Gates Corporation

2019 Summary Plan Description

› Medical, Dental, and Vision
› Health Savings Account
› Flexible Spending Accounts
› Personal Resilience Program
› Legal Services
› Critical Illness
› Accident Insurance
A Guide to Your Employee Welfare Benefits Plan

Here is your 2019 guide to Gates Corporation’s Employee Welfare Benefits Plan (the “Plan”). The Plan gives you the flexibility to choose benefits and coverage levels that are right for your personal situation. This Plan guide is a very important tool for understanding and taking advantage of these meaningful benefit choices as well as specific details about eligibility, changes in enrollment, paying for benefits, obtaining benefits, and filing and appealing benefit claims, for example. This document is updated periodically by Summaries of Material Modifications and Benefit Guides.

Read this document carefully for details on coverage and Plan operations. Gates is not responsible for Plan information communicated by an employee, any Claims Administrator, service provider, or other party, which is contrary to the information in this Plan guide and any other document that governs the terms of this Plan.

If you have questions not answered in this Plan guide, please contact the applicable Claims Administrator or service provider identified in the GENERAL ERISA FACTS Section of this Plan guide. If you are married, please share this Plan guide with your spouse. An electronic copy is available by visiting www.gateshealth.com. A paper copy is available for him or her from your Human Resources Department or Global Benefits Department.
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Plan Highlights

Plan Effective Date January 1, 2019

References to Specialized Words Used Throughout This Guide

References in this guide to the Plan are to Gates Corporation’s Employee Welfare Benefits Plan. This Plan guide contains numerous references to Gates and the Plan Sponsor. Sometimes in this Plan guide, the shortened name of Gates is used: reference to Gates means Gates Corporation. Gates is the Plan Sponsor. Except as described in the Medical Optional Benefit Booklet and the Dental Optional Benefit Booklet that are a part of this Plan guide, references in this Plan guide to you are to an employee who is eligible and/or enrolled for benefits described in this Plan guide. References in this Plan guide to a member are to an employee and/or his or her eligible dependents (or member of the employee’s household in the case of the Plan’s employee assistance program optional benefit who are enrolled for benefits described in this Plan guide and whose Plan coverage is not terminated or to a Qualified Beneficiary or his or her eligible dependent who is properly enrolled in COBRA coverage that is not terminated to the extent that that Qualified Beneficiary has rights under the Plan as provided by COBRA.

Other specialized words are only used in this Plan guide to describe a particular benefit or benefit right; so, the meaning for such specialized words is included with the description of the particular benefit. And the meaning of specialized and frequently used words in the Medical Optional Benefit Booklet and the Dental Optional Benefit Booklet are provided in the booklet.

Here are some other specialized words that are used throughout this Plan guide with their meaning.

**Claims Administrator** — The third-party administrator that assists with benefit claims. The Claims Administrator for a particular benefit is identified in the PLAN ADMINISTRATION INFORMATION section of this Plan guide under the heading BASIC BENEFIT FACTS or OPTIONAL BENEFIT FACTS, depending on whether the benefit is the Plan's Personal Resilience Program or one of the Plan's optional benefits.

**COBRA Administrator** — The third-party administrator that assists with the Plan Administrator's responsibilities for the administration of the Plan's COBRA coverage. The Plan's COBRA Administrators are listed in the CONTINUATION OF COVERAGE section of this Plan guide under the heading COBRA ADMINISTRATOR.

**Coinsurance** — A member's percentage share of the cost of covered benefits and services after any deductible is met.

**Copayment or Copay** — The flat dollar amount that a member pays for covered benefits and services.

**Deductible** — The amount a member pays each Plan Year before a coverage option begins to pay for covered benefits and services.

**ERISA** — The Employee Retirement Income Security Act of 1974 or ERISA, for short. The Plan's medical, dental, vision, and health flexible spending account, health savings account optional benefits and the Plan's Personal Resilience Program are subject to the requirements of this federal law.

**In-Network** — Benefits and services received from a Participating Provider.
**Network** — A group of health care providers (physicians, dentists, hospitals, labs, or pharmacies, for example) who agree to provide Plan benefits and services to Plan members at a specified discounted rate. These providers are called **Participating Providers**.

**Out-of-Network** — Benefits and services received from a group of health care providers (physicians, dentists, hospitals, labs, or pharmacies, for example) who have not agreed to provide Plan members a specified discounted rate. These providers are called **Non-Participating Providers**.

**Tier 1 Premium Provider Network (PPN)** - a group of primary care and certain specialist physicians who have been designated as a Tier 1 Premium Provider as part of the United Healthcare (UHC) Premium Provider Network program that is available in 148 markets across 41 states. If the Premium Provider Network program is available in your area, you must use a Tier 1 Premium Provider as a primary care or specialist doctor to pay the Premium Provider amount. If you choose a Participating Provider that is not designated as a Tier 1 Premium Provider, you will pay more in coinsurance. If you visit a Non-Participating Provider, you will pay coinsurance at an even higher Out-of-Network level. To find a UHC Tier 1 Premium Provider in your area, or to find out if your current doctor is designated as a Tier 1 Premium Provider visit [www.welcometouhc.com/gates](http://www.welcometouhc.com/gates) and search for providers designated as “Tier 1” or phone UHC at the number on the back of your UHC ID card.

**Your Basic Benefits**

The Plan provides automatically a benefit under the Magellan personal resilience program. Enrollment in the Plan is not required to receive the Personal Resilience Program.

**Your Optional Benefits**

All other benefits available under the Plan are optional. To receive these optional benefits for you and your family, you must timely enroll in the Plan. The exception is the wellness program in which you and your spouse (if enrolled in a Gates active medical plan) can register at any time. There is no cost to you to participate. You and Gates share the cost of the optional medical and dental benefit. You pay the entire cost of these optional benefits:

- Vision
- Health and Dependent Care Flexible Spending Accounts
- Health Savings Account
- Prepaid Legal Services
- Critical Illness
- Accident Insurance

**Coverage for Eligible Dependents**

You may choose coverage for your eligible dependents for the following optional benefits:

- Medical
- Dental
- Vision
- Critical Illness
- Accident Insurance
Plan Documents and Other Materials

This Plan guide is the summary description for Gates Corporation’s Employee Welfare Benefits Plan. The Plan guide is also the controlling document for the Plan's medical optional benefit, including the prescription drug benefit, dental optional benefits, optional health savings account, optional flexible spending accounts. If there is a conflict or inconsistency between the Plan guide and the other Plan documents or materials that pertain to these benefits, the terms of the Plan guide will control. There are also Plan documents and materials (such as insurance policies or other contractual agreements with service providers) that pertain to the Plan's Personal Resilience Program and the Plan's vision, critical illness, accident insurance and prepaid legal optional benefits. In the case of a conflict or inconsistency between the Plan guide and these other Plan documents and materials that pertain to the Plan's Personal Resilience Program, the vision and prepaid legal optional benefits, the provisions of the other Plan documents and materials will control.

Eligibility

Employee Eligibility

You are eligible as a qualified employee for the benefits described in this Plan guide if you are:

- An employee of Gates on U.S. payroll regularly scheduled to work at least 30 hours per week.
- Meet and continue to meet all eligibility requirements for the Plan described in this Plan guide.

Coverage will be effective the first day of the month following date of hire. In order to be eligible, you must work 30 hours or more per week; or must have worked an average of 30 or more hours per week for the 12-month period of time, which is considered the “measurement period” for determining eligibility. The measurement period to determine benefits eligibility for each January 1 will be from October 15 through October 14 of the prior year. If you are determined to be eligible for medical coverage in January, you will be eligible for the entire calendar year. The measurement period will be conducted each year to determine your on-going eligibility. Eligibility criteria and the measurement process to determine eligibility conforms to the Affordable Care Act (ACA) requirements for variable-hour employees. For more information, visit www.HealthCare.gov.

To be eligible for the Plan as a qualified employee you must be on the United States payroll system and a "common law" employee. For the Plan's purposes, you are a "common law" employee if Gates treats you as an employee for federal income tax withholding purposes under Section 3401 of the Internal Revenue Code of 1986, as amended from time to time ("IRC"). For example, a person who is paid outside of Gates payroll system, an independent contractor, a temporary or leased employee, or an out-sourced worker is not a common law employee eligible for the Plan. Employees who transfer from an International location to US payroll will become eligible on the date of transfer. Employees, who voluntarily or involuntarily separate from employment and are rehired within 30 days, are eligible participants upon the date of rehire. After 30 days of separation, you will need to satisfy the normal waiting period to participate in the Plan.

If you are first hired as an ineligible employee, but transfer into an eligible employee position, the time you were employed as an ineligible employee will not count toward the 30 days of continuous employment requirement.

In the event that there is a final binding determination by a court, the United States Department of Labor, or the Internal Revenue Service that reclassifies a person as a common law employee such reclassified person will be eligible for the Plan as of the effective date of the final determination if he or she meets and continues to meet all eligibility requirements for the Plan provided in this Plan guide. Any
dependent of the reclassified person will be eligible for the Plan as of the effective date of the final determination if that dependent meets and continues to meet all eligibility requirements for the Plan provided in this Plan guide. For periods prior to the effective date of the final determination, the reclassified person and any dependent of that reclassified person will have no rights to any benefit or service under the Plan or any other rights or entitlements under the Plan.

Dependent Eligibility

If you are a qualified employee regularly scheduled to work at least 30 hours per week, you can choose coverage for your eligible dependents for the benefits described in this Plan guide. No one may qualify as both a dependent and an employee.

An eligible dependent is:

- Your legal spouse who does not have or who is not eligible to elect coverage for himself or herself in a medical plan of his or her employer at a cost equal to or less than a monthly amount annually specified by Gates for each Plan Year for employee-only coverage. The term "spouse" means a legal spouse who is an individual of the same or opposite sex to whom you are legally married pursuant to the laws of the State in which the marriage was celebrated. Civil union partners of benefits-eligible employees in Colorado are eligible for vision and legal plan coverage only. The term "spouse" includes your common-law spouse if common-law marriage is recognized in your state of legal residency.
- Your child for whom a Qualified Medical Child Support Order is issued or a child who has not reached the limiting age of 26 and:
  - Is your biological son or daughter; or
  - Prior to his or her 26th birthday is legally adopted by you or lawfully placed with you for legal adoption; or
  - Prior to his or her 26th birthday becomes your stepchild; or
  - Prior to his or her 26th birthday is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction; or
  - For whom you or your legal spouse has permanent legal custody and/or permanent financial responsibility by a valid court order that issued prior to his or her 26th birthday.
- Your disabled dependent child after his or her 26th birthday, if he or she:
  - Is your biological child or prior to his or her 26th birthday is legally adopted by or lawfully placed with you for legal adoption or prior to his or her 26th birthday becomes your stepchild; or
  - Is unmarried; or
  - Is incapable of self-support because of mental or physical disability which commenced prior to age 26; or
  - Is principally supported by you.

If you believe your dependent child meets the above criteria for a disabled dependent child, obtain a statement from the attending physician indicating the complete diagnosis and prognosis for that dependent child or obtain a written acknowledgement or decision by the Social Security Administration of a permanent disability for him or her. If eligibility is approved, an eligible disabled adult dependent child must be continuously enrolled.

No one may qualify as a dependent of more than one employee: if you and your spouse both work at Gates, only one of you may cover your child as a dependent.

During the initial enrollment or open enrollment period, proof of dependent relationship documentation is not required for whom you elect any benefit coverage provided in this Plan guide. Proof of dependent relationship is required as periodically requested and with a Qualified Change in Status. See DOCUMENTATION OF DEPENDENT ELIGIBILITY in the ENROLLMENT section of this Plan guide. A dependent's enrollment is not complete and his or her coverage under the Plan will not begin until
this required documentation is provided according to the instructions in the enrollment tool. The Plan Administrator has the sole discretion to determine the acceptable documents for proof of relationship.

Enrollment

General

This section describes the rules and procedures to enroll in the Plan. For any enrollment described in this section or to make payment arrangements when payroll deductions cannot be made for the premiums and contributions for your elected optional benefits, see Enrollment Elections, Making Enrollment Changes and Payment Arrangements below in this section. For any enrollment of an eligible dependent described in this section see DOCUMENTATION OF DEPENDENT ELIGIBILITY below in this section. In general, all elected optional benefits are irrevocable during the plan year.

During Annual Open Enrollment as a Qualified Employee

Qualified Employee. If you are a qualified employee other than a newly hired or rehired qualified employee, you must timely complete an electronic application during the Plan's annual open enrollment period to enroll in any of the medical, dental, vision, health or dependent care flexible spending accounts, health savings account (if you are also enrolled for the Plan's CDHP (or, consumer driven health plan), critical illness, accident insurance and prepaid legal services optional benefits. The electronic application provides relevant eligibility information and authorizes Gates to make payroll deductions for the premiums and contributions for your elected optional benefits. If you don't timely enroll you will not have coverage - unless you are automatically enrolled in the benefit. Your elections during the annual open enrollment event are irrevocable, absent the health savings account and/or a qualified change in family status. When payroll deductions cannot be made, such as while on an authorized unpaid leave of absence, you must make other payment arrangements with your Human Resources Department.

Eligible Dependent. An eligible dependent must be enrolled in any medical, dental, and/or vision coverage that you choose for yourself. The dependent's legal name, date of birth, and social security number is required to enroll. You must also be enrolled in any optional benefit coverage that you choose for an eligible dependent. The dependent's enrollment must be made by the same deadline that applies to your enrollment application and his or her coverage will begin at the same time that your coverage begins.

