified under Who is Eligible in Section 2, Introduction;
- the last day of the month for which you paid the required contribution for coverage;
- the date the Plan is amended to eliminate coverage for the class of eligible individuals of which you are a member;
- the date the Plan is terminated; or
- the date you become covered under the Medicare Prescription Drug Benefit (Part D).

You may elect to terminate your coverage during the Annual Enrollment period held each year in May. If you do so, coverage will end June 30 of that year.

Cancellation of coverage due to a life event is generally effective on the last day of the month in which the life event occurs, provided you complete the change through Benefits Express in accordance with designated firm procedures (within 30 days of the life event). For further details on life events, see Section 2, Introduction.

Coverage for your Dependents will end on the earliest of the following dates:

- the same date your coverage terminates, except by reason of your death (see the Retiree Medical Plan SPD for details on this circumstance);
- the last day of the month in which your Dependent fails to meet the eligibility requirements as specified under Who is Eligible in Section 2, Introduction,
■ the date the Plan is amended to eliminate Dependent coverage;
■ the date the Plan is terminated; or
■ the date your Dependent becomes covered under the Medicare Prescription Drug Benefit (Part D).

Coverage for a divorced Spouse terminates on the last day of the month in which the divorce decree becomes final. In the event a divorce decree requires a staff member to provide coverage for an ex-Spouse, that coverage is available only under COBRA.

If you or your Dependents lose eligibility for medical coverage under the Plan, each of you may be entitled to elect temporary continuation coverage under COBRA, as described below. If however, you elect to terminate coverage for yourself or your Dependent(s) while still eligible for coverage (e.g., at Annual Enrollment), continued coverage under COBRA will not be available. If your coverage is terminated because of your enrollment in the Medicare Prescription Drug Benefit (Part D), COBRA will not be available. It is your responsibility to notify Benefits Express within 60 days of the date you or any of your Dependents lose eligibility for coverage. If the notification is not made within 60 days, you or your Dependents lose your rights to continued coverage under COBRA. See Continuing Coverage Through COBRA below for more details.

For purposes of COBRA, qualified beneficiaries do not include Domestic Partners. However PwC provides COBRA-like coverage benefits for Domestic Partners similar to those available to Spouses under COBRA. Further, a Domestic Partner may be able to obtain COBRA-like coverage upon termination of a domestic partnership, provided all other Plan and COBRA requirements are met.

PwC will provide COBRA-like benefits in accordance with COBRA regulations (e.g., duration of benefits). However, a Domestic Partner who continues coverage on his/her own may not add a new Spouse/Domestic Partner. PwC's COBRA administrator will be administering this benefit.

**Note:** If PwC terminates a contract or administrative services agreement with any medical plan carrier, coverage under that medical plan option will terminate when the contract or administrative services agreement terminates.

**Other Events Ending Your Coverage**

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

■ you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or

■ you commit an act of physical or verbal abuse that imposes a threat to PwC's staff, UnitedHealthcare's staff, a provider or another Covered Person.
**Note:** PwC has the right to demand that you pay back Benefits PwC paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

**Continuing Coverage Through COBRA**

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, Glossary.

*Continuation Coverage under Federal Law (COBRA)*

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

**Qualifying Events for Continuation Coverage under COBRA**

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

<table>
<thead>
<tr>
<th>If Coverage Ends Because of the Following Qualifying Events:</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td>Your work hours are reduced</td>
<td>18 months</td>
</tr>
<tr>
<td>Your employment terminates for any reason (other than gross misconduct)</td>
<td>18 months</td>
</tr>
<tr>
<td>You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage</td>
<td>29 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You divorce (or legally separate)</td>
<td>N/A</td>
</tr>
</tbody>
</table>
If Coverage Ends Because of the Following Qualifying Events:

<table>
<thead>
<tr>
<th>Event Description</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>For Yourself: N/A</td>
</tr>
<tr>
<td></td>
<td>For Your Spouse: N/A</td>
</tr>
<tr>
<td></td>
<td>For Your Child(ren): 36 months</td>
</tr>
<tr>
<td>You become entitled to Medicare benefits</td>
<td>For Yourself: N/A</td>
</tr>
<tr>
<td></td>
<td>For Your Spouse: See table below</td>
</tr>
<tr>
<td></td>
<td>For Your Child(ren): See table below</td>
</tr>
<tr>
<td>PwC files for bankruptcy under Title 11, United States Code.²</td>
<td>Date of death</td>
</tr>
<tr>
<td></td>
<td>36 months³</td>
</tr>
<tr>
<td></td>
<td>36 months³</td>
</tr>
</tbody>
</table>

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare benefits.

<table>
<thead>
<tr>
<th>If Dependent Coverage Ends When:</th>
<th>You May Elect COBRA Dependent Coverage For Up To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You become entitled to Medicare benefits and don't experience any additional qualifying events</td>
<td>18 months</td>
</tr>
<tr>
<td>You become entitled to Medicare benefits, after which you experience a second qualifying event before the initial 18-month period expires</td>
<td>36 months</td>
</tr>
</tbody>
</table>
If Dependent Coverage Ends When: | You May Elect COBRA Dependent Coverage For Up To:
---|---
You experience a qualifying event*, after which you become entitled to Medicare benefits before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan | 36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

**Getting Started**

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a change in family status, as described under Changing Your Coverage in Section 2, Introduction.

**Notification Requirements**

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.
You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

**Notification Requirements for Disability Determination**

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Benefits Express with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

**Trade Act of 2002**

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

**When COBRA Ends**

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:
the date, after electing continuation coverage, that coverage is first obtained under any
other group health plan;

the date, after electing continuation coverage, that you or your covered Dependent first
become entitled to Medicare;

the date coverage ends for failure to make the first required premium payment (premium
is not paid within 45 days);

the date coverage ends for failure to make any other monthly premium payment
(premium is not paid within 30 days of its due date);

the date the entire Plan ends; or

the date coverage would otherwise terminate under the Plan as described in the
beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by
coverage under this Plan, continuation coverage will end as scheduled under the prior plan
or in accordance with the terminating events listed in this section, whichever is earlier.

Other Coverage Options When You Lose Group Health Coverage

You may have other options available to you when you lose group health coverage. For
example, you may be eligible to buy an individual plan through the Health Insurance
Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower
monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day
special enrollment period for another group health plan for which you are eligible (such as a
spouse’s plan), even if that plan generally doesn’t accept late enrollees.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in
the Uniformed Services may elect to continue Plan coverage for the Employee and the
Employee's Dependents in accordance with the Uniformed Services Employment and

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army
National Guard and the Air National Guard when engaged in active duty for training,
inactive duty training, or full-time National Guard duty, the commissioned corps of the
Public Health Service, and any other category of persons designated by the President in time
of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to
continue coverage under the Plan by notifying the Plan Administrator in advance, and
providing payment of any required contribution for the health coverage. This may include
the amount the Plan Administrator normally pays on an Employee's behalf. If an
Employee's Military Service is for a period of time less than 31 days, the Employee may not
be required to pay more than the regular contribution amount, if any, for continuation of
health coverage.
An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

**Continuation Coverage for Domestic Partners**

For purposes of COBRA, qualified beneficiaries do not include Domestic Partners. However PwC provides COBRA-like coverage for Domestic Partners similar to that available to Spouses under COBRA. In the event that you lose coverage because of a reduction in hours, termination of employment or a withdrawal from PwC (for reasons other than gross misconduct), your Domestic Partner is eligible to elect COBRA-like continuation coverage. Further, a Domestic Partner may be able to obtain COBRA-like coverage upon termination of a domestic partnership, provided all other Plan and COBRA requirements are met.

PwC will provide COBRA-like benefits in accordance with COBRA regulations (e.g., duration of benefits). However, a Domestic Partner who continues coverage on his/her own may not add a new Spouse or Domestic Partner. PwC's COBRA administrator will be administering this benefit.
SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:
- Your relationship with UnitedHealthcare;
- Relationships with providers;
- Plan administration; and
- The future of the Plan.

Your Relationship with UnitedHealthcare
UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled but does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare does not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare informs you of decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Relationship with Providers
The relationships between UnitedHealthcare and Harvard Pilgrim Health Care and Network providers are solely contractual relationships between independent contractors.

UnitedHealthcare and Harvard Pilgrim Health Care do not provide health care services or supplies, nor do they practice medicine. Instead, UnitedHealthcare and Harvard Pilgrim Health Care arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. They are not employees of UnitedHealthcare or Harvard Pilgrim Health Care. UnitedHealthcare's and Harvard Pilgrim Health Care's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. UnitedHealthcare and Harvard Pilgrim Health Care do not have any other relationship with Network providers such as principal-agent or joint venture. PwC and UnitedHealthcare and Harvard Pilgrim Health Care are not liable for any act or omission of any provider.