Enrollment as a Newly Hired or Rehired Qualified Employee

Newly Hired or Rehired Qualified Employee. If you are a newly hired or rehired qualified employee you must timely complete an electronic application to enroll in any of the medical, dental, vision, health or dependent care flexible spending accounts, health savings account (if you are also enrolled for the Plan's CDHP (or, consumer driven health plan), critical illness, accident insurance and prepaid legal services optional benefits. The application provides relevant eligibility information and authorizes Gates to make payroll deductions for the premiums and contributions for your elected optional benefits. Your enrollment application must be made within 30 days of your date of hire or rehire. Coverage under the benefits options in which you enroll will then become effective on the first day of the month following your date of hire. If you wait longer than 30 days, you will not have coverage. When payroll deductions cannot be made, such as while on an authorized unpaid leave of absence, you must make other payment arrangements with your Human Resources Department.
You are automatically enrolled in certain benefits that are provided at no cost to you. Coverage under these benefits will become effective on the first day of the month following your date of hire.

If you are rehired less than 30 days following your last termination date with Gates, you are not required to reenroll in benefits. Instead, your prior elections that were made during your last period of employment with Gates will be automatically reinstated on your date of rehire.

**Eligible Dependent.** An eligible dependent must be enrolled in any medical, dental, and/or vision coverage that you choose for him or her. The dependent’s legal name, date of birth, and social security number is required to enroll. You must also be enrolled in any optional benefit coverage that you choose for an eligible dependent. The dependent’s enrollment must be made by the same deadline that applies to your enrollment application and his or her coverage will begin at the same time that your coverage begins. If you do not timely enroll an eligible dependent, he or she will not have coverage.

**Changes in Enrollment**

**During the Annual Open Enrollment Period.** During the designated annual open enrollment period, you can elect or change the medical, dental, vision, general purpose or limited purpose health flexible spending account, dependent care flexible spending account, health savings account (if you are also enrolled for the Plan's consumer driven health plan CDHP), critical illness, accident insurance and prepaid legal services. In general, elections made during the annual open enrollment period are irrevocable, absent the health savings account and/or a qualified change in family status. Benefits elected during the annual open enrollment period are effective the following January 1.

**Outside the Annual Open Enrollment Period.** You can enroll in the health savings account optional benefit (if you are also enrolled for the Plan's CDHP) or change or revoke your health savings account optional benefit election at any time. Your prepaid legal services optional benefits election can be changed only during an annual open enrollment period. Other changes outside the annual open enrollment period may be available with a Change in Family Status or Coverage or as permitted for a HIPAA special enrollment event, both of which are described below.

**Change in Family Status or Coverage.** Generally, your election or change of the medical, dental, vision, health flexible spending account, or dependent care flexible spending account optional benefits during an annual open enrollment period is effective for and must be maintained for the entire calendar. You may be able to make certain changes outside the annual open enrollment period to your medical, dental, vision, health flexible spending account, dependent care flexible spending account, critical illness or accident insurance optional benefits in the event of and consistent with a Change in Family Status or Coverage.

A Change in Family Status or Coverage is any of the following events:

- Your legal marital status changes due to your marriage, legal separation, legal annulment, divorce, or the death of your spouse.
- The number of your dependents changes due to the death of a dependent child or the birth of your child, your adoption of a child, or the placement for adoption or foster care of a child with you.
- A significant change in the employment status for yourself, your spouse or your dependent child due to: a termination or commencement of employment; a strike or lockout; a commencement or return from an unpaid Non-FMLA leave of absence; a change in worksite; or any other change in employment status (such as going from full-time to part-time employment or vice versa and other than in connection with a FMLA leave of absence) that affects eligibility for benefits under the Plan or another employee benefits plan for yourself, your spouse or dependent child.
- A change that causes your dependent child to satisfy or cease to satisfy the eligible dependent requirements for the Plan and additionally in the case of the Plan's dependent care flexible spending account optional benefit, change because your eligible dependent no longer meets the qualifications to be eligible for dependent care.
- A change in the place of residence for yourself or your eligible dependent.
- A gain or loss of other coverage or eligibility (such as through your spouse's employer) by you or your eligible dependent.

For a Change in Family Status or Coverage, an enrollment change is permitted provided that written notice of the change and the changed enrollment is received within 30 days after the change occurs. If the change is made within 30 days, coverage will be retroactive to the date of the event. Changes in payroll deductions consistent with the elected change will be made retroactive to the event date. Any change in an election must be both on account of and consistent with the Change in Family Status or Coverage. If you wait longer than 30 days, you will not be permitted to enroll in any of the Plan's optional benefits or make changes to your current enrollment except within 30 days of another Change in Family Status or Coverage or during the open enrollment period. You must also be enrolled in any optional benefit coverage that you choose for an eligible dependent. To enroll an eligible dependent, you must provide the dependent's full legal name, date of birth, and social security number. With a Change in Family Status or Coverage, verification of the dependent's relationship to you is required, such as a copy of the marriage certificate, court decree, or in the case of a newborn, the complimentary birth certificate issued by the hospital. Documentation of other qualified events is also required to determine that a Change in Family Status or Coverage occurred. Enrollment is not complete and coverage under the changed enrollment will not begin until this required documentation is provided within 30 days of the event.

**HIPAA Special Enrollment**

Enrollment may be available outside the annual open enrollment period for the Plan's medical optional benefit due to a special enrollment event under a federal law called the Health Insurance Portability and Accountability Act of 1996 or HIPAA for short. Although not required by HIPAA, the Plan also permits enrollment outside the annual open enrollment period for dental and vision benefits due to a HIPAA special enrollment event. Unless expressly provided by the terms of the Plan, the Plan terms shall not be construed to provide rights under HIPAA beyond those required by this federal law.

**New Dependents.** If you have a new eligible dependent, you must submit a written status change enrollment application within 30 days of the date the dependent became an eligible dependent. The dependent's legal name, date of birth, and social security number is required to enroll. If the application is completed within 30 days, coverage will be retroactive to the day that the dependent became eligible for coverage. If you wait longer than 30 days, the new eligible dependent may not be enrolled unless within 30 days of another Change in Family Status or Coverage or during the annual open enrollment period. In the case of any new eligible dependent, HIPAA special enrollment is available to that new dependent, you and your legal spouse if he or she is not the new eligible dependent. You must also be enrolled in the Plan's medical, dental, and/or vision optional benefit in order to enroll any new eligible dependent in that coverage. During any HIPAA special enrollment period for a new dependent, proof of relationship documentation and verification of disability prior to age 26 (for a child aged 26 or older) is required for each new dependent for which coverage is elected by you. HIPAA special enrollment is not complete and coverage under the Plan's medical, dental, and/or vision optional benefit will not begin until this required documentation is provided according to enrollment instructions within 30 days of the event.

**Eligibility For State Premium Assistance Subsidy or CHIP.** If you or your eligible dependent becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP, and you are not enrolled in the Plan, you may elect coverage by submitting in writing a completed Change in Family Status or Coverage enrollment application within 60 days of the date when you are or your
eligible dependent is determined eligible for the premium assistance subsidy. Coverage becomes effective from and after 12:01 a.m. on the first day when the Change in Family or Coverage enrollment application is completed. If you wait longer than 60 days, neither you nor your eligible dependent may be enrolled unless within 30 days of another Change in Family Status or Coverage or during the annual open enrollment period. You must also be enrolled in the Plan's medical, dental, and/or vision optional benefit in order to enroll any eligible dependent in that coverage. During the HIPAA special enrollment period, proof of relationship documentation and verification of disability prior to age 26 (for a child aged 26 or older) is required for the dependent for which coverage is elected by you. HIPAA special enrollment is not complete and coverage under the Plan's medical, dental, and/or vision optional benefit will not begin until this required documentation is provided within 60 days.

Loss Of Other Coverage. This HIPAA special enrollment applies to you and your eligible dependents if you decline or drop coverage under the Plan's medical optional benefit for yourself or any eligible dependents (including your spouse). The Plan also permits enrollment outside the annual open enrollment period for the dental, vision, and health flexible spending account optional benefits if you opt out of one or more of these optional benefits for yourself and all eligible dependents because you or your eligible dependents had that coverage through another source. You may enroll yourself and your eligible dependents in the Plan's medical, dental, vision, and/or health flexible spending account optional benefits if:

- You or your eligible dependent had coverage under a group health plan or had health insurance coverage when you declined, dropped, or opted out of the Plan's coverage;
- At the time the coverage was declined, dropped, or opted out from by you, you stated in writing that the coverage is declined, dropped or opted out from because you or your eligible dependent had coverage under a group health plan or other health insurance coverage; and
- The previous coverage that your or your eligible dependent had is one of the following:
  - COBRA coverage that is exhausted at the end of the applicable COBRA coverage period or ceases prior to the end of the applicable COBRA coverage period because, for example, the employer or party other than the individual who was responsible for premium payments failed to remit these premiums on a timely basis, the individual no longer resides in the HMO service area and no other benefits are available, or the individual incurs a claim that would meet or exceed a lifetime limit on all benefits but not because that individual failed to timely pay premiums or termination for cause;
  - Coverage other than COBRA coverage that is terminated because that individual lost eligibility for the coverage (including, for example, loss of coverage as a result of legal separation, divorce, death, termination of employment or reduction in hours of employment or cessation of dependent status, loss of coverage because the individual no longer resides, lives or works in an HMO service area and no other benefits are available, loss of coverage because the plan providing coverage no longer offers any benefits to the class of similarly situated individuals that includes the individual, or, loss of coverage under a state Medicaid plan or CHIP), and excluding loss of coverage as a result of failure to timely pay premiums or termination of coverage for cause); or
  - Coverage other than COBRA coverage that is terminated because the employer's contributions to the group health plan or other health insurance coverage ended.

If you or your eligible dependent's previous coverage ended for one of the above reasons, to be eligible for HIPAA special enrollment in the Plan's medical, dental and vision optional benefit, you must submit a completed enrollment application for yourself and/or your eligible dependent(s) within 30 days after previous coverage ended (or within 60 days after previous coverage ended under a Public Health Plan such as state Medicaid or CHIP). Coverage becomes effective retroactively to the event...
date (for enrollment received within 30 days of the event) or in the event of loss of state Medicaid or CHIP, 12:01 a.m. on the first day when the Change in Family or Coverage enrollment application is completed. If you wait longer than 30 days (or 60 days in the case of a loss of coverage under a state Medicaid plan or CHIP), your and/or your eligible dependent may not be enrolled in the Plan’s medical, dental, vision, and/or health flexible spending account optional benefit unless within 30 days of a Change in Family Status or Coverage or during the annual open enrollment period. You must also be enrolled in the Plan’s medical, dental, and/or vision optional benefit in order to enroll any eligible dependent in that coverage. During the HIPAA special enrollment period, proof of relationship documentation and verification of disability prior to age 26 (for a child aged 26 or older) is required for any new dependent for which coverage is elected by you. The dependent’s legal name, date of birth, and social security number is required to enroll. HIPAA special enrollment is not complete and coverage under the Plan’s medical, dental, and/or vision optional benefit will not begin until this required documentation is provided according to enrollment instructions.

Enrollment Applications, Making Enrollment Changes, and Payment Arrangements

Enrollment instructions are available from your Human Resources Department as indicated in the CONTACT INFORMATION section of this Plan guide. You should also contact your Human Resources Department to make enrollment changes and payment arrangements when payroll deductions cannot be made for your premium payments.

Documentation of Dependent Eligibility

<table>
<thead>
<tr>
<th>Type of Dependent</th>
<th>Required Documents</th>
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<tbody>
<tr>
<td>Spouse</td>
<td>Marriage Certificate or first page copy of federal tax filing. Common-Law Marriage Affidavit</td>
</tr>
<tr>
<td>Biological, Adopted, or step child under age 26</td>
<td>Birth Certificate (Complementary copy is sufficient for newborns). Adoption decree.</td>
</tr>
<tr>
<td>Biological, adopted, step child age 26 or older</td>
<td>Birth Certificate or Final Adoption Decree, and Attending physician statement or Social Security Administration written acknowledgement or decision as described in DEPENDENT ELIGIBILITY in ELIGIBILITY section of this Plan guide</td>
</tr>
<tr>
<td>Adopted/foster child under age 26 placed with you</td>
<td>Document reflecting that the child is placed with you for the purpose of adoption or foster care</td>
</tr>
<tr>
<td>Child for whom you or your legal spouse has permanent legal custody or permanent financial responsibility</td>
<td>Court order for permanent legal custody or permanent financial responsibility</td>
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</tbody>
</table>

Effective Date of Coverage

General Rule

For a qualified employee coverage for you and your eligible dependents under the medical, dental, vision, health flexible spending account, dependent care flexible spending account, health savings account (if you are also enrolled for the Plan’s CDHP, critical illness, accident insurance and prepaid
legal services optional benefits generally becomes effective at 12:01 a.m. on the first day of the month that coincides with or immediately follows compliance with the eligibility requirements and timely completed enrollment for those optional benefits. You are automatically enrolled in the Personal Resilience Program effective at 12:01 a.m. on the first day after you meet the Plan's eligibility requirements.

Exceptions to the General Rule

In the case of an election or enrollment change for a Change in Family Status or Coverage (or due to a HIPAA special enrollment event that does not involve the determination of eligibility for a premium assistance subsidy for the Plan under a state Medicaid plan or CHIP) the enrollment change is retroactive to the date of that Change in Family Status or Coverage or HIPAA special enrollment event. This retroactive enrollment change does not apply to any election or enrollment change with respect to the Plan's health flexible spending account for a Change in Family Status or Coverage or due to a HIPAA special enrollment event: any such election or enrollment change will be applied for the period after that change is completed. But you must complete an application for coverage or enrollment change within 30 days of that Change in Family Status or Coverage or HIPAA special enrollment event occurs.

In the case of an election or enrollment change for a HIPAA special enrollment event that involves the determination of eligibility for a premium assistance subsidy for the Plan under a state Medicaid plan or CHIP, the enrollment change is also retroactive to the date of that HIPAA special enrollment event. However, you must complete an application for coverage or enrollment change within 60 days of when that HIPAA special enrollment event occurs. Proof of relationship documentation and verification of disability prior to age 26 (for a child aged 26 or older) is required for any new dependent for which coverage is elected by you due to a Change in Family Status or Coverage or HIPAA special enrollment event. Enrollment is not complete and coverage under the Plan will not begin until this required documentation is provided according to enrollment instructions.

Special Situations

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is either a National Medical Child Support Notice issued by a state child support agency, or an order or judgment from a state court or administrative body directing the Plan to provide coverage for your child as a dependent. The Plan has detailed procedures for determining whether an order is a Medical Child Support Order is a Qualified Medical Child Support Order. You can obtain, without charge, a copy of these procedures from the Plan Administrator.

If the Plan Administrator determines that a Medical Child Support Order issued with respect to your child is a Qualified Medical Child Support Order, that child will be enrolled in the Plan according to the terms of that Order. The Plan may automatically change your enrollment application choice(s) in order to provide the coverage for your child according to the Qualified Medical Child Support Order. These changes may include enrollment of you in the Plan if you are eligible for and have declined Plan coverage. Premium payments for coverage according to a Qualified Medical Child Support Order are payable through payroll deductions. You may only discontinue Plan coverage under a Qualified Medical Child Support Order for your dependent child by providing written evidence that this Order is no longer in effect unless the Order provides for a specific period of coverage that has lapsed. Coverage will terminate as of the date the Order is no longer in effect as approved by the Plan Sponsor. If coverage terminates due to a lapse in the period specified in the Order, coverage terminates as of the date specified in the Order.
Leaves of Absence

Paid Leaves of Absence

If you take a paid leave of absence under the Family Medical Leave Act of 1993, or FMLA for short, or a paid Non-FMLA Leave, the Personal Resilience Program will continue and you are required to continue all optional benefits for which you and your eligible dependents are enrolled during that leave. The payroll deductions for the premiums and contributions for those optional benefits will continue during your leave. In other words, during your paid leave of absence the Plan terms apply to you and your eligible dependents without regard to your leave of absence.

Unpaid FMLA Leave

If you take an unpaid leave of absence under the Family Medical Leave Act of 1993, your Personal Resilience Program will continue during that leave. All optional benefits for which you and your eligible dependents are enrolled will continue as well during that leave, unless you choose to cancel coverage. Because payroll deductions cannot be made during your leave, you must make arrangements with your Human Resources Department to timely pay the required premiums and contributions for the optional benefits for which you and your eligible dependents are enrolled. You can make arrangements before your leave begins to pre-pay all or a portion of those premiums and contributions on a pre-tax salary reduction basis for the remainder of the Plan Year. Or if you do not wish to make pre-payment premium and contribution payments for the optional benefits for which you and your eligible dependents are enrolled, you must make arrangements with your Human Resources Department to pay those premiums and contributions during that period on a pay-as-you-go basis by personal check, money order, or certified funds. Alternatively, you can choose to have those amounts deducted from your compensation when you return from your leave by catching up deductions with the first 3 paychecks upon return to work, if those payroll deductions will occur in the same year as your leave.

Unpaid Non-FMLA Leave

If you take a Non-FMLA Leave, including a leave of absence by reason of service in the United States uniformed services, your Personal Resilience Program will continue during that leave. All optional benefits for which you and your eligible dependents are enrolled will continue as well during that leave unless you make a change in enrollment due to a Change in Family Status or Coverage. Because payroll deductions cannot be made during your leave, you must make arrangements with your Human Resources Department to pay the required premiums and contributions for the optional benefits for which you and your eligible dependents are enrolled. Rules for the payment of your premiums and contributions are described in the PAYMENTS section of this Plan guide under the heading When Payroll Deductions Cannot Be Made. If you elected the health savings account optional benefit under the Plan and you wish to continue contributions during your unpaid leave of absence, your contributions to your health savings account must be made after-tax and be paid directly to the bank holding your account.

Payments

Premium Payments
Payroll Deductions

You and any eligible dependent are only entitled to the Plan's optional benefits for which you enroll if the required premiums and contributions for those benefits are paid in full by you. Those premiums and contributions are paid by you with payroll deductions. Premiums for the Plan's medical and dental optional benefits are generally paid on a pre-tax basis by payroll deductions, or contributions, under the Plan's premium expense account optional benefit. When you enroll for any of the Plan's medical, vision or dental optional benefits, you agree to and are automatically enrolled for the Plan's premium expense account optional benefit for your premiums for that coverage. If there is any increase or decrease in your premiums for the medical, vision or dental optional benefits for which you are enrolled, your premium expense account contributions will be automatically adjusted to reflect the change. Contributions under the Plan's general-purpose or limited-purpose health flexible spending account, dependent care flexible spending account, and health savings account optional benefits are also paid with pre-tax payroll deductions. The Plan's prepaid legal services, critical illness and accident insurance optional benefits are paid with after-tax payroll deductions.

When Payroll Deductions Cannot Be Made

When payroll deductions cannot be made, such as while you are on an authorized unpaid leave of absence, other payment arrangements must be made with your Human Resources Department. Completing the Payment Election for Unpaid Leave of Absence form outlines payment options, details, and instructions for payment. The premium payment must be received by the close of business no later than the premium due date. If a premium is paid by you with a personal check made on an account with insufficient funds (in other words, the check "bounces"), you have not paid that premium in full and coverage will be terminated.

Mid-Year Changes in Enrollment

Any change in your premiums or contributions in the event of a change in enrollment outside the annual open enrollment period will be applied retroactively to the enrollment change event.

CHIP

If you are eligible for coverage under the Plan for medical and dental options, but unable to afford the premiums for medical coverage, some states have premium assistance programs (or CHIP) that can help pay for coverage. These states use funds from the Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance paying their premiums. You can contact your state Medicaid or CHIP office to find out if premium assistance is available and whether you might be eligible and how to apply. You can also contact 1-877-KIDS NOW or www.insurekidsnow.gov. If you qualify for premium assistance and are not currently enrolled, you may enroll in the Plan’s medical and dental plans as long as you apply within 60 days after it is determined that you are eligible for premium assistance. If you live in one of the following States, you may be eligible for financial assistance in paying for coverage under the Plan’s medical option. The following list of States is current as of January 31, 2019. You should contact your State for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Website</th>
<th>Phone</th>
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<th>Medicaid Eligibility</th>
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<td>ALASKA - Medicaid</td>
<td><a href="http://myakhipp.com">http://myakhipp.com</a></td>
<td>1-866-251-4861</td>
<td><a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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<td>FLORIDA</td>
<td>Website: <a href="https://www.flmedicaidtplrecovery.com/">https://www.flmedicaidtplrecovery.com/</a></td>
<td>Phone: 1-877-357-3268</td>
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<td>Website: Medicaid <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> Click on Health Insurance Premium Payment (HIPP) Phone: 1-404-656-4507</td>
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<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fsa/hip/">http://www.in.gov/fsa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone: 1-800-403-0864</td>
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<td>MINNESOTA</td>
<td>Website: <a href="https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-651-3739 or 651-431-2670</td>
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<td>MISSOURI</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</td>
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<td>NEBRASKA</td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178</td>
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<td>NEW YORK</td>
<td>Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831</td>
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<td>NORTH CAROLINA</td>
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<td>NORTH DAKOTA</td>
<td>Medicaid Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825</td>
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<td>OKLAHOMA</td>
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<tr>
<td>State</td>
<td>Medicaid and CHIP Website and Phone</td>
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<td>Pennsylvania</td>
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<td>Texas</td>
<td>Website: <a href="http://gethipptexas.com">http://gethipptexas.com</a>  Phone: 1-800-440-0493</td>
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<td>Vermont</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>  Phone: 1-800-250-8427</td>
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<td>Washington</td>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a>  Phone: 1-800-562-3022 ext. 15473</td>
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<tr>
<td>Wisconsin</td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a>  Phone: 1-800-362-3002</td>
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<tr>
<td>Wyoming</td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a>  Phone: 307-777-7531</td>
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To see if any more States have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, you can contact either:

- U.S. Department of Labor  
  Employee Benefits Security Administration  
  [www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
  1-866-444-EBSA (3272)

- U.S. Department of Health and Human Services  
  Centers for Medicare & Medicaid Services  
  [www.cms.hhs.gov](http://www.cms.hhs.gov)  
  1-877-267-2323, Menu Option 4, Ext. 61565
Copayments, Coinsurance, and Deductible Payments

You may be required by a provider to pay all copayments, coinsurance, and deductible payments at the time medical, prescription, dental, and/or vision services are received. You are responsible for all such charges. If you fail to pay them, the provider may refuse service. There is a limit on the total amount of coinsurance and deductibles that you must pay in any year.

Termination of Coverage

By Amendment or Termination of the Plan

Gates has the absolute right in its sole discretion to amend or terminate the Plan or any Plan provision in whole or in part at any time, including any cost sharing arrangements. An amendment or termination of the Plan or Plan provision may apply to end coverage under a Plan benefit or optional benefit for active, inactive, or former employees and their eligible dependents. The Plan Administrator will notify you if such an amendment or termination substantially affects your Plan benefits or those of your eligible dependents.

For Cause

Coverage under any Plan benefit or optional benefit will end for you and any eligible dependent of yours if:

- You provide false or misrepresent information on any enrollment application for that coverage;
- You or your eligible dependent permit a person who is not enrolled for the coverage to use a Plan ID card to obtain that coverage; or
- You or your dependent obtain or attempt to obtain the coverage by means of false, misleading or fraudulent information, acts, or omissions.

After coverage is terminated other than under the Plan's medical optional benefit or Personal Resilience Program, the Plan will reject any claim for that coverage incurred by you or any dependent of yours. The coverage will be terminated automatically and without notice to you or any eligible dependent of yours beginning at 12:01 a.m. on the first day after the determination of the cause for that termination; provided, that if it is determined within two years (or at any time in the case of an act, practice, or omission that constitutes fraud) that you or a dependent of yours omitted or misrepresented a material fact on the documents applying for the coverage, that coverage for you and any dependent of yours will be null and void from inception. Any services or other benefits provided under the terminated coverage will become your legal responsibility to pay individually and together with any dependent who received those services or other benefits.

If your coverage under the Plan's medical optional benefit is terminated, the Plan Administrator will notify you and each enrolled eligible dependent in writing of that termination. If your coverage under the Plan's Personal Resilience Program is terminated, the Plan Administrator will notify you in writing of that termination. The Plan will reject any claim for such terminated coverage as described in that notice. Typically, the Plan will only reject claims incurred after the determination of the cause for the termination. But if it is determined within two years (or at any time in the case of an act, practice, or omission that constitutes fraud) that you or a dependent of yours omitted or intentionally misrepresented a material fact on the documents applying for coverage under the Plan's medical optional benefit, that coverage for you and each enrolled eligible dependent will be null and void from inception. Any services or other benefits provided under the terminated coverage will become
your legal responsibility to pay individually and together with any dependent who received those services or other benefits.

For purposes of retroactive rescission of coverage, fraud and misrepresentation are as defined under the Affordable Care Act, which means collectively, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, both as amended from time to time.

Coverage will also end for you and any eligible dependent of yours:

- If you engage in gross misconduct related to your employment; or
- If you or any dependent of yours fails to reimburse the Plan under any Plan subrogation provision.

After coverage is terminated other than under the Plan's medical optional benefit or Personal Resilience Program, the Plan will reject any claim for that coverage incurred by you or any eligible dependent of yours. The coverage will be terminated automatically and without notice to you or any dependent of yours beginning at 12:01 a.m. on the first day after the determination of the cause for that termination. If your coverage under the Plan's medical optional benefit is terminated, the Plan Administrator will notify in writing you and each enrolled eligible dependent of that termination. If your coverage under the Plan's Personal Resilience Program is terminated, the Plan Administrator will notify you in writing of that termination. The Plan will reject any claim for that coverage as described in that notice.

By Reason of Ineligibility

If you are no longer eligible under the Plan, all of your coverage under the Plan (other than any COBRA coverage, if available) will automatically end at 12:01 a.m. on the first day of your ineligibility.

All coverage under the Plan for which you have enrolled your spouse and any eligible dependent child (other than any COBRA coverage, if available) will automatically end at 12:01 a.m. on the first day that:

- All dependent coverage under the Plan is discontinued;
- The dependent becomes covered under the Plan as an employee;
- The dependent no longer meets the Plan's definition of an eligible dependent; or
- Your coverage under the Plan (other than COBRA coverage, if available) terminates.

Notwithstanding the foregoing, if a dependent no longer meets the definition of eligible dependent due to attaining age 26, coverage will automatically end at 12:01 am on the first day of the month following the month in which the dependent attains age 26.

All coverage under the Plan for your dependent spouse (other than any COBRA coverage, if available) will also automatically end at 12:01 a.m. on the first day that:

- You are legally divorced from him or her; or
- You are legally separated from him or her.

For Nonpayment of Premiums

You and any eligible dependent are only entitled to the Plan's optional benefits for which you enroll if the required premiums and contributions for those benefits are paid in full by you. Those premiums and contributions are paid by you with payroll deductions. Premiums for the Plan's medical and dental optional benefits are generally paid on a pre-tax basis by payroll deductions. Contributions to the Plan's general-purpose or limited-purpose health flexible spending account, dependent care flexible spending account and health savings account optional benefits are also paid with pre-tax payroll deductions. The Plan’s critical illness, accident insurance and prepaid legal services optional
benefit are paid with after-tax payroll deductions.