Your Relationship with Providers
The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;

are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;

must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and

must decide with your provider what care you should receive.

Plan Administration

The Plan Administrator has delegated to the Claims Administrator, UnitedHealthcare, fiduciary responsibility for deciding whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan (Claims Administration). The relationship between the Claims Administrator and the Plan Administrator is a contractual one and the Claims Administrator is not an entity of the Plan Administrator.

Subject to the Plan’s claims procedures (see Section 9, Claims Procedures), with respect to Claims Administration matters: The Claims Administrator has full, complete and exclusive discretionary authority to interpret the Plan and to make any and all determinations related to the administration of the Plan to the maximum extent permitted by law; the decisions, actions and interpretations of the Claims Administrator will be conclusive and binding on all parties concerned; and the Claims Administrator will be deemed to have properly exercised its authority unless it has abused its discretion through arbitrary or capricious action.

With respect to matters other than Claims Administration: The Plan Administrator (PwC) has full, complete and exclusive discretionary authority to interpret the Plan and to make any and all determinations related to the administration of the Plan (including eligibility and enrollment matters, funding for payment of Benefits and notifying you of modifications to the Plan) to the maximum extent permitted by law; the decisions, actions and interpretations of the Plan Administrator will be conclusive and binding on all parties concerned; and the Plan Administrator will be deemed to have properly exercised its authority unless it has abused its discretion through arbitrary or capricious action.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Plan Amendments and Termination

Although PwC currently intends to continue the benefits provided by the Plan, PwC reserves the right at any time and for any reason or no reason at all, to amend, interpret or terminate this Plan in its sole determination without prior notice to or approval by Plan participants and their beneficiaries.
Any amendment of the Plan shall be effectuated by one of the following authorized persons through a written instrument (which need not be a formal resolution, and which may take the form of a revised Summary Plan Description or a Summary of Material Modification):

- U.S. Partner Affairs Leader;
- National Benefits Leader;
- Managing Director, National Benefits;
- Director, National Benefits; or
- Any individual (including an individual who has been identified by virtue of his or her title with the firm) who has been authorized, in writing, by a Partner Affairs Leader to amend the Plan.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and PwC’s decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to PwC and others as may be required by any applicable law.
SECTION 14 - GLOSSARY

What this section includes:
■ Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

**Addendum** – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

**Alternate Facility** – 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; or
■ rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

**Amendment** – any written amendment to the Plan.

**Annual Deductible (or Deductible)** – the amount you must pay for Covered Health Services in a Plan Year before the Plan will begin paying Benefits subject to the Deductible in that Plan Year. The Deductible is shown in the first table in Section 5, Plan Highlights. For the Middle Deductible and High Deductible plan options, the Annual Deductible applies to all Covered Health Services under the Plan, including items covered under your separate prescription drug coverage.

**Annual Enrollment** – the period of time, determined by the Plan Administrator, during which eligible Employees may enroll themselves and their Dependents under the Plan.

**Assisted Reproductive Technology (ART)** – 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); and
- zygote intrafallopian transfer (ZIFT).

**Autism Spectrum Disorders** – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

**Benefits** – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

**Body Mass Index (BMI)** – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

**BMI** – see Body Mass Index (BMI).

**Cancer Resource Services (CRS)** – a program administered by UnitedHealthcare or its affiliates made available to you by PwC. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

**CHD** – see Congenital Heart Disease (CHD).

**Claims Administrator** – UnitedHealthcare (also known as UnitedHealthcare Service LLC.) and its affiliates and subsidiaries (including Optum), which provide certain claim administration services for the Plan.

**Clinical Trial** – 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 you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

**Congenital Anomaly** – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

**Congenital Heart Disease (CHD)** – 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; or
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.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works.

Cosmetic Procedures – 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 Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which UnitedHealthcare determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-related and Addictive Disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;
- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan’s eligibility requirements, as described under Eligibility in Section 2, Introduction; and
- not identified in Section 8, Exclusions.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding
specific services. You can access these clinical protocols (as revised from time to time) on [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare toll-free at (888) PwC-1545 (792-1545). This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

**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.

**CRS** – see Cancer Resource Services (CRS).

**Custodial Care** – 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; or

- 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 under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

**Designated Facility** – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the 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 specified conditions.

**Designated Virtual Network Provider** – a Physician or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on behalf of the Plan, to deliver Covered Health Services via virtual visits (interactive audio and video modalities). To ensure that you are using a Designated Virtual Network Provider, access the virtual visits benefit through [www.myuhc.com](http://www.myuhc.com). Refer to Section 6, *Additional Coverage Details*, for a description of Physician Virtual Visits.

**DME** – see Durable Medical Equipment (DME).
Domestic Partner – an individual of the same or opposite sex as you, who shares an intimate, committed and mutually dependent relationship with you and who meets the eligibility requirements specified in the Plan, as described under Who is Eligible in Section 2, Introduction.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as detailed below and in Section 3, How the Plan Works.

Eligible Expenses are determined solely in accordance with the Claims Administrator’s reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

You may request a copy of the guidelines related to your claim from the Claims Administrator.

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any
difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.

Eligible Expenses are determined as follows:

<table>
<thead>
<tr>
<th>For Services Provided by a:</th>
<th>Eligible Expenses are Based On:</th>
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</thead>
<tbody>
<tr>
<td>Network Provider</td>
<td>Contracted fee(s) with that provider</td>
</tr>
</tbody>
</table>
| Non-Network Provider      | - negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the discretion of the Claims Administrator's discretion.  
                          | - if rates have not been negotiated, then one of the following amounts:  
                          |   - 300% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or  
                          |   - when a rate is not published by CMS for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:  
                          |     - For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Claims Administrator based on an internally developed pharmaceutical pricing resource.  
                          |     - For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by OptumInsight, Inc. and/or a third party vendor. If the relative value scale(s) currently in use becomes no longer available, a comparable scale will be used. The Claims Administrator and OptumInsight, Inc. are
<table>
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<tr>
<th>For Services Provided by a:</th>
<th>Eligible Expenses are Based On:</th>
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<td>related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at <a href="http://www.myuhc.com">www.myuhc.com</a> for information regarding the vendor that provides the applicable gap fill relative value scale information;</td>
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<td>for facility claims, if one of the above methods does not apply, the Eligible Expense is based on 50% of the facility's billed charge. This method is used when the facility does not participate with Medicare, or because a CMS rate is not published, or when the claim has missing or incorrect information. <strong>Note:</strong> A relative value scale does not apply to facility charges so a gap methodology is not used;</td>
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<tr>
<td></td>
<td>for Physician claims, if one of the above methods does not apply, the Eligible Expense is based on 50% of the Physician's billed charge. This method is used if the service code submitted does not have a published CMS rate and if in addition a gap methodology does not apply to the service or if the provider does not submit sufficient information on the claim to pay it under a gap methodology.</td>
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</table>

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

These provisions do not apply if you receive Covered Health Services from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator as described in Section 3, *How the Plan Works*, under Health Services from Non-Network Providers Paid as Network Benefits. In that case, Eligible Expenses are billed charges, unless a lower amount is negotiated or authorized by law.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

**IMPORTANT NOTICE**

Non-Network Physicians and providers may bill you for any difference between the Physician's or provider's billed charges and the Eligible Expense described above.
Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance-related and Addictive Disorder which:

■ arises suddenly; and
■ in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee – a staff member of PwC who meets the eligibility requirements specified in the Plan, as described under Who is Eligible in Section 2, Introduction.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

EOB – see Explanation of Benefits (EOB).


Experimental or Investigational Services – 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 UnitedHealthcare 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 identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
■ 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); or
■ 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.

Exceptions:

■ Clinical Trials for which Benefits are available as described under Clinical Trials in Section 6, Additional Coverage Details.
■ If you are not a participant in a qualifying Clinical Trial as described under Section 6, Additional Coverage Details, 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)** – 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; and
- the reason(s) why the service or supply was not covered by the Plan.

**Gender Identity Disorder** – a disorder characterized by the following diagnostic criteria:

- a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex);
- persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex;
- the disturbance is not concurrent with a physical intersex condition;
- the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning;
- the transsexual identity has been present persistently for at least two years; and
- the disorder is not a symptom of another mental disorder or a chromosomal abnormality.

**Genetic Testing** - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

**Habilitation Services** – health care services that help a person keep, learn or improve skills and functioning for daily living. Day care, therapeutic recreation, vocational training and residential treatment are not Habilitation Services.