When payroll deductions cannot be made, such as while on an authorized unpaid leave of absence, payment arrangements must be made with your Human Resources Department. Completing the Payment Election for Unpaid Leave of Absence form outlines payment options, details, and instructions for payment. Any such premium payment that is not made by payroll deduction can be mailed or hand delivered by each regular payroll date. Your Human Resources Department will provide you with the appropriate address and due date for any such premium payment. If mailed, a premium payment must be postmarked no later than the premium due date. If hand delivered, the premium payment must be received by the close of business no later than the premium due date. You are responsible for correctly addressing or hand delivery to the correct address. If a premium is paid by you with a personal check made on an account with insufficient funds (in other words, the check “bounces”), you have not paid that premium in full.

Coverage will automatically end at 12:01 a.m. on the first unpaid day, if the premium payment (including any grace period) for that coverage is not paid in full by the due date. The Plan will reject any claim incurred by you or any eligible dependent of yours for any coverage for which the premium is not timely paid in full. Any services or other benefits mistakenly provided under the terminated coverage will become your legal responsibility to pay individually and together with any dependent who received those services or other benefits.

Continuation of Coverage

General

Continuation of coverage is required by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA for short. This federal law requires the Plan to provide you and your eligible dependents with the opportunity to elect a temporary extension of coverage under the Plan’s Personal Resilience Program, the medical, dental, and vision optional benefits and, in limited circumstances, under the Plan’s general-purpose or limited-purpose health flexible spending account optional benefit for certain events—called Qualifying Events—when that coverage would otherwise end. A person who becomes entitled to COBRA coverage under the Plan is classified as a Qualified Beneficiary under the continuation of coverage rules. A Qualified Beneficiary must pay the entire monthly premium for any COBRA coverage that he or she elects. Where the Plan terms are prescribed by COBRA coverage rules, these terms will be applied in a manner that is consistent with the rules and regulations providing the requirements of COBRA coverage. Unless expressly provided by them, the Plan terms shall not be construed to provide rights under COBRA coverage beyond those required by this federal law.

Other Coverage Options

There may be other coverage options for you and your family outside of COBRA. With the Affordable Care Act, you are now able to buy coverage through the Health Insurance Marketplace by accessing www.healthcare.gov or 800-318-2596. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage and a tax credit through the Marketplace. However, enrolling in COBRA qualifies as minimal essential coverage and disqualifies you from electing coverage through the Marketplace mid-year. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. To purchase marketplace insurance outside of the Federal Open Enrollment period, you must qualify for a special enrollment period due to a qualifying life event such as marriage, birth
or adoption of a child, or loss of health care coverage.

Qualifying Events

If any one of the following Qualifying Events occurs, you have the right to elect COBRA coverage with respect to your coverage under the Plan’s Personal Resilience Program, the Plan’s medical, dental, and vision optional benefits and with respect to your coverage under the Plan’s health flexible spending account if this account is underspent:

- You lose that Plan coverage because your employment terminates either voluntarily or involuntarily (for reasons other than your gross misconduct); or
- You lose that Plan coverage because your hours of employment are reduced.

If any one of the following Qualifying Events occurs, your dependent spouse has the right to elect COBRA coverage with respect to the Plan’s Personal Resilience Program and his or her coverage under the Plan’s medical, dental, and vision optional benefits and with respect to his or her coverage under the Plan’s health flexible spending account if this account is underspent:

- The dependent spouse loses that Plan coverage because your employment terminates (for reasons other than gross misconduct), or because your hours of employment are reduced;
- The dependent spouse loses that Plan coverage because you die;
- The dependent spouse loses that Plan coverage because of his or her divorce or legal separation from you; or
- The dependent spouse loses that Plan coverage under the Plan terms because you become enrolled in Medicare (Part A or Part B, whichever occurs earlier).

If any one of the following Qualifying Events occurs, your dependent child has the right to elect COBRA coverage with respect to the Plan’s Personal Resilience Program and his or her coverage under the Plan’s medical, dental, and vision optional benefits and with respect to his or her coverage under the Plan’s health flexible spending account if this account is underspent:

- The dependent child loses that Plan coverage because your employment terminates (for reasons other than gross misconduct), or because your hours of employment are reduced;
- The dependent child loses that Plan coverage because you die;
- The dependent child loses that Plan coverage because of your divorce or legal separation;
- The dependent child loses that Plan coverage under the Plan terms because you become enrolled in Medicare (Part A or Part B, whichever occurs earlier); or
- The dependent child loses that Plan coverage because he or she ceases to be an eligible dependent under the Plan terms.

Determination of an Underspent Health Flexible Spending Account

A health flexible spending account is underspent as to a particular qualifying event if the annual limit that you elected for the calendar year of the qualifying event, reduced by the reimbursable medical care expenses submitted for that year up to the time of that qualifying event, is equal to or more than the amount of premiums for COBRA coverage for the remainder of that year.

Leaves of Absence

FMLA Leave

The taking of leave under the Family and Medical Leave Act of 1993, or FMLA for short, does not constitute a COBRA Qualifying Event under the Plan. But a Qualifying Event will occur if you do not return to employment at the end of your FMLA leave or, if earlier, when you definitively inform Gates that you are not returning to employment. COBRA coverage then can be elected by you and any of
your dependents with respect to the Plan's Personal Resilience Program and for coverage under the Plan's medical, dental, and vision optional benefits and with respect to the Plan's health flexible spending account, if underspent, that you and your dependents had on the day before your FMLA leave begins (or enrolled for during the FMLA leave).

**Dependent Qualifying Events**

Your dependent spouse's coverage under the Plan's medical, dental, and vision optional benefits and his or her coverage under the Plan's health flexible spending account will end at 12:01 a.m. on the first day after his or her divorce or legal separation from you. A dependent child's coverage under the Plan's medical, dental, and vision optional benefits and his or her coverage under the Plan's health flexible spending account will end at 12:01 a.m. on first day after he or she ceases to be an eligible dependent under the Plan terms. You or your dependent spouse or dependent child, as the case may be, or any representative acting on behalf of you or your dependent, must inform the Plan Administrator in writing of a Qualifying Event that is the divorce, legal separation, or a child losing dependent status under the Plan. This notice must be provided by the date that is 60 days after the date when Plan coverage would end due to the divorce, legal separation, or loss of dependent child status, as the case may be. A mailed notice must be postmarked within the 60-day notice period described above. A hand-delivered notice must be received by the close of business on the 60th day of the notice period. A Qualified Beneficiary is responsible for correctly addressing or hand delivery to the correct address. The address for the required notice is provided in NOTICES TO THE PLAN ADMINISTRATOR below in this section.

Any notice of a Qualifying Event that is the divorce, legal separation, or a child losing dependent status under the Plan must identify the optional benefit to which the Qualifying Event applies (that is, the Plan's medical, dental, vision, and/or health spending flexible account optional benefits), your name and address; the name and address of each Qualified Beneficiary with respect to the Qualifying Event; and the date and type of Qualifying Event (that is, divorce, legal separation, or a child's loss of dependent status under the Plan). In the case of a Qualifying Event that is a divorce or legal separation, a copy of any court order or decree for the divorce or legal separation must be included with the notice of this Qualifying Event.

If you or your dependent fails to provide the above-described notice to the Plan Administrator within the 60-day notice period, any Qualified Beneficiary who loses coverage due to the divorce, legal separation, or loss of dependent status will not be offered any continuation of coverage. Also, if you or your dependent fails to provide the required notice and Plan benefits are paid for expenses after coverage is terminated due to a divorce, legal separation, or loss of dependent child status, you and any dependent who receives those benefits will be required to reimburse them to the Plan.

**Election of Continuation Coverage**

If the Plan Administrator is provided with a timely notice of a divorce, legal separation, or loss of dependent status, the COBRA Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage under the Plan.

The COBRA Administrator will automatically notify a Qualified Beneficiary of the right to elect continuation of coverage under the Plan with respect to a Qualifying Event other than a divorce, legal separation, or loss of dependent child status.

A Qualified Beneficiary must elect continuation of coverage within 60 days after the Plan coverage ends or, if later, within 60 days of when he or she is provided with the continuation of coverage election notice.

The election can be mailed, faxed, completed on line, scanned and emailed, or, in some cases, hand delivered as instructed in the continuation of coverage election form. The COBRA
Administrator's continuation of coverage notice will describe how to return the election. A mailed election must be postmarked within the 60-day election period. A hand-delivered election, if hand delivery is accepted by the COBRA Administrator, must be received by the close of business on the 60th day of the election period. A Qualified Beneficiary is responsible for correctly addressing or hand delivery to the correct address. As a Qualified Beneficiary, either you or your dependent spouse may elect continuation of coverage for any dependent who is a Qualified Beneficiary.

Each Qualified Beneficiary can independently elect continuation of coverage for himself or herself. Consequently, a Qualified Beneficiary who is a dependent spouse or a dependent child can elect continuation of coverage for himself or herself even if you as a Qualified Beneficiary do not elect continuation of coverage for that dependent spouse or dependent child.

Unless otherwise elected, all Qualified Beneficiaries who were covered an underspent health flexible spending account will be covered together under that health flexible spending account. Alternatively, each Qualified Beneficiary can elect separate health flexible spending account continuation coverage for himself or herself, with a separate health flexible spending account annual limit and continuation coverage premium. For more information about this alternative, contact the Plan Administrator. The contact information for the Plan Administrator is provided in NOTICES TO THE PLAN ADMINISTRATOR below in this section.

A Qualified Beneficiary can elect continuation of coverage under the Plan even if he or she is then covered under another employer-sponsored group health plan or enrolled in Medicare (Part A or Part B). The COBRA plan pays secondary for those eligible for Medicare, regardless of Medicare enrollment.

A Qualified Beneficiary is not required to show that he or she is insurable in order to elect continuation of coverage.

When he or she enrolls in continuation of coverage, a Qualified Beneficiary may receive from the COBRA Administrator a confirmation letter outlining the payment schedule for the elected coverage. This confirmation letter is not a bill for any continuation of coverage payment or premium and typically in this case, the Qualified Beneficiary will not be billed for any continuation of coverage payment or premium. So it will be the responsibility of the Qualified Beneficiary to make continuation of coverage payments or premiums according to the payment schedule as outlined in the confirmation letter. In other cases, the COBRA Administrator does not send a confirmation letter when a Qualified Beneficiary enrolls in continuation of coverage but does send a continuation of coverage payment or premium invoice upon that enrollment and, then, bills for each subsequent month of continuation coverage payment or premium.

A Qualified Beneficiary who does not elect continuation of coverage within the 60-day election period with respect to a particular Qualifying Event will lose his or her right to elect this coverage in the future with respect to the same Qualifying Event. If a Qualified Beneficiary does not elect continuation of coverage under the Plan, any claim that he or she incurs after the Qualifying Event will not be covered under the Plan.

Type of Coverage and Premium Payments

Ordinarily, a Qualified Beneficiary who elects continuation of coverage will be offered the same coverage that he or she had on the day before the Qualifying Event (except when there is no coverage because it was eliminated in anticipation of a Qualifying Event). For example, if you do not have coverage under the Plan's medical optional benefit on the day before termination of employment, you will not be entitled to continue this Plan coverage unless that coverage was eliminated in anticipation of your termination. If Plan coverage for similarly situated qualified employees or their eligible dependents is modified, the Plan's continuation of coverage will be modified in the same way.

If a Qualified Beneficiary is covered by more than one of the Plan's optional benefits for which COBRA
coverage is available (such as the Plan's dental optional benefit and the Plan's medical optional benefit, for example), he or she can elect continuation of coverage with respect to any one or more of these benefits under which he or she was covered on the day before the Qualifying Event. A Qualified Beneficiary can always elect continuation of coverage with respect to the Plan's Personal Resilience Program.

A Qualified Beneficiary must pay the entire monthly premium for any continuation of coverage elected. The first premium payment is due within 45 days following the date when the Qualified Beneficiary elected continuation of coverage. When he or she enrolls in continuation of coverage, a Qualified Beneficiary may receive a confirmation letter outlining the payment schedule for the elected coverage from the COBRA Administrator. This confirmation letter is not a bill for any continuation of coverage payment or premium and typically in this case, the Qualified Beneficiary will not be billed for any continuation of coverage payment or premium. So it will be the responsibility of the Qualified Beneficiary to make continuation of coverage payments or premiums according to the payment schedule outlined in the confirmation letter. In other cases, the COBRA Administrator does not send a confirmation letter when a Qualified Beneficiary enrolls in continuation of coverage but does send a continuation of coverage payment or premium invoice upon that enrollment and, then, bills for each subsequent month of continuation coverage payment or premium. The COBRA Administrator's confirmation letter or premium payment bill or invoice will describe the Qualified Beneficiary's options for making his or her premium payment. For example, a particular COBRA Administrator may permit a premium payment to be mailed or hand delivered. Or another COBRA Administrator may not accept hand delivery of a premium payment but will accept payment through its website, over the phone, or by automatic draft. A Qualified Beneficiary is responsible for correctly addressing or, if the COBRA Administrator accepts it, hand delivery to the correct address. If mailed, an initial premium payment must be postmarked by the 45th day of the 45-day payment period. If the COBRA Administrator accepts hand delivery, the premium payment must be received by the close of business of the 45th day of the 45-day premium payment period.

The initial payment must be equal to all premiums for all prior months of continuation of coverage, including the month during which the initial payment is made. Generally, no allowable Plan claims under continuation of coverage are paid until the entire initial premium payment is made. If the initial premium is not paid in full within the 45-day payment period, the Plan coverage will be permanently terminated and no continuation of coverage will be provided.

Any subsequent premium payment is due on the first day of the month for which the premium is paid, subject to a 30-day grace period. Generally, no allowable Plan claims under continuation of coverage are paid for any month until the entire premium is paid for that month. If a premium for a particular month is not paid in full within the 30-day grace period, the Plan coverage will be permanently canceled retroactively to the first day of that month.

If a Qualified Beneficiary pays a continuation of coverage premium with a personal check made on an account with insufficient funds (in other words, the check "bounces"), the Qualified Beneficiary has not paid the premium in full and his or her continuation of coverage will be permanently canceled unless the entire premium is paid within the payment period for that premium. The monthly premium amount will equal the full amount of the monthly premium for similarly situated qualified employees and their eligible dependents plus a two percent continuation of coverage administration charge. If the continuation of coverage period is extended solely due to the disability of a Qualified Beneficiary, as described below, the continuation of coverage monthly premium will be 150% of the monthly premium for similarly situated qualified employees and their eligible dependents during the extended coverage period while the disabled Qualified Beneficiary has continuation of coverage. In all events, the continuation of coverage premium will change if the premium for similarly situated qualified employees and their eligible dependents changes. All premiums for continuation of coverage are made on an after-tax basis.
Maximum COBRA Coverage Periods

COBRA coverage may only be elected for a Qualified Beneficiary’s underspent health flexible spending account for the remainder of the Plan Year in which the Qualifying Event occurs including the grace period that applies for that Plan Year. The maximum period for COBRA coverage elected for the Plan's medical, dental, or vision optional benefits or the Plan's Personal Resilience Program are described below in this section.

36 Months. If the Qualified Beneficiary is your dependent spouse or dependent child who loses Plan coverage due to your death, divorce, legal separation, or becoming enrolled in Medicare, the maximum continuation of coverage period is 36 months from the date of that Qualifying Event. Similarly, if the Qualified Beneficiary loses Plan coverage because he or she loses dependent status under the Plan, the maximum continuation of coverage period is 36 months from the date of that Qualifying Event.

18 Months. If the Qualifying Event is due to your termination of employment (for reasons other than gross misconduct) or reduction in hours, the maximum continuation of coverage period for any Qualified Beneficiary with respect to that termination is 18 months from the termination or reduction in hours. This maximum coverage period will be extended if any one of the three following circumstances exists.

Medicare Entitlement. If the Qualifying Event occurs within 18 months after you became enrolled in Medicare (Part A or Part B), the maximum continuation of coverage period for a Qualified Beneficiary who is your dependent spouse or dependent child is 36 months from the date that you became enrolled in Medicare (Part A or Part B, whichever occurs earlier).

Disability. If you or another Qualified Beneficiary is disabled at any time during the first 60 days after your termination or reduction in hours, the continuation of coverage period for you and any other Qualified Beneficiary with respect to that termination or reduction in hours Qualifying Event is extended to 29 months from the termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when this disability began.

- In order for the 29-month continuation of coverage period to apply, you or the other Qualified Beneficiary, or any representative acting on behalf of either of you, must provide the COBRA Administrator with notice of the determination of the disability under the Social Security Act both within the 18-month period immediately following the termination or reduction in hours and within 60 days after the determination is made by the Social Security Administration.
- Any such notice must identify the benefit to which the Qualifying Event applies (that is, the Plan's medical, dental, and/or vision optional benefits or the Plan's Personal Resilience Program), your name and address and contain: the name and address of each Qualified Beneficiary with respect to the Qualifying Event; the name of the disabled Qualified Beneficiary; the date when the Qualified Beneficiary became disabled and the date of the Social Security Administration disability determination; and a copy of the Social Security Administration disability determination. The COBRA Administrator's address for the required notice is provided below in this section.
- If the required notice of the Social Security Administration disability determination is not timely and properly provided to the COBRA Administrator, the 18-month continuation of coverage period will not be extended for any Qualified Beneficiary.
- You or another Qualified Beneficiary, or any representative acting on behalf of either of you, must provide the COBRA Administrator with notice of any final determination by the Social Security Administration that you or the other Qualified Beneficiary is no longer disabled within 30 days after that final determination. Any such notice must identify the benefit to which extended continuation of coverage period applies (that is, the Plan's...
medical, dental, and/or vision optional benefits or the Plan's Personal Resilience Program) and contain: your name and address; the name and address of each Qualified Beneficiary with respect to the Qualifying Event; the name of the disabled Qualified Beneficiary; the date of the Social Security Administration final determination that the Qualified Beneficiary is no longer disabled; and a copy of the Social Security Administration final determination that the Qualified Beneficiary is no longer disabled. The COBRA Administrator's address for the required notice is provided below in this section.

Second Qualifying Event: If during the 18-month or 29-month continuation of coverage period, a second Qualifying Event occurs that would have entitled your dependent spouse or child who is a Qualified Beneficiary to a 36-month maximum coverage period (for example, the your death or legal separation or divorce from that dependent spouse or loss of coverage under the Plan terms due to your enrollment in Medicare Part A or Part B, or loss of dependent child status under the Plan), the maximum continuation of coverage period for that Qualified Beneficiary who is a dependent spouse or child is 36 months from the original Qualifying Event.

In order for the 36-month continuation of coverage period to apply, you or another Qualified Beneficiary, or any representative acting on behalf of either of you, must provide the COBRA Administrator with notice of any second Qualifying Event no later than 60 days after the date of that second Qualifying Event.

- Any such notice must identify the benefit to which the Qualifying Event applies (that is, the Plan's medical, dental, and/or vision optional benefits or the Plan's Personal Resilience Program) and contain: your name and address; the name and address of each Qualified Beneficiary with respect to the second Qualifying Event; and the date and type of second Qualifying Event (that is, for example, divorce, legal separation, or a child's loss of dependent status under the Plan). In the case of a second Qualifying Event that is a divorce or legal separation a copy of any court order or decree for the divorce or legal separation must be included with the notice of this second Qualifying Event. The COBRA Administrator's address for the required notice is provided below in this section.

- If the required notice of the second Qualifying Event is not timely and properly provided to the COBRA Administrator, the 18-month or 29-month continuation of coverage period will not be extended.

Children Born, Adopted, or Placed for Adoption with You After the Qualifying Event

A child born to, adopted by or placed for adoption with you during your elected continuation of coverage period is also a Qualified Beneficiary with respect to the continuation of coverage that you have elected for yourself. You or another guardian can obtain that continuation of coverage for the new child provided the child is otherwise an eligible dependent under the Plan terms.

You or another eligible dependent must notify the COBRA Administrator of the birth, adoption, or placement for adoption to enroll the child in the continuation of coverage that you have elected. Any such notice must identify the benefit to which the child's enrollment applies (that is, the Plan's medical, dental, vision, and/or health spending flexible account optional benefits or the Plan's Personal Resilience Program for which you have elected continuation of coverage) and contain: your name and address; the name and address of the child to be enrolled as a Qualified Beneficiary; and the date and a description of the event that permits the child's enrollment for continuation of coverage (that is, that child's birth, adoption, or placement for adoption with you). The COBRA Administrator's address for the required notice is provided below in this section.

A mailed notification of any new child must be postmarked within the Qualified Beneficiary's
continuation of coverage period and no later than 30 days after the child is adopted or placed for adoption. A hand-delivered notification must be received by the close of business on the last day of the Qualified Beneficiary's continuation of coverage period and no later than 30 days after the child is adopted or placed for adoption.

The COBRA Administrator will provide the Qualified Beneficiary with the appropriate enrollment form for his or her new child. The enrollment must be completed within the Qualified Beneficiary's continuation of coverage period and the 30 days immediately following the adoption or placement for adoption.

Continuation of coverage will begin when the child is enrolled and any additional premium due is timely paid and will last as long as it lasts for your other dependents, if longer than your continuation of coverage period. The initial premium payment must be equal to all premiums for all prior months of continuation of coverage, including the month during which the initial premium payment is made. Generally, no allowable Plan claims are paid until that entire premium payment is made.

If your or your dependent, or a representative acting on behalf of either of you, does not notify the COBRA Administrator in a timely fashion, the child cannot be enrolled.

Changes in Enrollment

During the Annual Open Enrollment Period. With one exception, any Qualified Beneficiary who has elected continuation of coverage under the Plan will be given the same opportunity as similarly situated qualified employees to change that coverage or add or drop eligible dependents during the Plan's annual open enrollment. The exception to this rule is that a Qualified Beneficiary may not enroll in the Plan's health flexible spending account optional benefit during the Plan's annual open enrollment period.

Outside the Annual Open Enrollment Period for a Change In Family Status Or Coverage. Any Qualified Beneficiary who has elected continuation of coverage under the Plan will be given the same opportunity as similarly situated qualified employees to change that coverage or add or drop eligible dependents in the event of and consistent with a Change in Family Status or Coverage. A dependent who is added under these open enrollment rules is not a Qualified Beneficiary and, consequently, his or her coverage will end at the same time when continuation of coverage ends for the Qualified Beneficiary who elected continuation of coverage and, later, added that eligible dependent.

The Qualified Beneficiary must notify the COBRA Administrator of the Change in Family Status or Coverage within the Qualified Beneficiary's continuation of coverage period. Any such notice must be provided to the COBRA Administrator must identify the benefit to which the Change in Family Status or Coverage applies (that is, the Plan's medical, dental, vision, and/or health spending flexible account optional benefits or the Plan's Personal Resilience Program for which the Qualified Beneficiary has elected continuation of coverage) and contain: the Qualified Beneficiary's name and address; the name and address of any dependent to be enrolled; and the date and a description of the event that permits the dependent's enrollment (the dependent's placement for adoption with the Qualified Beneficiary, for example) or other change due to the Change in Family Status or Coverage. The COBRA Administrator's address for the required notice is provided below in this section.

A mailed notification must be postmarked no later than 30 days after the Change in Family Status or Coverage. A hand-delivered notification must be received by the close of business on the 30th day after the Change in Family Status or Coverage. The COBRA Administrator will provide the Qualified Beneficiary with the appropriate enrollment or other form for his or her Change in Family Status or Coverage. The enrollment or other change must be completed within the 30 days immediately following the Change in Family Status or Coverage.

Any continuation of coverage for the Qualified Beneficiary's dependent will begin when the
Qualified Beneficiary's dependent is enrolled and any additional premium due is timely paid and will last as long as it lasts for that Qualified Beneficiary. The initial premium payment must be equal to all premiums for all prior months of continuation of coverage, including the month during which the initial premium payment is made. Generally, no allowable Plan claims are paid until that entire premium payment is made.

**HIPAA Special Enrollment Outside the Annual Open Enrollment Period.** Any Qualified Beneficiary who has elected continuation of coverage under the Plan will be given the same special enrollment opportunity under HIPAA and the Plan as similarly situated qualified employees to enroll his or her eligible new dependent, an eligible dependent who becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP, and an eligible dependent who loses other coverage.

A dependent who obtains coverage under these special enrollment rules is not a Qualified Beneficiary and, consequently, his or her coverage will end at the same time as the continuation of coverage ends for the Qualified Beneficiary who elected continuation of coverage and, later, added that eligible dependent.

The Qualified Beneficiary must notify the COBRA Administrator of the new eligible dependent, eligibility for premium assistance subsidy or loss of other coverage by an eligible dependent within the Qualified Beneficiary's continuation of coverage period. Any such notice must be provided to the COBRA Administrator must identify the benefit for which special enrollment continuation of coverage will be elected (that is, the Plan's medical, dental, vision, and/or health spending flexible account optional benefits or the Plan's Personal Resilience Program) and contain: the Qualified Beneficiary's name and address; the name and address of any dependent to be enrolled; and the date and a description of the event that permits the dependent's enrollment (the dependent's placement for adoption with the Qualified Beneficiary, for example). The COBRA Administrator's address for the required notice is provided below in this section.

A mailed notification must be postmarked no later than 30 days after the new dependent (other than a newborn child) is acquired or the loss of coverage (other than loss of coverage under a state Medicaid plan or CHIP). A hand-delivered notification must be received by the close of business on the 30th day after the new dependent is acquired or the loss of coverage. The COBRA Administrator will provide the Qualified Beneficiary with the appropriate enrollment form. The enrollment must be completed within the 30 days immediately following the acquisition of the new dependent or loss of coverage and within the Qualified Beneficiary's continuation coverage period.

In the case of an eligible dependent who becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP or who loses eligibility for coverage under a state Medicaid plan or CHIP, the Qualified Beneficiary's notification to the COBRA Administrator must be postmarked no later than 60 days after that determination of eligibility or loss of eligibility for coverage. A hand-delivered notification must be received by the close of business on the 60th day after the determination of eligibility or loss of eligibility for coverage. The COBRA Administrator will provide the Qualified Beneficiary with the appropriate enrollment form. The enrollment must be completed within the 60 days immediately following the determination of eligibility or loss of eligibility for coverage and within the Qualified Beneficiary's continuation coverage period.

Any continuation of coverage for the Qualified Beneficiary's new dependent will begin when the Qualified Beneficiary's dependent is enrolled and any additional premium due is timely paid and will last as long as it lasts for that Qualified Beneficiary. The initial premium payment must be equal to all premiums for all prior months of continuation of coverage, including the month during which the initial premium payment is made. Generally, no allowable Plan claims are paid until that entire premium payment is made.

**Qualified Medical Child Support Orders**
If your child has Plan coverage pursuant to a Qualified Medical Child Support Order received by the Plan while you are employed, he or she is entitled to the same continuation of coverage rights as your eligible dependent child, subject to any limitations provided in the Order and the Plan terms.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

Continuation of coverage for a Qualified Beneficiary will automatically terminate before the end of the maximum coverage period if any one of the following circumstances exists.