**Health Statement(s)** – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

**Home Health Agency** – a program or organization authorized by law to provide health care services in the home.
**Hospital** – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, Substance-related and Addictive Disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

**Injury** – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility** – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intensive Outpatient Treatment** – a structured outpatient Mental Health or substance-related and disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care** – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

**Manipulative Treatment** – the 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.

**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.

**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 – 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 Use Disorder (MH/SUD) Administrator – Optum Behavioral Health, an associated entity of UnitedHealthcare that specializes in and arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, Exclusions.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by PwC. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, Plan Highlights for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, Plan Highlights for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every Plan Year. Refer to Section 5, Plan Highlights for the Out-of-Pocket Maximum amount. See Section 3, How the Plan Works for a description of how the Out-of-Pocket Maximum works. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services. For the Middle Deductible and High Deductible plan options, the Out-of-Pocket Maximum
applies to all Covered Health Services under the Plan, including items covered under your separate prescription drug coverage.

**Partial Hospitalization/Day Treatment** – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Personal Health Support** – 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** – U.S. Food and Drug Administration (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** – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please 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.

**Plan** – The Staff Medical Plan.

**Plan Administrator** – PricewaterhouseCoopers LLP or its designee.

**Plan Sponsor** – PricewaterhouseCoopers LLP.

**Plan Year** – the annual period of time from July 1 through June 30.

**Pregnancy** – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

**Primary Physician** – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Private Duty Nursing** – shift or continuous nursing care that encompasses nursing services for Covered Persons who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Private Duty Nursing services are provided where longer durations of skilled nursing care are required and may include shift care or 24/7 continuous care in certain settings. Private Duty Nursing care is not care provided primarily for the convenience of the Covered Person.
Reconstructive Procedure – 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.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which 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 and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, Plan Highlights.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.
Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness and Substance-related and Addictive Disorder, regardless of the cause or origin of the Mental Illness or Substance-related and Addictive Disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a 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.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – a federally-defined spouse.

Substance-related and Addictive Disorder - a maladaptive pattern of substance use leading to clinically significant impairment or distress.

Substance Use Disorder Services - 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.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision 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; or
- supervised living arrangement which are residences such as transitional living 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 a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

**Unproven Services** – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not 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 from more than one institution 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 [www.myuhc.com](http://www.myuhc.com).

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), 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, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

- UnitedHealthcare may, in its discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Covered Person must consent to the procedure acknowledging that UnitedHealthcare does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow UnitedHealthcare to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

**Urgent Care** – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

**Urgent Care Center** – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.
SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

PricewaterhouseCoopers LLP is the Plan Sponsor and Plan Administrator of the PricewaterhouseCoopers LLP Health & Welfare Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
PricewaterhouseCoopers LLP
National Benefits
300 Madison Avenue, 21st Floor
New York, NY 10017
(646) 471-3000

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The Plan Administrator has assigned fiduciary responsibility for claim determinations under the Plan to UnitedHealthcare.

You may contact the Claims Administrator by phone toll-free at (888) PwC-1545 (792-1545) or in writing at:

UnitedHealthcare Service LLC.
2950 Expressway Drive South, Suite 240
Islandia, NY 11749-1412

For purposes of claims administration of the prescription drug Benefits, the Plan Administrator has assigned fiduciary responsibility for claim determinations to Express Scripts.

You may contact Express Scripts by phone toll-free at (800) PwC-9501 (792-9501) or in writing at:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

The Plan's claims procedures for prescription drug Benefits are described in Addendum – Prescription Drug Benefits.
Agent for Service of Legal Process
Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Office of the General Counsel
PricewaterhouseCoopers LLP
300 Madison Avenue
New York, NY 10017
(646) 471-3000

Legal process may also be served on the Plan Administrator.

Other Participating Employers
As of the publication date, the following affiliates of PricewaterhouseCoopers LLP are participating employers in this Plan:

PricewaterhouseCoopers Advisory Services LLC
PricewaterhouseCoopers Corporate Finance LLC
PricewaterhouseCoopers Public Sector LLP

For the avoidance of doubt, the following entities are not participating employers in the Plan and the staff members of such entities are not eligible to participate in the Plan:
PricewaterhouseCoopers Information Technologies (Shanghai) Company Limited,
PricewaterhouseCoopers Service Delivery Center (Bangalore) Private Limited, Diamond Management & Technology Consultants Private Limited, PricewaterhouseCoopers PRTM Management Consultants Japan, LLC, PRTM Management Consultants (India) Private Limited, PwC Consulting LLC (and any subsidiaries), PwC Consulting China Holdings Ltd. (and any subsidiaries) and PwC Mexico.

Other Administrative Information
This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration
The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

The Plan Sponsor also has selected a Provider Network established by United HealthCare Services, Inc. and, within the Harvard Pilgrim Health Care service area, a Provider Network established by Harvard Pilgrim Health Care.
**Plan Name:** The Staff Medical Plan is part of the PricewaterhouseCoopers LLP Health & Welfare Benefits Plan

**Plan Number:** 502

**Employer ID:** 13-4008324

**Plan Type:** Welfare benefits plan

**Plan Year:** July 1 – June 30

**Plan Administration:** Self-Insured

**Source of Plan Contributions:** Employee and PwC

**Source of Benefits:** Assets of PwC

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**Your ERISA Rights**

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

- receive information about Plan Benefits;

- examine, without charge, at the Plan Administrator’s office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and

- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of any plan documents from the Plan, and do not receive it 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

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 if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by PricewaterhouseCoopers, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and PricewaterhouseCoopers are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare and PricewaterhouseCoopers are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.
ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

*Patient Protection Notices*

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 Claims Administrator toll-free at (888) PwC-1545 (792-1545).

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims 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 the Claims Administrator’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 pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator toll-free at (888) PwC-1545 (792-1545).
ATTACHMENT II - LEGAL NOTICES

Notice of PricewaterhouseCoopers' Group Health Plans' 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 this notice carefully.

As part of the PwC Privacy Program, National Benefits and the PwC Ethics & Compliance Office have developed this privacy notice to inform you of the privacy practices surrounding your health plan’s use and disclosure of your health information. The PricewaterhouseCoopers Group Health Plans (the "Plans") – which include the medical, prescription drug, dental, vision, employee assistance and health care spending account programs – consider your personal health information to be confidential. The Plans protect the privacy of that health information in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable privacy laws. The Plans have been designated as an "Organized Health Care Arrangement" for purposes of HIPAA.

The Plans are required by law to take reasonable steps to ensure the privacy of your individually identifiable health information (which is referred to in this notice as “health information” or “protected health information”), and to inform you about:

- The Plans' uses and disclosures of your health information.
- Your privacy rights with respect to your health information.
- The Plans' obligations with respect to your health information.
- Your right to file a complaint with the Plans or with the Secretary of the U.S. Department of Health and Human Services.
- The person or office to contact for further information about the Plans' privacy practices.

Effective Date of Notice: July 1, 2016.

How the Plans Use and Disclose Health Information

This section of the notice describes the uses and disclosures that the Plans may make of your health information for certain purposes permitted by law – as well as instances in which the Plans may request your written authorization to use or disclose your health information.

Uses and Disclosures Related to Payment and Health Care Operations. The Plans and their vendors who perform administrative and other services for the Plan, called “business associates,” may use your health information to carry out payment or health care operations related to your health care and the operations of the Plan. Through written agreements, the Plans require these business associates to protect the privacy of your health information.

- **Payment** includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review
for medical necessity and appropriateness of care, utilization review and pre-authorizations). For example, the Plans' business associates will process your medical claims and calculate the amount that will be paid by your medical plan.

- **Health care operations** include, but are not limited to, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse programs, underwriting (although we are prohibited from using or disclosing any genetic information for these underwriting purposes), business planning and development, business management and general administrative activities. It also includes quality assessment and improvement as well as reviewing competence or qualifications of health care professionals. For example, the Plans may use medical claims information to conduct a review of the accuracy of how medical claims are being paid.

**Uses and Disclosures That Do Not Require Your Written Authorization**

The Plans also may disclose your health information for certain identified public purposes as permitted by law:

**Disclosures for Public Health Activities.**

- **Public Health Authorities:** The Plans may disclose health information to public health authorities who need the information to prevent or control disease, injury, disability or to handle situations where children are abused or neglected.

- **Food and Drug Administration (FDA):** The Plans may disclose health information when there are problems with a product that is regulated by the FDA. For instance, when the product has harmed someone, is defective, or needs to be recalled, the Plans may disclose certain information.

- **Communicable Diseases:** The Plans may disclose health information to a person who has been exposed to a communicable disease or may be at risk of spreading or contracting a disease or condition.

**Disclosures to Your Employer.** The Plans may disclose information to your employer, PricewaterhouseCoopers LLP, for purposes relating to administration of the Plans. For example, your employer may wish to audit the payments made under the Plans. However, through privacy restrictions in its Plan documents, your employer has agreed to handle your health information consistent with the use and disclosure restrictions of HIPAA.