- Gates and any related employer cease to provide any group health plan.
- After electing continuation of coverage (other than in the case of a Non-FMLA Leave for uniformed service), a Qualified Beneficiary becomes enrolled in Medicare (Part A or Part B, whichever occurs earlier) or covered under another group health plan (as an employee or otherwise).
  - The Qualified Beneficiary or you (if the Qualified Beneficiary is your dependent) or a representative acting on behalf of either of you, must provide the COBRA Administrator with notice that the Qualified Beneficiary is enrolled in Medicare or covered under another health plan without exclusion or limitation. The COBRA Administrator's address for the required notice is provided below in this section.
  - Any such notice must be provided to the COBRA Administrator and contain the name of the Qualified Beneficiary who is enrolled in Medicare or who has other health plan coverage and the date of this Medicare or other coverage.
- Any premium for the Qualified Beneficiary’s continuation of coverage is not timely paid in full.
- In the case of a 29-month continuation of coverage period due to the disability of a Qualified Beneficiary, the Social Security Administration determines finally under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled. In this event continuation of coverage will end for all Qualified Beneficiaries with respect to the termination or reduction in hours Qualifying Event but not until the first of the month that begins more than 30 days after the determination.
  - The occurrence of any event that permits termination of coverage for cause under the Plan with respect to similarly situated qualified employees and their eligible dependents.
  - A Qualified Beneficiary notifies the COBRA Administrator that he or she wishes to terminate continuation of coverage for himself or herself.
  - In the case of your Non-FMLA Leave for uniformed service and the expiration of 18-month maximum coverage period, if you have elected continuation of coverage and fail to return or to reapply for work within the time period required by USERRA (as described below) following completion of that uniformed service or you lose USERRA rights due to your misconduct.

Other Important Information

The Plan Administrator has the right to verify whether a Qualified Beneficiary is eligible for continuation of coverage at any time. If a Qualified Beneficiary is determined to be ineligible for continuation of coverage for any reason, if an event occurs that permits termination of coverage for cause with respect to similarly situated qualified employees and their eligible dependents under the Plan, or if there is another circumstance that causes the termination of continuation of coverage before the end of the maximum coverage period, the Qualified Beneficiary’s continuation of coverage will be terminated. The Plan Administrator will notify in writing each Qualified Beneficiary of any termination of COBRA continuation of coverage. The Plan will reject any claim for that coverage as described in that notice. Typically, the Plan will only reject claims incurred after the termination.
But if it is determined within two years (or at any time in the case of an act, practice, or omission that constitutes fraud) that a Qualified Beneficiary omitted or intentionally misrepresented a material fact on the documents applying for COBRA continuation of coverage, that coverage for the Qualified Beneficiary and any dependent of that Qualified Beneficiary will be null and void from inception. Any services or other benefits provided under the terminated coverage will become the Qualified Beneficiary's legal responsibility to pay.

If any premium for a Qualified Beneficiary's COBRA continuation coverage is not paid in full by the due date, including any grace period, for that payment, that continuation of coverage will be terminated. The COBRA Administrator will notify in writing each Qualified Beneficiary of any such termination of coverage. The Plan will reject any claim incurred by a Qualified Beneficiary for any COBRA continuation coverage for which the premium is not timely paid in full. If, for any reason, a Qualified Beneficiary receives Plan benefits for claims incurred after his or her coverage is terminated, the Qualified Beneficiary will be required to reimburse the Plan for these benefits.

To ensure that you as a Qualified Beneficiary and your dependents receive information about their continuation of coverage rights, you must immediately notify the COBRA Administrator of any address change. The COBRA Administrator's address is provided below in this section. Failure to provide this information may result in delayed notifications or a loss of continuation of coverage.

Benefits and Services Under COBRA Coverage

Ordinarily, the benefits and services under a Qualified Beneficiary's continuation of coverage will be the same as those that he or she had on the day before the Qualifying Event (except when there is no coverage because it was eliminated in anticipation of a Qualifying Event). If the Plan is changed for qualified employees and/or their eligible dependents, the changes will apply to any Qualified Beneficiary and his or her eligible dependents. There will be no interruption or lapse in coverage for anyone who properly elects COBRA continuation coverage if all premiums are paid in full by the due date, including any grace period, for their payment.

Special COBRA Coverage Rights

**Uniformed Services Employment and Reemployment Rights Act of 1994.** The Uniformed Services Employment and Reemployment Rights Act of 1994 or, for short, USERRA, requires continued coverage rights for the Plan's medical, dental, vision, and health flexible spending account optional benefits and for the Plan's Personal Resilience Program for you and your eligible dependents in the event that you are absent from work by reason of service in the United States uniformed services. An absence from work for uniformed service is treated as a Non-FMLA Leave. The maximum continuation of coverage period is 24 months from the first date of your leave of absence for uniformed service. In most cases, this continued coverage is provided as COBRA coverage and the election of COBRA coverage in these cases will be an election of both, or concurrent, COBRA and USERRA continuation coverage. The Plan Administrator will automatically notify you of your USERRA continued coverage rights and reemployment rights when it learns that you will experience a Non-FMLA Leave for uniformed service.

The continuation of coverage rights under COBRA and USERRA are similar but not identical. If COBRA and USERRA give you (or your eligible dependents) different rights or protections, the law that provides the greater benefit will apply. You can obtain more information about USERRA's continuation of coverage from the Plan Administrator at the address provided in NOTICES TO THE PLAN ADMINISTRATOR below in this section.

Notices to the Plan Administrator
All required notices to the Plan Administrator should be addressed to the Global Benefits Department.

**COBRA Administrator**

The Plan Administrator contracts with third-party administrators to assist with the Plan Administrator's responsibilities for the administration of the Plan's COBRA coverage. The COBRA Administrator for continuation of coverage for you and your eligible dependents is:

<table>
<thead>
<tr>
<th>COBRA Administrator</th>
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<tbody>
<tr>
<td>United Healthcare Benefit Services</td>
</tr>
<tr>
<td>PO Box 221709</td>
</tr>
<tr>
<td>Louisville, KY 40252</td>
</tr>
<tr>
<td>866-747-0048</td>
</tr>
<tr>
<td><a href="mailto:cobra_kyoperations@uhc.com">cobra_kyoperations@uhc.com</a></td>
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<tr>
<td><a href="http://www.uhcservices.com">www.uhcservices.com</a></td>
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**Additional COBRA Coverage Information**

For additional information on electing COBRA continuation of coverage, contact the Plan Administrator. The contact information for the Plan Administrator is provided in NOTICES TO THE PLAN ADMINISTRATOR earlier in this section.

**Wellness Program**

The Plan includes a voluntary wellness program available to all regular U.S. employees, through election in the medical plan. Spouses participating in the medical plan can also participate.

The wellness program provides health education, goals, and tools to drive positive behavior change.

**Medical Optional Benefit**

**General**

The Plan's medical optional benefit offers 3 medical plan options: CDHP1, CDHP2 and PPO for qualified employees and their eligible dependents. Coverage options are described in detail in the Medical Optional Benefit Booklet that is a part of this Plan guide.

**Prescription Drug Benefits**

**General**

The Plan's medical coverage options include prescription drug benefits administered by CVS/Caremark as the Claims Administrator on behalf of the Plan Sponsor. CVS/Caremark has a national network of 65,000 retail pharmacies. Visit www.caremark.com to find an in-network pharmacy and a list of drugs covered on its formulary. The Plan includes an expanded preventive drug list, which reduces your cost.
for select prescriptions that help prevent chronic health conditions when taken regularly. If you take medications on the preventive drug list, you will pay only the coinsurance for these medications, even if you have not met your annual deductible. To review the Preventive Drug List, please visit www.gateshealth.com.

**Covered Drugs.** The prescription drug benefit is available for prescription drugs ordered in writing by a physician for a member's treatment incurred because of an accidental injury or illness, or as a result of pregnancy, childbirth, or a related medical condition of which the following are examples.

- Federal legend drugs.
- Over-the-counter and legend needles and syringes.
- Over-the-counter and legend diabetic supplies/insulin needles, and syringes (except Glucowatch products).
- Prescribed smoking cessation products (including smokeless tobacco use) and over-the-counter smoking cessation patches with a $0 copayment for a maximum of 90 days within a rolling 365 days.

Before purchasing it, a member should verify whether any drug is covered by the Plan's prescription drug benefit by calling CVS/Caremark at (855) 220-5731 or by visiting www.caremark.com.

**Formulary List.** The Formulary List is a list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. The list is regularly updated. A member is responsible for determining whether a brand-name drug prescribed for him or her is on the Formulary List. To do so, a member can contact CVS/Caremark at (855) 220-5731. More information is available at www.caremark.com.

**Maintenance Drugs.** Maintenance drugs must be purchased through the CVS/Caremark Mail Service Pharmacy. A maintenance drug is a drug that is taken on an ongoing basis (blood pressure medication, high cholesterol medication, for example). A member will be allowed an original retail pharmacy fill on a maintenance drug prescription and two refills before he or she will be required to use the CVS/Caremark Mail Service Pharmacy. To use the mail-order program, you must complete a Mail Service Order Form. Forms are available at www.caremark.com.

**Mandatory Generics.** A generic drug is a medication that contains the same active ingredient(s) and is manufactured according to the same strict federal regulations as its brand-name counterpart. Generic medications may differ in color, size, or shape but the Food and Drug Administration requires that these medications have the same strength, purity, and quality as their brand-name counterparts. Brand-name medications are more expensive because their prices include the cost of research and development as well as marketing and advertising. A generic medication is produced without those costs; so, it has a lower price than its brand-name counterpart. If a member selects a brand-name drug when a generic equivalent is available, the member will pay the brand-name copayment for that drug plus the excess price for the brand name drug over the price for the generic drug and even if his or her physician indicates "dispense as written" or "do not substitute" on the member's prescription.

**Retail Pharmacy**

**Network Retail Pharmacy.** CVS/Caremark has a national network of 65,000 retail pharmacies. To find a local in-network retail pharmacy, a member can visit www.caremark.com. Upon his or her enrollment in the Plan's medical optional benefit, CVS/Caremark will provide the member with a benefit ID card. (To request a temporary ID card or a replacement ID card, a member should contact CVS/Caremark at (855) 220-5731 or visit www.caremark.com) To purchase a prescription drug that is covered by the prescription drug benefit at a network retail pharmacy, the member should present his or her benefit ID card and pay the applicable coinsurance.

**Out-of-Network Retail Pharmacy.** To purchase a prescription drug covered by the prescription drug benefit at an out-of-network retail pharmacy, a member must pay the full cost of that drug when purchased, not just his or her applicable coinsurance amount. The member must then complete and
send a direct reimbursement claim form to CVS/Caremark according to the instructions on that form. A member can obtain a direct reimbursement form from CVS/Caremark at (855) 220-5731 or visit www.caremark.com. A member will be reimbursed the CVS/Caremark-discounted price less the member's coinsurance, and that reimbursement will be based on the generic or lower cost brand-name product, if either is available.

**CVS/Caremark by Mail Service Pharmacy.** The CVS/Caremark Mail Service Pharmacy delivers a member's maintenance drugs directly to his or her home or other requested location, postage paid. To ensure timely delivery, a member should place his or her order at least two weeks in advance to allow for mail delays and other unexpected circumstances.

**Ordering a Drug for the First Time.** To order a drug through the CVS/Caremark Mail Service Pharmacy for the first time, a member must mail his or her original prescription, order form, and payment for the drug. A member can obtain the order form and envelope from CVS/Caremark at (855) 220-5731. A member should allow two weeks after the order is received by the CVS/Caremark Mail Service Pharmacy to process his or her prescription. If a new medication is prescribed for a member to take immediately, he or she should ask the physician to issue two prescriptions; one should be written and filled at the member's local network retail pharmacy and the second should be written for up to a 90-day supply and mailed to the CVS/Caremark Mail Service Pharmacy.

**Ordering Refills.** To order a refill, the member should call CVS/Caremark at (855) 220-5731 or visit www.caremark.com.

**Prior Authorization.** Certain drugs may require “prior authorization” to obtain the information necessary to determine whether or not the drug is covered. If your pharmacist tells you that your prescription needs a “prior authorization” it means that your doctor has to give CVS/Caremark the information it needs to make sure you get the right drug at the right cost. For more information or to see if your drug required prior authorization call (855) 220-5731.

**Exclusions and Limitations.** The following is a list of some of the benefits and services that are not covered by the Plan's prescription drug benefit unless required by applicable law.

- Most drugs that can be purchased without a prescription order (commonly called over-the-counter or OTC drugs);
- Investigational or experimental drugs;
- Prescriptions that a member is entitled to receive without charge under any workers' compensation law or any municipal state or federal program;
- Hair growth stimulants;
- Drugs prescribed to remove or reduce wrinkles in the skin;
- Appetite suppressants or any drug used for weight loss, unless pre-authorized;
- Fertility medications;
- Nutritional supplements;
- Ostomy supplies;
- Topical fluoride products;
- Non-systemic contraceptives;
- Growth hormones, unless pre-authorized;
- Implantable, time-released medications;
- Injectables (contact CVS/Caremark for a list of exceptions);
- Charges for the administration or injection of any drug;
- Vaccines/Immunization agents (outside the ACA requirement);
- Plasma/Blood Products (except hemophilia factors);
- Allergy serums;
- Any prescription filled in excess of the number specified by the doctor or any refill dispensed after one year from the doctor's original order;
- Drugs with cosmetic implications;
Medication that is to be taken or administered to the member, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises a facility for dispensing pharmaceuticals; and

Therapeutic devices or appliances, support garments, and other non-medical devices.

There may be other limitations and exclusions that are not listed. Before purchasing it, a member should verify whether any drug is not covered by the Plan’s prescription drug benefit by calling CVS/Caremark at (855) 220-5731 or visiting www.caremark.com.

Denials of Eligibility and Benefits and Appeal Procedures

Denial of Eligibility

CVS/Caremark verifies eligibility using information provided by the Global Benefits Department. If an employee or his or her dependent is not satisfied with the final determination of eligibility, he or she has the right to a formal review and appeal as described in ADMINISTRATIVE CLAIMS in the PLAN ADMINISTRATION section of this Plan guide.

Denial of Benefits

CVS/Caremark as the Claims Administrator has the complete discretion to determine the Plan’s prescription drug benefits on behalf of the Plan Sponsor. A member who is dissatisfied with a benefit determination made by CVS/Caremark can appeal that determination in writing.

Non-Urgent Claims (Pre-Service and Post-Service Other than Direct Claims)

A pre-service claim is a request for coverage of a medication when your plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don’t provide the needed information within the 45-day period, your claim is considered “deemed” denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, 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 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. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language.
If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

**Urgent Claims (Expedited Reviews)**

An urgent care claim is defined as a request for treatment when, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don’t provide the needed information within the 48-hour period, your claim is considered “deemed” denied and you have the right to appeal as described below.

If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, 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 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. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

**Non-Urgent Appeal Other than Independent External Reviews**

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered “deemed” denied because missing information was not timely submitted), 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 and
- Any additional information that may be relevant to your appeal

This information should be mailed Caremark, Inc., Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If your appeal is denied, the denial notice will include information to identify the claim involved, 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 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. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If you are not satisfied with the coverage decision made on your 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
- Any additional information that may be relevant to your appeal

This information should be mailed to Caremark, Inc., Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084.

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable 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 a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). 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 (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you have the right to bring a civil action under
ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you have the right to an independent review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

Urgent Appeal (Expedited Review)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call CVS/Caremark at (855) 220-5731 or fax the request to 1-866-443-1172, Attn: Appeals Department. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. 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.

If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable 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 a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). 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 of any final adverse determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of Appeal prior to an external review.

If your appeal is denied and you are not satisfied with the decision of the appeal (i.e., your “final adverse benefit determination”) or any appeal denial notice (i.e., “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you have the right to bring a civil action under ERISA section 502(a).
In addition, for cases involving medical judgment or rescission, if your appeal is denied and you are not satisfied with the decision (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., your “adverse benefit determination” or “final adverse benefit determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you have the right to an independent review by an external review organization.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or you do not agree with the determination of the external review organization, you have the right to bring a civil action under ERISA section 502(a).

Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

External Review Procedures

The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the plan (e.g., plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed or faxed to: Caremark, Inc., Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084 or FAX: 1-866-443-1172, Attn: Appeals Department.

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan and
Caremark written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a). If the IRO has determined that your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA section 502(a).

**Urgent External Review**

Once you have submitted your urgent external review request, your claim will immediately be reviewed to determine if you are eligible for an urgent external review. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will immediately be reviewed to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the plan and Caremark written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

**Member Submitted Paper Claims**

Your plan provides for reimbursement of prescriptions when you pay 100 percent of the prescription price at the time of purchase. The claim will be processed based on your plan benefit. To request reimbursement, complete the claim form found on www.caremark.com, and send your claim to the address on the claim form. You will be notified of the decision within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

If your claim does not provide sufficient information for the claim to be processed, you will be notified that more information is needed within 30 days of receipt of the claim. If your claim provides sufficient information to determine the last day that your plan allows you to submit the claim for reimbursement (i.e., plan’s stale date), then you will be notified that more information is needed and you will have until that date to submit the missing information. If you do not submit the information by the required date, your claim is deemed denied and the appeal rights discussed below apply. If you do submit the information by the required date, you will be notified of the decision within 15 days after the information is received. If your claim is missing information, and without the information the claim’s stale date cannot be determined, your claim will be denied and you have the right to appeal the decision as described below.

If your claim is denied, the denial notice will include information to identify the claim involved, 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 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. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If you are not satisfied with the decision on your claim or your claim is deemed denied, you have the
right to appeal this decision. See below for appeal instructions.

Appeal

To appeal a denied claim or a claim that is deemed denied, you must submit your request within 180 days of receipt of notice of the decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal, provide in writing:

- Your name
- Member ID
- Phone number
- The prescription drug for which benefit coverage has been denied and
- Any additional information that may be relevant to your appeal including missing information

This information should be mailed to:

CVS/Caremark
Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved, 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 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. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If you are not satisfied with the decision made on the 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
- Any additional information that may be relevant to your appeal

This information should be mailed to:

CVS/Caremark
Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136
A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable 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 a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights please call CVS/Caremark at (855) 220-5731. In addition, you may also have the right to request a written translation of your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). 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 (i.e., your “final adverse benefit determination”) or your initial benefit denial notice or any appeal denial notice (i.e., any “adverse benefit determination notice” or “final adverse benefit determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), you may have the right to an independent review by an external review organization if the case involves medical judgment or rescission. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below.

External Review Procedures – IRO

The right to an independent external review is only available for claims involving medical judgment or rescission. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed or faxed to: Caremark, Inc., Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084 or FAX: 1-866-443-1172, Attn: Appeals Department.

Once you have submitted your external review request, your claim will be reviewed within five business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and you will be notified within one business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right
to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you, the plan and Caremark written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a). If the IRO has determined that your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA section 502(a).

**Creditable Coverage Notice**

The Plan Sponsor has determined that the Plan's medical optional benefit prescription drug coverage is, on average for all members enrolled for this coverage, expected to pay out as much as standard Medicare prescription drug coverage pays out and is therefore considered creditable coverage. Because the prescription drug coverage under the Plan is creditable coverage, a member who has it can keep the Plan's prescription drug coverage and not pay a higher premium (a penalty) if the member later decides to join a Medicare prescription drug plan.

**Dental Optional Benefit**

**General**

The Plan's dental optional benefit coverage for you and your eligible dependents is described in this section. This dental optional benefit is available under Dental Plan 1 and Dental Plan 2 and administered by Metlife as the Claims Administrator.

**Benefits Summary**

With the Dental Plan 1 and 2, you have the flexibility to choose any dentist in order to receive benefits. However, if you choose a dentist who is part of the Preferred Dentist Provider (PDP) Network, you will pay less because PDP dentists have agreed to charge lower, negotiated rates.

This schedule summarizes the main elements of the two dental plans’ optional benefits.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A – Preventive</td>
<td>Plan pays 100% of PDP Fee*</td>
<td>Plan pays 100% of R&amp;C Fee**</td>
</tr>
<tr>
<td>Type B – Basic</td>
<td>Plan pays 80% of PDP Fee*</td>
<td>Plan pays 80% of PDP Fee*</td>
</tr>
<tr>
<td>Type C – Major</td>
<td>Plan pays 50% of PDP Fee*</td>
<td>Plan pays 50% of R&amp;C Fee**</td>
</tr>
<tr>
<td>Type D – Orthodontia</td>
<td>Plan pays 50% of PDP Fee*</td>
<td>Plan pays 50% of R&amp;C Fee**</td>
</tr>
<tr>
<td>Deductible for Type B &amp; C services per calendar year</td>
<td>$50 per member</td>
<td>$50 per member</td>
</tr>
<tr>
<td></td>
<td>$100 per family (aggregate family maximum)</td>
<td>$100 per family (aggregate family maximum)</td>
</tr>
<tr>
<td>Separate lifetime deductible for Type D</td>
<td>$50 per member</td>
<td>$50 per member</td>
</tr>
<tr>
<td>Annual maximum benefit under Dental Plan 1 for Type A, B, C services</td>
<td>$1,500 per member</td>
<td>$1,500 per member</td>
</tr>
</tbody>
</table>
Annual maximum benefit under Dental Plan 2 (buy-up option) for Type A, B, C services | $2,500 per member | $2,500 per member

Lifetime maximum benefit for Type D | $2,000 per member | $2,000 per member

*PDP Fee refers to the negotiated fees that a Participating Provider has agreed to accept as payment in full.

**R&C refers to the reasonable and customary charge, which is based on whichever is lowest of a dentist’s actual charge, the dentist’s usual charge for the same or similar services, or the charge of most dentists in the same geographic area for the same or similar services as determined by the carrier.

A member must verify at the time of service that a Participating Provider listed in the Network directory is still in the Network at the time services are rendered. The most current listing of Participating Providers, including a general description of the Network is available without charge from the Claims Administrator at 1-800-438-6388 by following the prompts. Or the member can look up the Participating Providers in his or her area by going to www.metlife.com/dental.

Deductible

Depending on the service received, the member may be required to pay a portion of the expenses. For instance, Type A (preventive care) services which are provided within reasonable charges do not require payment from the member. However, Type B (restorative care) and Type C (major care) services carry a deductible before the Plan’s dental optional benefit pays benefits (as described above in the schedule). The deductible for Type B and C services must be satisfied only once per calendar year regardless of whether the member receives services under Type B, Type C or both. The per member deductible is separate for you and your eligible dependents who are enrolled for the dental optional benefit, up to the aggregate family maximum. If two or more members in a family have deductible expenses totaling the family limit, the aggregate family maximum deductible for the year will have been met.

The deductible for Type D (orthodontia) services is payable in addition to the deductible payable for Type B and C services. However, the deductible for Type D services is payable only once per member and is not payable again once met.

The deductibles and out-of-pocket maximums do not cross-accumulate between In-Network and Out-of-Network benefits and services.

Maximum Benefit Limits

The Plan’s dental optional benefit pays a maximum benefit in the amount set forth in benefit summary above. The maximum benefit is for each member per calendar year, and is for Type A, B and C services and benefits combined.

The total amount payable for all services and benefits incurred for Type D services during a member’s lifetime is the lifetime maximum benefit set forth in the benefit summary above. The maximum benefit is for each member and is a lifetime maximum.

Alternate Benefit

If the Claims Administrator determines that there is a less costly service than the covered service the dentist performed that could have been performed to treat a dental condition, the Plan’s dental optional benefit will pay benefits based upon the less costly service if such service:

- Would produce a professionally acceptable result under generally accepted dental
standards; and
• Would qualify as a covered service.

For example:
• When a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Claims Administrator may base the benefit determination upon the filling which is the less costly service;
• When a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the Claims Administrator may base the benefit determination upon the partial denture which is the less costly service.

If benefits are paid based upon a less costly service in accordance with this subsection, the dentist may charge the member for the difference between the service that was performed and the less costly service and even if the service is performed by a Participating Provider.

Orthodontic Covered Services

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits for adult and child members. The benefit payable for the initial placement will not exceed 20% of the amount charged by the dentist.

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:
• Dental benefits are in effect for the person receiving the orthodontic treatment; and
• Proof is given to the Claims Administrator that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to Coverage Under the Plan's Dental Optional Benefit

If the initial placement was made prior to coverage under the Plan's dental optional benefit being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to coverage under the Plan's dental optional benefit being in effect:
• The number of months for which benefits are payable will be reduced by the number of months of treatment performed before coverage under the Plan's dental optional benefit was in effect; and
• The total amount of the benefit payable for the periodic visits will be reduced proportionately.

Benefits the Plan's Optional Dental Benefit Will Pay After Coverage Ends

The Plan's optional dental benefit will pay benefits for a 31 day period after the member's coverage ends for the completion of installation of a prosthetic device if:
• The dentist prepared the abutment teeth or made impressions before the member's coverage ends; and
• The device is installed within 31 days after the date that coverage ends.

The Plan's dental optional benefit will pay benefits for a 31 day period after the member's coverage ends for the completion of installation of a cast restoration if:
• The dentist prepared the tooth for the cast restoration before the member's coverage; and
• The cast restoration is installed within 31 days after the date that ends.

The Plan's dental optional benefit will pay benefits for a 31 day period after the member's coverage ends for completion of root canal therapy if:
• The dentist opened into the pulp chamber before the member's coverage ends; and
The treatment is finished within 31 days after the date that coverage ends.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. These separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these separate services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, this Plan's dental optional benefit will only pay benefits for the root canal therapy.

Benefits and Services

General

Only dental care provided by a legally qualified dentist (or a physician, who is also licensed to do dental work) is covered by the Plan's dental optional benefit described in this section of the Plan guide. In addition, only the part of the charge that is considered the usual, reasonable and customary charge is covered by under this dental optional benefit.

Coverage is provided only for a service or supply which is necessary for the diagnosis, care, or treatment of the dental condition involved. The service or supply must be widely accepted in the United States as effective, appropriate, and essential based on professionally recognized standards of dentistry.

A dental service is deemed to start when the date of service is submitted, except that:

- For fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared;
- For a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved; and
- For root canal therapy, it starts when the pulp chamber of the tooth is opened.

A temporary dental service is included in the allowance of the final dental service and is not a separate dental service.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, a member has the option of requesting a pretreatment estimate of benefits. The dentist should submit a claim detailing the services to be performed and the amount to be charged. After the Claims Administrator receives this information, the Claims Administrator will provide the member with an estimate of the dental benefits available for the service. The estimate is not a guarantee of the amount the Plan's dental optional benefit will pay. Under the alternate benefit provision, benefits may be based on the cost of a service other than the service that the member chooses. The member is required to submit proof on or after the date the dental service is completed in order for the Plan's dental optional benefit to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. A member is not required to obtain a pretreatment estimate of benefits. As always, the member and the dentist are responsible for choosing the services to be performed.

What the Plan's Dental Optional Benefit Pays

Dental benefits are divided into four different types: Type A (preventive care), Type B (restorative care), Type C (major care) and Type D (orthodontia).
Type A - Preventive Care

The Plan's dental optional benefit covers preventive care dental services, including:

- Oral exams and problem-focused exams but no more than twice in a calendar year.
- Full mouth or panoramic x-rays once every 36 months.
- Bitewing x-rays two sets in a calendar year.
- Intraoral-periapical x-rays.
- X-rays, except as mentioned elsewhere.
- Pulp vitality and bacteriological studies for determination of bacteriologic agents.
- Diagnostic casts.
- Cleaning of teeth (oral prophylaxis) four times in a calendar year.
- Topical fluoride treatment for a Child under age 15, twice in a calendar year.
- Sealants for a Child under age 19 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 36 months.