Health information will not be disclosed to your employer to be used for employment-related activities without your authorization. Keep in mind that your employer may obtain the health information from another source outside the Plans. If you apply for leave under the Family and Medical Leave Act or request an accommodation for your disability under the Americans with Disabilities Act, the Plans will not give your health information to your employer for this purpose unless you authorize the disclosure in writing. However, you may still be required to provide the health information to your employer for purposes of the employer considering your requests under these Acts.
Disclosures for Judicial or Administrative Proceedings. The Plans may disclose health information in a court or other type of legal proceeding if it is requested through a legal process, such as a court order or a subpoena.

Disclosures for Health Care Oversight. The Plans may disclose health information so that government agencies can monitor or oversee the health care system and government benefit programs and be sure that certain health care entities are following regulatory programs or civil rights laws like they should.

Disclosures about Victims of Abuse, Neglect, or Domestic Violence. The Plans may disclose health information to appropriate authorities if there is reason to believe that a person has been a victim of abuse, neglect, or domestic violence.

Disclosures for Law Enforcement Purposes. The Plans may disclose health information to law enforcement officials if it is required by law; if needed to help identify or locate a suspect, fugitive, material witness, or missing person; if it is about an individual who is or is suspected to be the victim of a crime; if the Plans think that a death may have resulted from criminal conduct; or if the Plans think the health information is evidence that criminal conduct occurred on the Plans' premises.

Uses or Disclosures to Avert Serious Threat to Health or Safety. The Plans may use or disclose health information to appropriate persons or authorities if there is reason to believe it is needed to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses or Disclosures in Situations Involving Decedents. The Plans may use or disclose health information to coroners, medical examiners, or funeral directors so that they can carry out their responsibilities.

Uses or Disclosures Related to Organ Donation. The Plans may use or disclose health information to organizations involved in organ donation or organ transplants.

Uses or Disclosures Relating to Research. The Plans may use or disclose health information for research purposes if the privacy of the health information will be protected in the research.

Uses or Disclosures Related to Specialized Government Functions. The Plans may use or disclose health information to the federal government for military purposes and activities, national security and intelligence, or so it can provide protective services to the U.S. President or other official persons.

Uses or Disclosures for Law Enforcement Custodial Situations. The Plans may use or disclose health information about a person in a prison or other law enforcement custody situation for health, safety, and security reasons.

Uses and Disclosures for Workers Compensation Purposes. The Plans may use or disclose health information as authorized by state worker’s compensation laws.
Disclosures to Your Family and Friends. The Plans or its vendors may disclose limited protected health information to a family member, friend, or other person to the extent necessary to help with payment for your health care. You may object to such a disclosure by contacting the appropriate vendor as described below. However, if you are not present, or in the event of your incapacity or an emergency, the Plans will use professional judgment in deciding whether disclosing your protected health information would be in your best interest.

Uses and Disclosures That Require Your Written Authorization
In situations other than those described above, the Plans will ask for your written authorization before using or disclosing your health information. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. If you have questions regarding authorizations or need an authorization form, fax your questions to National Benefits at (813) 637-4737 or call the HIPAA Helpline at (646) 471-4203.

Information Safeguards
The Plans and their business associates have developed reasonable and appropriate safeguards to protect the privacy and security of your health information. These individuals are trained on appropriate protections for your information. We restrict access to your PHI to authorized individuals who need that information for specific permitted purposes. We maintain technical, physical and administrative safeguards to ensure the privacy of your PHI.

Your Privacy Rights
This section of the notice describes your rights with respect to your health information and how you may exercise these rights.

Restrict Uses and Disclosures. You have the right to make a request to the Plans' vendors to restrict uses and disclosure of your health information for activities related to treatment, payment and health care operations. The Plans' vendors will consider this request, but are not required to agree to any such requests. To make such a request, you must contact the appropriate plan vendor.*

*The list of current vendors and their contact information can be found in the Summary Plan Descriptions accessible through Benefits Express online at https://www.benefitsweb.com/pwc.html, or by calling (877) PwC-BenX (792-2369). Alternatively, you can call the toll-free number on the back of your ID card: (888) PwC-1545 (792-1545).
Alternative Communication. The Plans' vendors will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plans to send health information to a different address than that of the Employee. To make such a request, you must contact the appropriate vendor.*

Copy of Health Information. You have a right to request a copy of health information that is contained in a specific set of records, e.g., records used in making enrollment, payment, claims adjudication, and other such decisions. To request a copy, you must contact the appropriate vendor.* If you agree in advance, the Plans' vendors may provide you with a summary of the health information. You may be asked to pay a reasonable fee based on the Plans' vendors copying, mailing, and other preparation costs. An electronic copy of this information may be available in certain situations.

Amend Health Information. You have the right to request an amendment to health information that is in a specific set of records, as described above. To make such a request, you must contact the appropriate vendor.* The Plans' vendors may deny your request to amend your health information if the Plans' vendors did not create the health information, if the health information is not part of the Plans' records, if the health information was not available for inspection, or if the health information is accurate and complete.

List of Certain Disclosures. You have the right to request a list of certain disclosures of your health information. To request a copy of the list, you must contact the appropriate vendor.* The Plans' vendors will provide you with one free accounting of the disclosures made each year. For subsequent requests, you may be charged a reasonable fee.

Right to a Copy of Privacy Notice. You have the right to receive a paper copy of this notice upon request.

Breach Notification. In the event of breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Complaints. If you believe your privacy rights have been violated, you may file a complaint to: (1) the Office for Civil Rights Regional Manager, U.S. Department of Health and Human Services at 26 Federal Plaza, Suite 3312, New York, New York, 10278, and/or (2) the Plans. The Privacy Officer (or his or her designee) of PricewaterhouseCoopers LLP also serves as Privacy Officer for the Plans.

*The list of current vendors and their contact information can be found in the Summary Plan Descriptions accessible through Benefits Express online at https://www.benefitsweb.com/pwc.html, or by calling (877) PwC-BenX (792-2369). Alternatively, you can call the toll-free number on the back of your ID card: (888) PwC-1545 (792-1545).
To file a complaint with the Plans, contact the Plans’ Ethics & Compliance Office by:

- Calling the Ethics Helpline:
  - Inside the U.S. only: 1-888-438-4427.
  - Outside the U.S.: +1-201-521-3300.
- Sending an email to ethics.office@us.pwc.com.

The firm prohibits retaliation for reporting concerns in good faith.

**The Plans’ Responsibilities**

The Plans are required by HIPAA to keep your health information private, to give you notice of the Plans’ legal duties and privacy practices, and to follow the terms of the notice currently in effect.

**This Notice is Subject to Change**

The terms of this notice and the Plans’ privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plans. If any material changes are made, the Plans will distribute or make available a new notice to participants.

**Your Questions and Comments**

If you have questions regarding this notice or regarding any of your rights under HIPAA, please contact the National Benefits HIPAA Helpline at (646) 471-4203.

**Women’s Health and Cancer Rights Act of 1998**

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 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; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amounts you must pay for such Covered Health Services (including Copayments and any Annual 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.
Statement of Rights under the 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 provide notification. For information on notification, contact your issuer.
ADDENDUM - PRESCRIPTION DRUG BENEFITS – ADMINISTERED BY EXPRESS SCRIPTS

If you elect coverage under one of the medical plan options described in the SPD, you will automatically receive prescription drug coverage administered by Express Scripts at no additional cost. If you elected to cover your eligible Dependents under the medical plan option, your Dependents will automatically be covered as well.

The prescription drug Benefits are administered by Express Scripts, a leading national administrator of prescription drug programs. No retail or mail-order prescription drug Benefits will be paid through UnitedHealthcare and the UnitedHealthcare pharmacy network is not used.

The Plan provides Benefits for covered drugs and supplies when prescribed by your Physician for use outside of the hospital. Refills, if allowed by law, may be obtained for up to one year from the initial date of the purchase.

Prescription drug products are categorized into the following classes: generic, preferred brand, non-preferred brand and Specialty medications. As new medications and generic alternatives become available, drugs may be reclassified throughout the year. As classifications changes occur, applicable copays may change at any time throughout the year.

The program includes a pharmacy network for retail medications, out-of-network services and mail-order for long-term maintenance and Specialty medications.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Open Access Plan</th>
<th>Middle and High Deductible Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You Pay</td>
<td>You Pay</td>
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<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
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<tr>
<td>Retail (up to a 30-day supply)</td>
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<td></td>
</tr>
<tr>
<td>■ Generic</td>
<td>$10 copay</td>
<td>40% (The Plan pays 60%)</td>
</tr>
<tr>
<td>■ Preferred brand</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>■ Non-preferred brand</td>
<td>$50 copay</td>
<td></td>
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<tr>
<td>Type of Service</td>
<td>Open Access Plan ¹</td>
<td>Middle and High Deductible Plans ³</td>
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<td></td>
<td>In-Network</td>
<td>Out-of-Network ¹</td>
</tr>
<tr>
<td><strong>Mail Order</strong> (up to a 90-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>$20 copay</td>
<td>Not available</td>
</tr>
<tr>
<td>• Preferred brand</td>
<td>$60 copay</td>
<td>Not available</td>
</tr>
<tr>
<td>• Non-preferred brand</td>
<td>$100 copay</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Specialty</strong> (up to a 90-day supply is available by mail) ⁵</td>
<td>$75 copay for up to a 30-day supply</td>
<td>Not available</td>
</tr>
</tbody>
</table>

¹All participants:
- Certain medications require prior authorization. Contact Express Scripts’ Member Services for details.
- For prior authorization regarding fertility medication, contact WIN Fertility at (877) 528-0300.
- A $10,000 lifetime maximum applies to all fertility medications.

²Open Access plan option participants: When you purchase your prescriptions from participating in-network pharmacies, there is a maximum prescription drug copay of $1,750 per person per Plan year, not to exceed $8,000 for all covered family members per Plan year. Your prescription drug costs do not apply to your Annual Deductible or your annual Out-of-Pocket Maximum.

³Middle and High Deductible plan option participants: Your eligible prescription drug and medical expenses are combined and applied toward the Annual Deductible and annual Out-of-Pocket Maximum described in the SPD. See Section 3, How the Plan Works, for a description and Section 5, Plan Highlights, for specific Deductible and Out-of-Pocket Maximum amounts.

⁴Out-of-network reimbursement percentages are based on the lesser of the purchase price or the price that would have been charged for the drug by an in-network pharmacy.

⁵After the first fill, you are required to use Accredo, Express Scripts’ Specialty pharmacy. You will pay the entire cost of certain Specialty medications if you continue to purchase them at a retail pharmacy in-network or out-of-network after the first purchase. Further, if you do not use Accredo, charges will not apply toward your Annual Deductible or your Out-of-Pocket maximum. To find out if your Specialty medication is affected, visit Express-Scripts.com or call Express Scripts Member Services.
Specialty Prescriptions

Specialty medications are ones that are used to treat complex conditions; examples include, but are not limited to: cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. When you purchase the first 30-day supply of a Specialty medication at a participating retail pharmacy, you will be responsible for the copayment/Deductible/coinsurance, as applicable under the plan option in which you participate. After the first fill, you are required to use Accredo, Express Scripts' Specialty pharmacy. You will be responsible for the entire cost of Specialty medications if you continue to purchase them at a retail pharmacy after the first purchase. Further, if you participate in the Middle or High Deductible plan option and do not use Accredo after the first fill, charges will not apply toward your Annual Deductible or your Out-of-Pocket Maximum. To avoid paying more for these medications, use Accredo.

Through Accredo, you can receive up to a 90-day supply of medication (note that certain limitations apply). Medications are conveniently delivered to the address you designate in the continental U.S. Once all of the information is verified and ready to ship, all medications are shipped by the appropriate delivery method that meets the patient’s needs and ensures the stability of the product. You will receive a confirmation phone call prior to shipment.

To begin utilizing this service or to find out if your medication is affected, call Accredo at (855) 849-6651.

WIN Fertility

Prior authorization by WIN Fertility is required for coverage of fertility medications. Contact WIN Fertility at (877) 528-0300. WIN Fertility provides consultative services regarding fertility treatment along with prior authorization for coverage of fertility medications. When you contact WIN, you have access to your own personal FertilityCoach NurseSM who will assist you in understanding your best treatment options. FertilityCoach Nurses are available for questions, concerns and clinical assistance 24 hours a day, seven days a week. Your personal treatment plan will be continually reviewed in collaboration with your reproductive endocrinologist.

Preventive Medications

In accordance with the Affordable Care Act (ACA), the Plan provides certain preventive prescription drugs to participants at no cost. The Plan pays the full cost of these drugs, and they are not subject to the Annual Deductible, coinsurance or copays. A listing of preventive drugs is available from Express Scripts and is subject to change as ACA guidelines are updated or modified.

Women's Preventive Medication

The Health Resources and Services Administration issued guidelines that address those preventive health services that must be offered to women at no cost, including contraception methods and counseling. Due to these guidelines, the prescription drug program covers brand contraceptive medications with no generic equivalent and generic contraceptive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a
participating retail pharmacy or the Express Scripts Pharmacy. In order to receive a non-preferred brand contraceptive medication at 100%, your provider must go through a coverage review.

**Preventive Medications in the High and Middle Deductible Plans**

In the Middle and High Deductible plan options, covered prescription drugs include certain preventive medications. Per federal regulations, these preventive medications are not subject to the Deductible, and they are limited to the following that require a prescription by law:

- immunizations and vaccines;
- prescription vitamins and minerals;
- topical fluoride products;
- smoking cessation medication;
- weight loss agent and appetite suppressants;
- contraceptives;
- aspirin therapy; and
- respiratory syncytival virus prevention.

**Retail Benefits Using Participating In-Network Pharmacies**

The retail prescription drug coverage provides up to a 30-day supply of medication when filled through a participating retail pharmacy. Participating pharmacies include major chains as well as local drugstores.

To verify if your pharmacy is participating with Express Scripts or for a list of participating pharmacies, contact Express Scripts Member Services at (800) PwC-9501 (792-9501) or access their website, Express-Scripts.com. If you are a first-time visitor to Express-Scripts.com, take a moment to register. (Be sure to have your member ID number, which can be found on your Express Scripts ID card.)

If you go to a participating pharmacy, but you do not present your ID card when you purchase your prescription drug, your prescription drug purchase will be treated as an out-of-network claim.

When you go to a participating pharmacy, present your Express Scripts member ID card and you will be responsible for your copay if you're in the Open Access Plan. There are no exceptions to the copay levels, regardless of your or your physician's reason for choosing a particular drug. If you're enrolled in the Middle or High Deductible Plan, you will be responsible for your Deductible and coinsurance. By having your prescription(s) filled at a network pharmacy, you can take advantage of the network’s discounted rates. Covered prescription drugs include a comprehensive listing of FDA-approved brand-name and generic medications that are in common use for outpatient emergency, acute and chronic care settings.
You may refill your prescription at a retail pharmacy when you have used 75% of the medication since your last fill (for example, you may refill a 30 day supply of medication after 23 days have passed since your last fill).

**Non-Participating Pharmacies**

If you prefer to use a non-participating pharmacy, the out-of-network Benefits will apply. At a non-participating pharmacy, you will be responsible for paying the full cost of prescriptions at the time of purchase. By submitting a claim for eligible expenses, you will later be reimbursed at the out-of-network benefit level.

All benefit limitations and requirements applicable to retail prescriptions using in-network pharmacies also apply to out-of-network Benefits. The Plan provides no Benefits for using a home delivery service other than the Express Scripts Pharmacy.

**Coordination of Benefits**

The Express Scripts prescription drug benefit does not provide for coordination of Benefits. As a result, when the Plan is considered second or third because you have primary coverage through another source, Express Scripts will not pay anything toward the cost of your prescription drug products.

**Special Note for Open Access Plan Participants**

If you are enrolled in the Open Access Plan, you do not need to meet the medical plan option's Annual Deductible in order to receive prescription drug Benefits. Expenses for prescription drugs do not apply toward your Annual Deductible or your Out-of-Pocket Maximum.

**Generic Substitution**

- Generics have the same active ingredients as their brand-name counterparts.
- FDA-approved generics meet the same Food and Drug Administration quality standards as brand-name drugs.
- Generics cost about 80% to 85% less than brand-name drugs, according to the FDA web page.

Ask your doctor to consider prescribing lower-cost generic drugs. Subject to state law and/or plan benefit rules, a generic equivalent of a brand-name drug may be dispensed.

**Direct Reimbursement Claim Instructions**

You must file a claim for reimbursement of your prescription drug costs in certain circumstances:

- If you do not present your ID card when you purchase your prescription drugs at a participating pharmacy you will have to pay the full cost for the medication and submit the claim for reimbursement. The reimbursement will be at the out-of-network benefit level.
If you use a non-participating pharmacy, you will have to pay the full cost for the medication and submit the claim for reimbursement. In the Open Access plan, the reimbursement will be 60% of the lesser of the purchase price or the discounted price. In the High and Middle Deductible Plans, the reimbursement will be the applicable coinsurance (i.e., 100%, 90% or 70%) of the lesser of the purchase price or the discounted price. Out-of-network pharmacy claims will not apply to your Out-of-Pocket Maximum if you are enrolled in the Open Access Plan.

Compound prescriptions: If you do not present your ID card when you purchase a compound prescription you will have to pay the full cost for the medication and submit the claim for reimbursement. When submitting for reimbursement, make sure the pharmacist lists all the valid NDC numbers, cost and quantity for each ingredient on the back of the claim form. The reimbursement will be at the out-of-network benefit level.

Foreign claims: If you needed to fill a prescription outside of the United States, you may submit the claim via the direct claim reimbursement process. For participants in the Open Access Plan, the reimbursement will be the converted dollar amount spent minus your 40% coinsurance. For participants in the High Deductible or Middle Deductible plans, the reimbursement will be the converted dollar amount spent minus the formulary coinsurance of 10%.

You must file a claim within twelve (12) months from the end of the Plan Year in which the service was incurred. Return the completed form and receipt(s) to: Express Scripts, P.O. Box 14711, Lexington, KY 40512. This claim will be processed based on your Plan benefit.

If your claim is denied, you will receive written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30-day period if additional information is needed to process the claim, and a one-time extension of not more than 15 days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be deemed denied.

If coverage is not approved, you have the right to appeal the decision. Information on how to request the appeal is included in the determination letter that you receive from Express Scripts.

Express Scripts Pharmacy

If you use long-term medications for a chronic condition, such as high blood pressure or diabetes, you can have your prescriptions filled through the Express Scripts Pharmacy home delivery service. This service normally features better negotiated prices than are available at a retail pharmacy, and it allows larger supplies (up to 90 days) than when purchased at a retail pharmacy (up to a 30-day supply). Plus the prescription is delivered directly to you with no standard shipping charges and there are easy refill options.
How to Order Your New Prescriptions through Express Scripts Pharmacy

1. By mail:
   ■ Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to one year (if appropriate).
   ■ Mail the new prescription using the Express Scripts Pharmacy Order Form provided in your Express Scripts Welcome Kit.
   ■ Your prescription order will usually arrive within 8 days after Express Scripts Pharmacy receives the order.

2. By fax:
   ■ Ask your doctor for a new long-term prescription as described on the left.
   ■ Give your doctor your member ID number (located on your prescription drug benefit card) and ask him or her to call (888) 327-9791 for instructions on how to use our fax service to send prescriptions. (Only your doctor can fax your prescriptions.)
   ■ You will be billed later.
   ■ Your prescription order will usually arrive within 8 days after Express Scripts Pharmacy receives the faxed order.

For refills remaining on long-term prescriptions filled at retail, log into Express-Scripts.com. In the Prescription section click “Transfer to home delivery” for the medications you’d like to transfer to the Express Scripts Pharmacy. Express Scripts Pharmacy will do the rest.

Express Scripts offers Automatic Refills for prescriptions that you fill through the Express Scripts Pharmacy. When you enroll a prescription in Automatic Refills, prescriptions will be automatically refilled and sent to you. You will be contacted when a refill starts, and you will be given the opportunity to stop or reschedule the refill. You may enroll in Automatic Refills at any time via Express-Scripts.com or by calling Express Scripts customer service.

If you do not use automatic refills, you may refill your home delivery prescription when you have used 75% of the medication since your last fill (for example, you may refill a 90 day supply of medication after 68 days have passed since your last fill).

Standard shipping is free. Expedited shipping is available for an extra charge.

The Plan provides no Benefits for using a home delivery service other than the Express Scripts Pharmacy.

Express Scripts Pharmacy Payment Options
When ordering a covered medication through the Express Scripts Pharmacy, you should always include payment when you submit the prescription, just as you would at a participating retail pharmacy. (If you have your doctor fax a prescription to Express Scripts Pharmacy, you will be billed for the medication unless the amount exceeds your account limit.) Express Scripts Pharmacy accepts the following payment methods: e-check; check; money order; MasterCard (credit or debit card); Visa®; Discover/NOVUS®; American Express; and Diners Club®.
If you order prescriptions by mail on an ongoing basis, we recommend that you enroll in one of these secure, convenient automatic payment programs:

- e-check to have payments automatically deducted from your checking account.
- AutoCharge to have payments automatically charged to the credit card of your choice.
- Extended Payment Program to have payments automatically charged to your credit or debit card in three monthly installments instead of paying all at once. Enrollment in this program requires a credit or debit card. Flexible Spending Account (FSA) cards or any other forms of payment are not acceptable for this program. Any outstanding balances must be paid in full when enrolling or dis-enrolling in the Extended Payment Program. Please review the Terms & Conditions for more details when enrolling in the Extended Payment Program.

To enroll in any of these programs, visit Express-Scripts.com or call Express Scripts Member Services at (800) PwC-9501 (792-9501). You can also enroll in AutoCharge on the Express Scripts Pharmacy order form.

Your Plan allows you to maintain a balance of up to $100 on your mail-order account. This amount is known as your account limit, and Express Scripts Pharmacy will bill you up to this limit. Unpaid balances from previous orders, the amount owed for orders in process, and the amount of any new prescriptions or refills you order count toward the limit. If you exceed your account limit, you will be required to pay by e-check or credit card before Express Scripts Pharmacy can process any more orders. If the balance is unpaid seven days after you submit a prescription, the prescription will be returned to you. You can check your account balance by visiting Express-Scripts.com or calling Member Services.

It is Express Scripts Pharmacy’s policy to obtain credit card approval before processing when the amount of your order exceeds $500.

**Covered Prescription Drugs**

Covered medications are available by prescription for up to a 30-day supply at retail and a 90-day supply via mail-order unless otherwise noted. Covered drugs include:

- drugs that require a prescription by law;
- injectable insulin only and disposable syringes and needles needed for its administration;
- diabetic supplies such as blood glucose strips and lancets;
- inhaler assisting devices;
- compounded medications. To be covered under the Plan, the compounded medication must meet all of the following requirements: 1) it must be medically necessary; 2) it cannot be experimental or investigatory; 3) it must not contain any ingredient on a list of excluded ingredients. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable. For example, if the cost of any ingredient has increased more than 5% every other week or more than 10% annually, the cost will not be considered reasonable;
■ prescription prenatal vitamins and pediatric vitamins with fluoride;
■ smoking cessation drugs; and
■ vaccines.

Important
If you have any questions about coverage for a particular medication, call Express Scripts Member Services at (800) PwC-9501 (792-9501) or log onto Express-Scripts.com before you incur expenses.

Medications requiring prior authorization will be reviewed by Express Scripts (with the exception of Fertility Drugs which will be reviewed by WIN Fertility) and Benefits will be paid only if the use of the medication is consistent with the Plan’s coverage guidelines. See Pre-Authorization Process below for instructions.

Contact Express Scripts for details on prescription drugs requiring prior authorization before the medication(s) will be dispensed and covered by the Plan.

**Prescription Drugs Not Covered**

Excluded medications are not covered, regardless of the diagnosis for which they are prescribed. These medications are not eligible to be reviewed for coverage determination. Medications excluded under the prescription drug plan are:

■ pharmaceuticals that you can buy without a prescription or that have an over-the-counter equivalent, except for insulin, syringes and needles and other diabetic supplies;

■ medical supplies such as dressings and antiseptics;

■ non-prescription vitamins;

■ non-prescription dental topical fluoride, rinses and gels;

■ compounded medications that do not meet all of the following requirements: 1) it must be medically necessary; 2) it cannot be experimental or investigative; 3) it must not contain any ingredient on a list of excluded ingredients. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable. For example, if the cost of any ingredient has increased more than 5% every other week or more than 10% annually, the cost will not be considered reasonable;

■ allergy sera, blood; and blood products;

■ drugs and supplies that you buy from a non-participating mail-order pharmacy;

■ blood glucose monitors including Glucowatch;

■ ostomy supplies;

■ cosmetic drugs such as Renova®, Vaniqa®;

■ nutritional supplements; and
- drugs and supplies dispensed or administered by providers such as physician assistants, home health care providers and visiting nurses when these drugs are supplied by the provider during the visit.

**Note:** The cost of delivering drugs to you when you request expedited delivery is not covered by the Plan.

**Prescription Drug Program - Prior Authorization Requirement**

Medications requiring prior authorization will be reviewed by Express Scripts (with the exception of fertility drugs, which will be reviewed by WIN Fertility) and Benefits will be paid only if the use of the medication is consistent with the Plan’s coverage guidelines. See *Pre-Authorization Process* below for instructions.

The following is a list of therapeutic classes and drugs that fall under the prior authorization requirement. This list is not all-inclusive and is subject to change as new drugs are introduced.

Since a retail pharmacist will need clearance from Express Scripts before filling a prescription for a drug requiring prior authorization, you may wish to call Express Scripts to find out if your drug is one that requires prior authorization before going to the pharmacy.

- Actemra®;
- alpha1 proteinase inhibitors - (Prolastin®, Prolastin® C, Aralast®, Glassia®, Zemaira®);
- Ampyra®;
- Aranesp®;
- Arcalyst®;
- Avonex®;
- Berinert®;
- Betaseron®;
- Boniva® (Ibandronate);
- Botox®;
- Chenodal®;
- Cholbalm®;
- Cimzia®;
- Cinryze®;
- Copaxone®;
- Cosentyx®;
- Daliresp®;
- Daklinza®;
- Egrifta®;
- Enbrel®;
- Entyvio®;
- Erbitux®;
- erythroid stimulants - (Epogen®, Procrit®);
- Esbriet®;
- Extavia®;
- fentanyl transmucosal drugs - (Abstral®, Actiq®, Fentora®, Onsolis®, Subsys®, Lazanda®);
- Firazyr®;
- Forteo®;
- Granix®;
- Grastek®;
- growth hormones - (Genotropin®, Humatrope®, Norditropin®, Nutropin®, Nutropin® AQ, Omnitrope®, Saizen®, Serostim®, Tev-Tropin®, Zorbtive®);
- H.P. Acthar® gel;
- Harvoni®;
- Herceptin®;
- Hetlloz®;
- Humira®;
- hyaluronic acid derivatives - (Euflexxa®, Hyalgan®, Synvisc®, Synvisc-One®, Gel-One®, Supartz®, Orthovisc®, Monovisc®);
- Ilaris®;
- Incivek®;
- Increlex®;
- injectable testosterone - (Aveed®, Depo® - Testosterone (testosterone cypionate injection, generics), Delatestryl® (testosterone enanthate injection, generics), Testopel® (testosterone pellet));
- IVIG - (Bivigam®, Carimune®, Flebogamma® DIF, Gammagard®, Gammagard S/D, Octagam®, Privigen®, Gammaplex®, Gamunex®, Gammaked®);
- Juxtapid®;
- Kadecyla®;
- Kalbitor®;
- Kalydeco®;
- Kineret®;
- Korlym®;
- Krystexxa®;
- Kuvan®;
- Kynamro®;
- Lemtrada®;
- leuprolide long acting - (Lupron Depot®, Lupron Depot-Ped®, Eligard®, Lupaneta®);
- Lidoderm®;
- Lovaza®;
- macular degeneration - (Eylea®, Lucentis®, Macugen®);
- Makena®;
- Mircera®;
- Myalept®;
- Myobloc®;
- Natpara®;
- Northera®;
- Neulasta®;
- Neupogen®;
- Nplate®;
- Nuvigil®, Provigil®;
- Ofev®;
- Olysio®;
- Oralair®;
- Orencia®;
- Orenitram®;
- Orkambi®;
- Otezla®;
- PCSK9's - Praluent, Repatha;
- Pegasys®, PegIntron®;
- Perjeta®;
- Plegridy®;
- Prolia®;
■ Promacta®;
■ pulmonary arterial hypertension - (Adcirca®, Adempas®, Flolan®, Letairis®,
  Osumit®, Remodulin®, Revatio®, Tracleer®, Tyvaso®, Velotri®, Ventavis®);
■ Ragwitek®;
■ Rebif®;
■ Reclast®;
■ Regranex®;
■ Remicade®;
■ ribavirin - (Copegus®, Rebetol®, Ribasphere);
■ Rituxan®;
■ Ruconest®;
■ Samsca®;
■ SCIG - (Gammagard® Liquid, Gammaked®, Gamunex-C®, Hizentra®, Hyqvia®);
■ Selzentry®;
■ Signifor® & Signifor LAR®;
■ Simponi®;
■ Solaraze®;
■ Somavert®;
■ Sovaldi®;
■ Stelara®;
■ Synagis®;
■ Technivie®;
■ topical tazarotene products - (Tazorac® 0.05% and 0.1% cream, gel, Fabior 0.1% foam);
■ topical testosterone - (Androderm®, AndroGel®, Axiron®, Fortesta®, Striant®,
  Testim®, First®-Testosterone MC, First®-Testosterone);
■ Tysabri®;
■ Vascepa®;
■ Vectibix®;
■ Vickira®;
■ weight loss drugs - (Adipe® (Phentermine), Bontril® (phendimetrazine), Contrave®
  (bupropion, naltrexone), Didrex® (benzphetamine), Sanore® (mazindol), Saxenda®,
  Suprenza® (phentermine), Tenuate® (diethylpropion), Xenical® (orlistat), Belviq®,
  Qsymia®);
Xenazine®, Xeomin®, and Xolair®.

The following is a list of therapeutic classes and drugs that also fall under the prior authorization requirement. However, if Express Scripts has enough information on file (for example, age, gender, or certain drug history information) a prior authorization review may not be necessary. This list is not all-inclusive and is subject to change as new drugs are introduced.

- ADHD non-stimulant;
- ADHD stimulant;
- alpha-1 inhibitors;
- cryopyrin-associated periodic syndrome (CAPS);
- erythroid stimulants;
- Gaucher's Disease;
- growth hormones;
- hepatitis C - injectable;
- hepatitis C - oral;
- infertility;
- inflammatory conditions;
- multiple sclerosis;
- prostate cancer GnRH analogs;
- prostate cancer oral;
- pulmonary arterial hypertension;
- tetracyclines - oral; and
- topical tretinoin - indication age limit is 35 (Retin-A®, Retin-A® Micro®, Avita® - Tretin-X™ - Triax; Atralin™ gel; generic topical tretinoin products and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel (Ziana®, Veltin™).

**Prescription Drug Program – Dispensing Quantity Limits**

Certain medications are limited to specific quantities per copayment amount or specific quantities in a specified period of time. If you fill a prescription that exceeds the quantity allowed, you may ask your doctor to start a coverage review, or pay full cost for the extra medication. The following therapeutic classes and drugs are subject to dispensing quantity rules:
- allergies;
- anaphylaxis;
- anti-fungal;
- anti-infective - specialty drugs;
- anti-infective;
- anti-influenza
- asthma - specialty drugs;
- asthma;
- blood cell deficiency;
- bone conditions;
- contraceptives;
- COPD;
- diabetes;
- endocrine disorder;
- eye conditions;
- fertility;
- hepatitis C;
- high blood cholesterol;
- high blood pressure;
- hormone supplementation;
- impotence;
- inflammatory conditions - specialty drugs;
- inflammatory conditions;
- migraine headaches;
- multiple sclerosis;
- nausea/vomiting;
- overactive bladder;
- pain – narcotic;
- pain;
- PCSK9's;
- pulmonary hypertension;
- respiratory miscellaneous;
sleep disorder;
ulcer; and
wound care.

If you are not sure whether or not a drug is covered or if a prior authorization is required, call Express Scripts Member Services at (800) PwC-9501 (792-9501).

Pre-Authorization Process

To determine if a drug is covered under the Plan, go to Express-Scripts.com and price a medication. Certain drugs need prior approval before you will receive coverage under the benefit. In addition, this Plan includes certain coverage limits.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets the Plan's coverage conditions.

You, your doctor, or your pharmacist may initiate the review process by calling Express Scripts Member Services at (800) PwC-9501 (792-9501). Express Scripts will then provide your doctor with a Coverage Management Review Fax Form to fill out and send back to Express Scripts at the fax number indicated on the form.

If you submit a prescription for a drug that has coverage limits, your pharmacist will be advised by Express Scripts that approval is needed before the prescription can be covered under the benefit. The pharmacist will give you or your doctor a toll-free number to call to activate the review process.

If you place an order with the Express Scripts Pharmacy before receiving approval, Express Scripts Pharmacy will contact your doctor to begin the coverage review. Express Scripts Pharmacy will send you and your doctor a letter advising whether or not coverage is approved (usually within two business days but not later than 15 days). However, Express Scripts Pharmacy may extend the review for up to an additional 15 days if you or your doctor failed to include all the necessary information. You will be told what information is needed and you will have 45 days to provide the missing information.

In the case of an urgent care request, if the time periods given above would seriously jeopardize your life or health or your ability to regain maximum function, or if, in the opinion of a physician familiar with your case, you have a condition that cannot be managed without the requested services, the certification will be made on an expedited basis within 72 hours of receiving your request. The determination of whether an urgent care request meets these requirements will be made by the attending provider. If there is insufficient information to make a determination, Express Scripts will notify you and your doctor within 24 hours of receipt of your request. In such case, you or your doctor will have 48 hours to provide the specified information and Express Scripts will notify you and your doctor of its coverage decision within 24 hours of receiving the necessary information.

Express Scripts will notify you and your doctor of its decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, the notice of denial will include the information necessary to identify the claim...
involved (including, if applicable, the date of service, the health care provider, the claim amount and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning); the specific reasons for the decision; the plan provisions on which the decision is based; a description of applicable internal and external review processes (and how to initiate an appeal) and a statement of your right to bring a civil action under Section 502(a) of ERISA; information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge; information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment or about your right to request this explanation free of charge; contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim and an explanation of why such material or information is necessary.

For claims involving urgent/concurrent care, the notice will also include a description of the applicable urgent/concurrent review process. Express Scripts may notify you or your authorized representative within 24 hours orally and then furnish a written notification of any determination.

If coverage is approved, you will pay your normal copay for the medication. If coverage is not approved, you will be responsible for the full cost of the medication. You have the right to appeal the decision. Information on how to request the appeal is included in the determination letter that you receive from Express Scripts.

**Appeal of Denied Claims**

When authorization of pharmacy Benefits is denied, you are entitled to obtain a review of the denial.

Coverage review description – You have the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests.

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan; for example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan’s benefit design.

How to request an initial coverage review:

The preferred method to request an initial clinical coverage review is for the prescriber or dispensing pharmacist to call the Express Scripts Coverage Review Department at (800) 753-2851. Alternatively, the prescriber may submit a completed coverage review form to Fax (877) 329-3760. Forms may be obtained online at www.express-scripts.com/services/physicians/. Requests may also be mailed to Express Scripts, Attn:
Prior Authorization Dept., P.O. Box 66571, St. Louis, MO 63166-6571. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the prescription.

To request an initial administrative coverage review, you or your representative must submit the request in writing to Express Scripts, Attn: Benefit Coverage Review Department, P.O. Box 66587, St Louis, MO 63166-6587.

If the patient’s situation meets the definition of urgent under applicable law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient’s provider, the patient’s health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient’s situation is urgent, the expedited review must be requested by the provider by phone at (800) 753-2851.

For appeals of all claims:

In the event you receive an adverse determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes), brief description of why the claimant disagrees with the initial adverse benefit determination and any additional information that may be relevant to your appeal, including prescriber statements/letters, bills or any other documents.

For clinical appeals, this information should be mailed to: Express Scripts, Attn: Clinical Appeals Department, P.O. Box 66588, St Louis, MO 63166-6588 or faxed to: (877) 852-4070.

For administrative appeals, this information should be mailed to: Express Scripts, Attn: Administrative Appeals Department, P.O. Box 66587 St Louis, MO 63166-6587 or faxed to: (877) 328-9660.

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the information necessary to identify the claim involved (including, if applicable, the date of service, the health care provider, the claim amount and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), the specific reasons for the decision, new or additional evidence, if any, considered and relied upon by the Plan in reviewing your appeal, the Plan provisions on which the decision is based, a description of applicable internal and external review processes (and how to initiate an appeal) and a statement of your right to bring a civil action under Section 502(a) of ERISA, information about any internal rule, guideline, protocol, or other similar criterion relied upon.
in making the claim determination and about your right to request a copy of it free of charge, information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim and a statement that the plan may have other voluntary alternative dispute resolution options, such as mediation and that more information may be obtained from your local U.S. Department of Labor office. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, brief description of why the claimant disagrees with the adverse benefit determination, the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes), and any additional information that may be relevant to your appeal, including prescriber statements/letters, bills or any other documents. For clinical appeals, this information should be mailed to: Express Scripts, Attn: Clinical Appeals Department, P.O. Box 66588, St Louis, MO 63166-6588 or faxed to: (877) 852-4070.

For administrative appeals, this information should be mailed to: Express Scripts, Attn: Administrative Appeals Department, P.O. Box 66587 St Louis, MO 63166-6587 or faxed to: (877) 328-9660.

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered and relied upon by the plan in reviewing your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal or your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA, you also have the right to bring a civil action under Section 502(a) of ERISA, but it must be brought within one year of the final adverse benefit determination.
Upon exhaustion of your internal appeal rights, you have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are available only for questions of medical judgment or rescission of coverage.

For claims involving urgent/concurrent care, the notice will also include a description of the applicable urgent/concurrent review process. Express Scripts may notify you or your authorized representative within 24 hours orally and then furnish a written notification of any determination.

You have the right to request an urgent appeal of an adverse determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written by fax. For urgent clinical and administrative appeals, the expedited review must be requested by phone or fax:

Clinical appeal requests: phone (800) 935-6103; fax (877) 852-4070.

Administrative appeal requests: phone (800) 946-3979; fax 1 877-328-9660.

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

**Rules applicable to appeals of claims:**

Your appealed claim will be reviewed through a process that does not afford deference to the initial adverse benefit determination, and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the initial decision on your claim nor that individual's subordinate. The internal appeal will take into account all comments, documents, records and other information submitted by you relating to your claim, whether or not such information was submitted or considered in the initial benefit determination.

If the determination of your appealed claim is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or
other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has the appropriate training and experience in the relevant medical field. Any such health care professional must be an individual who was neither consulted in connection with the initial benefit determination nor the subordinate of such an individual. Information regarding the identities of any medical or vocational experts consulted by the plan in connection with a denial of Benefits will be provided to you (free of charge) without regard to whether their advice was actually relied upon in the benefit determination.

Additionally, any new or additional evidence considered, relied upon, or generated in connection with your claim that is used in deciding your appeal will be provided to you (free of charge) in advance of any final internal adverse benefit determination. Before the plan can base its decision on new or additional rationale, the plan will provide you with the proposed rationale sufficiently in advance of the deadline to allow you an opportunity to respond.

The plan ensures that appeals are adjudicated with independence and impartiality of all persons involved. The plan does not hire, promote, or terminate appeals reviewers based on how they have supported or will support a denial of Benefits. The plan does not pay bonuses based on the number of appeals denied by a reviewer.

**Programs and Tools**

**Express-Scripts.com**

Use Express Scripts’ secure, consumer-friendly website to:

- order mail-order refills and renewals (new prescriptions cannot be submitted on the Web);
- view potential lower cost options for medications you take regularly using My Rx Choices®;
- receive medication-related safety alerts on your personalized pharmacy care profile and timely refill reminders;
- check the status of your mail-order prescriptions;
- view your prescription history and pay mail-order balances;
- review plan highlights;
- get information about preferred medications;
- compare brand-name and generic drug prices at both retail and via mail-order;
- print mail-order forms, direct claim forms, and temporary ID cards; and
- locate participating retail pharmacies.

It’s easy to get started and use. To register:

1. Have your member ID number handy. Your member ID number can be found on your member ID card. Your prescription number can be found on the label of any recent
retail prescription or a mail-order prescription filled under your benefit. (If you don’t have a prescription number, you can still register.)

2. Go to Express-Scripts.com. (Note: You can also access Express-Scripts.com via MY Rewards and Benefits on myKcurve.)

3. Click on the “Create online account” button and follow the on-screen instructions.

Once registered, all you need to do is log in each time you visit the Express Scripts site via Express Scripts.com. There’s no need to routinely enter your member ID number and prescription numbers. (Note: If you go to Express-Scripts.com via myKcurve, no log in is required.)

The Express Scripts Mobile App
The Express Scripts mobile app provides you with instant access to your personal medication information – wherever and whenever. From the mobile app, you can:

- order mail-order refills and renewals (new prescriptions cannot be submitted);
- check the status of your mail-order prescriptions;
- view your medications and set reminders to take them or notify you when you are running low;
- request home delivery for medications taken on an ongoing basis that are currently obtained from a retail pharmacy;
- view lower-cost prescription options available under your plan;
- review personalized alerts to help ensure you are following the treatment plan as prescribed by your doctor;
- use your current location or enter a zip code to search for the nearest in-network, preferred retail pharmacies, view contact information and access directions;
- use your phone to display your virtual ID card at the pharmacy; and
- search detailed drug information by medication name, condition or drug category, and see potential side effects, drug interactions, pill images and more.

The app is compatible with most iPhone®, iPad®, Android™, Windows Phone®, Amazon and BlackBerry® mobile devices and can be downloaded for free from the iTunes, Google Play, Windows Phone, and Amazon app stores.

My Rx Choices®
My Rx Choices is a complimentary program offered by Express Scripts. My Rx Choices provides you with potential lower-cost options available under your program for the medications you take on an ongoing basis in order to help you save on your prescription drug costs. For further details and disclosures regarding My Rx Choices, call (800) 319-7750 or visit Express-Scripts.com/choices.
Commercial Retail Vaccine Administration Program

Vaccinations are essential in the prevention of many severe illnesses. The commercial retail vaccine administration program provides you the option of using a certified pharmacist at a participating Express Scripts pharmacy for your vaccinations. All vaccines are covered at no cost under the program, where allowed by law.

- Before your visit, contact your local pharmacy to check availability and hours. State regulations govern pharmacy practice, and as a result vaccine administration practices differ by state. For example, you may be required to present a prescription from your physician for the immunization.

- At the time of your visit, present your Express Scripts ID card and pay nothing. If you do not present your ID card, you will be responsible for the full cost of the immunization and its administration.

- Confirm your vaccine will be administered by a certified pharmacist. If the vaccine is administered by another medical provider (e.g., a nurse practitioner from a convenience care clinic located in the pharmacy), coverage will be under the medical plan’s preventive care services benefit (See Section 6, Additional Coverage Details).