Type B - Restorative Care

After the deductible is paid, the Plan's dental optional benefit covers restorative care including:

- Emergency palliative treatment to relieve tooth pain.
- Amalgam fillings.
- Resin-based composite fillings.
- Sedative fillings.
- Oral surgery.
- Consultations.
- Root canal treatment, but not more than once in any 36 month period for the same tooth.
- Periodontal scaling and root planing, but not more than once per quadrant in a calendar year.
- Full mouth debridements, once per lifetime.
- Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in a 10 year period.
- Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four times in a calendar year less the number of teeth cleanings received during such year.
- Simple extractions.
- Surgical extractions.
- Pulp capping (excluding final restoration).
- Pulp therapy.
- Apexification/recalcification.
- Local chemotherapeutic agents.
- Injections of therapeutic drugs.
- Relinings and rebasings of existing removable dentures:
  - If at least six months have passed since the installation of the existing removable denture; and
  - Not more than once in any 36 month period.
- Re-cementing of cast restorations or dentures.
- Adjustments of dentures, if at least six months have passed since the installation of the denture.
- Addition of teeth to a partial removable denture to replace natural teeth removed while coverage under the Plan's dental optional benefit is in effect for the member receiving such services.
- Tissue conditioning.
- Simple repairs of cast restorations or dentures other than recementing.
- Space maintainers.
• Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
• Occlusal adjustments.
• Therapeutic pulpotomy.
• Other removable prosthetic services not described elsewhere.

Type C - Major Care
After the deductible is paid, the Plan's dental optional benefit covers major dental care including:
• Cone beam imaging, but not more than once for the same tooth position in five years.
• General anesthesia in connection with oral surgery, extractions or other covered services, when the Claims Administrator determines such anesthesia is necessary in accordance with generally accepted dental standards.
• For a member who is an eligible dependent under age eight, intravenous sedation/analgesia in connection with oral surgery, extractions or other covered services, when the Claims Administrator determines such sedation is necessary in accordance with generally accepted dental standards.
• Initial installation of full or partial dentures (other than implant supported prosthetics).
• Replacement of a non-serviceable fixed denture if such denture was installed more than five years prior to replacement.
• Replacement of a non-serviceable removable denture if such denture was installed more than five years prior to replacement.
• Replacement of an immediate, temporary full denture with a permanent, full denture, if the immediate, temporary full denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full denture.
• Initial installation of cast restorations.
• Replacement of any cast restoration with the same or a different type of cast restoration, but no more than one replacement for the same tooth surface within a five year period of a prior replacement.
• Prefabricated stainless steel crown or prefabricated resin crown for a member, once per tooth in a period of five years.
• Core buildup.
• Posts and cores.
• Labial veneers, but no more than once per tooth in a period of five years.
• Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a five year period.
• Repair of implants, but not more than once in a 12 month period.
• Implant supported cast restorations, but no more than once for the same tooth position in a five year period.
• Implant supported fixed dentures, but no more than once for the same tooth position in a five year period.
• Implant supported removable dentures, but no more than once for the same tooth position in a five year period.
• Repairs & Adjustments to Occlusal guards/Bruxism are limited to 1 in 36 months.
• Precisions attachments.

Prosthesis Replacement Rule
Certain replacements or additions to existing dentures or bridgework will be covered under the Plan's dental optional benefit if satisfactory proof is given that:
The present denture is an immediate, temporary denture and cannot be made permanent.
Replacement by a permanent denture must be completed within 12 months of installation or the immediate, temporary denture is considered permanent and replacement will not be considered for five years. If a new crown is placed and the tooth is lost or removed, the Plan's dental optional benefit covers replacement of the tooth only if it is at least five years old. The same rule applies to bridgework and partial dentures if supporting teeth are lost or removed within five years. The Plan's dental optional benefit does cover replacement of missing teeth which have not been crowned within five years.

The prosthesis replacement rule (described above) has a frequency limit of 1 in 5 years with no age limit.

**Type D - Orthodontia**

You, your spouse and your dependent children are covered up to age 26 while dental insurance is in effect. All dental procedures performed in connection with orthodontic treatment are payable as orthodontia. Payments for comprehensive full banded orthodontic treatments are made in quarterly installments (at the end of each quarter). Orthodontic treatment benefits are payable at 50% of either the PDP fee (if a Participating Provider is used) or the R&C fee (if a Non-Participating is used) subject to the deductible and orthodontia lifetime maximum. At the time that the appliance is placed, 20% of the total charge is considered to be incurred. The balance of the total charge is prorated over the estimated months of the treatment. Benefits for these months of treatment will be paid automatically provided that the member is still eligible for coverage, active treatment is still being rendered, and the maximum benefit has not been reached.

**Exclusions and Limitations**

The Plan's dental optional benefit will not pay dental benefits for charges incurred for:

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which the Plan's dental optional benefit deems experimental in nature;
- Services for which the member would not be required to pay in the absence of dental benefits;
- Services or supplies received by the member before coverage begins under the Plan's dental optional benefit;
- Services which are neither performed nor prescribed by a dentist, except for those services of a licensed dental hygienist which are supervised and billed by a dentist, and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services which are primarily cosmetic;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the Plan is not required to pay; or
  - Received at a facility maintained by Gates, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by Gates;
- Biopsies of hard or soft oral tissue;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following, when charged by the dentist on a separate basis:
  - Claim form completion;
  - Infection control, such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide (except that analgesia/nitrous oxide is covered for children up to the age of 8 years);
  - Dental services arising out of an accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
  - Fixed and removable appliances for correction of harmful habits;
  - Adjustment of a denture made within six months after installation by the same dentist who installed it;
  - Duplicate prosthetic devices or appliances;
  - Replacement of a lost or stolen appliance, cast restoration or denture;
  - Diagnosis and treatment of temporomandibular joint disorders;
  - Intra and extraoral photographic images.

Coordination of Benefit

When the member incurs charges for covered services under the Plan's dental optional benefit, there may be other plans, as defined below that also provide benefits for those same charges. In that case, the Plan's dental optional benefit may reduce its payment based on what the other plans pay.

Definitions

The following terms have the following meanings for the purpose of the coordination of benefits under the Plan's dental optional benefit:

**Allowable Expense** means a necessary dental expense for which both of the following are true:

- A covered member must pay it; and
- It is at least partly covered by one or more of the plans that provide benefits to the covered member.

If a plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are allowable expenses.

If a plan provides benefits in the form of services, the Plan's dental optional benefit treats the reasonable cash value of each service performed as both an allowable expense and a benefit paid by that plan.

**The term does not include:**

- Expenses for services performed because of a job-related injury or sickness;
- Any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more plans compute their benefit payments on the basis of reasonable and customary fees;
- Any amount of expenses in excess of the higher negotiated fee for a service, if two or more plans compute their benefit payments on the basis of negotiated fees; and
- Any amount of benefits that a primary plan does not pay because the covered person fails to
comply with the primary plan’s managed care or utilization review provisions, these include provisions requiring:

- Second surgical opinions;
- Pre-certification of services;
- Use of providers in a plan’s network of providers; or
- Any other similar provisions.

The Plan's dental optional benefit won’t use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO contract does not require the HMO to pay for providing those services.

**Claim Determination Period** means a period that starts on any January 1 and ends on the next December 31. A claim determination period for any covered member will not include periods of time during which that person is not covered under the Plan's dental optional benefit.

**Custodial Parent** means a parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

**HMO** means a health maintenance organization or dental health maintenance organization.

**Job-Related Injury or Sickness** means any injury or sickness:

- For which the member is entitled to benefits under a workers’ compensation or similar law, or any arrangement that provides for similar compensation; or
- Arising out of employment for wage or profit.

**Parent** means a person who covers a child as a dependent under a plan.

**Plan** means any of the following, if it provides benefits or services for an allowable expense:

- A group insurance plan;
- An HMO;
- A blanket plan;
- Uninsured arrangements of group or group type coverage;
- A group practice plan;
- A group service plan;
- A group prepayment plan;
- Any other plan that covers people as a group;
- Motor vehicle no fault coverage, if the coverage is required by law; and
- Any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- Individual or family insurance or subscriber contracts;
- Individual or family coverage through closed panel plans or other prepayment, group practice or individual practice plans;
- Hospital indemnity coverage;
- A school blanket plan that only provides accident-type coverage on a 24 hour basis, or a “to and from school basis,” to students in a grammar school, high school or college;
- Disability income protection coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Nursing home or long term care coverage; or
- Any government program or coverage if, by state or federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of the Plan's dental optional benefit, which limit benefits based on benefits or services
provided under Government plans will not be affected by this coordination of benefits provisions.

Each policy, contract, or other arrangement for benefits is a separate plan. If part of a plan reserves the right to reduce what it pays based on benefits or services provided by other plans, that part will be treated separately from any parts which do not.

**The Plan's Dental Optional Benefit** means the dental benefits described in this DENTAL OPTIONAL BENEFIT section, except for any provisions in this section that limit coverage based on benefits for services provided under government plans.

**Primary Plan** means a plan that pays its benefits first under the heading in Rules To Decide Which Plan Is Primary. A primary plan pays benefits as if the secondary plans do not exist.

**Secondary Plan** means a plan that is not a primary plan. A secondary plan may reduce its benefits by amounts payable by the primary plan. If there are more than two plans that provide coverage, a plan may be primary to some plans, and secondary to others.

### Rules to Decide Which Plan Is Primary

When more than one Plan's dental optional benefit and another plan covers a member for whom allowable expenses were incurred, the Claims Administrator determines which plan is primary by applying the rules in this section.

When there is a basis for claim under the Plan's dental optional benefit and another plan, the Plan's dental optional benefit is secondary unless:

- The other plan has rules coordinating its benefits with those of the Plan's dental optional benefit; and
- The Plan's dental optional benefit is primary under the Plan's dental optional benefit rules.

The first rule below, which will allow the Claims Administrator to determine which plan is primary, is the rule that the Claims Administrator will use.

### Dependent or Non-Dependent

A plan that covers a member other than as a dependent (for example, as an employee) is primary and shall pay its benefits before a plan that covers the member as a dependent; except that if the member is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the plan covering the member as a dependent; and
- Primary to the plan covering the member as other than a dependent (an employee, for example);

then the order of benefits between the two plans is reversed and the plan that covers the member as a dependent is primary.

### Child Covered Under More Than One Plan – Court Decree

When the Plan's dental optional benefit and another plan cover the same child as the dependent of two or more parents, and the specific terms of a court decree state that one of the parents must provide health coverage or pay for the child’s health care expenses, that parent’s plan is primary, if that plan has actual knowledge of those terms. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

### Child Covered Under More Than One Plan – The Birthday Rule

When the Plan's dental optional benefit and another plan cover the same child as the dependent of two or more parents, the primary plan is the plan of the parent whose birthday falls earlier in the year if:
- The parents are married; or
- The parents are not separated (whether or not they have ever married); or
- A court decree awards joint custody without specifying which parent must provide health coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is the primary plan.

However, if the other plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the Plan's dental optional benefit and the other plan do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

**Child Covered Under More Than One Plan – Custodial Parent**

When the Plan's dental optional benefit and another plan cover the same child as the dependent of two or more parents, if the parents are not married, or are separated (whether or not they ever married), or are divorced, the primary plan is:

- The plan of the custodial parent; then
- The plan of the spouse of the custodial parent; then
- The plan of the non-custodial parent; and then
- The plan of the spouse of the non-custodial parent.

**Active or Inactive Employee**

A plan that covers a person as an employee who is neither laid off nor retired is primary to a plan that covers the person as a laid-off or retired employee (or as that person’s dependent). If the other plan does not have this rule and, if as a result, the Plan's dental optional benefit and the other plan do not agree on the order of benefits, this rule is ignored.

**Continuation of Coverage**

The plan that covers a person as an active employee (or as that employee’s eligible dependent) is primary to a plan that covers that person under a right of continuation pursuant to federal law (such as COBRA coverage, for example) or state law. If the plan that covers the person has not adopted this rule, and if, as a result, the Plan's dental optional benefit and the other plan do not agree on the order of benefits, this rule shall not apply.

**Longer/Shorter Time Covered**

If none of the above rules determine which plan is primary, the plan that has covered the person for the longer time shall be primary to a plan that has covered the person for a shorter time.

**No Rules Apply**

If none of the above rules determine which plan is primary, the allowable expenses shall be shared equally between all the plans. In no event will the Plan's dental optional benefit pay more than it would if it were primary.

**Effect on Benefits of This Plan**

If the Plan's dental optional benefit is secondary, when the total allowable expenses incurred by the member in any claim determination period are less than the sum of:

- The benefits that would be payable under the Plan's dental optional benefit without applying this coordination of benefits provision; and
- The benefits that would be payable under all other plans without applying this coordination of benefits provision or similar provisions;

then benefits that would otherwise be payable under it will be reduced by the Plan's dental optional
benefit. The sum of these reduced benefits, plus all benefits payable for such allowable expenses under all other plans, will not exceed the total of the allowable expenses. Benefits payable under all other plans include all benefits that would be payable if the proper claims had been made on time.

Right to Receive and Release Needed Information

The Claims Administrator needs certain information to apply the coordination of benefits rules described above. The Claims Administrator has the right to decide which facts the Claims Administrator needs. The Claims Administrator may get facts from or give them to any other organization or person. The Claims Administrator does not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a member who incurs allowable expenses should file a claim under each plan which covers him or her. Each member claiming benefits under the Plan's dental optional benefit must give the Claims Administrator any facts needed to pay the claim under the Plan's dental optional benefit.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under the Plan's dental optional benefit. If it does, the Plan's dental optional benefit may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the Plan's dental optional benefit. The Plan's dental optional benefit will not have to pay that amount again. The term “payment made” includes benefits provided in the form of services, in which case The Plan's dental optional benefit may pay the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount the Plan's dental optional benefit pays is more than it should have paid under this coordination of benefits provision, the Plan's dental optional benefit may recover the excess from one or more of:

- The person the Plan's dental optional benefit has paid or for whom it has paid;
- Insurance companies;
- Other organizations

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

Assignment

Upon receipt of a covered service, the member may assign dental benefits to the dentist providing such service.

Dental Benefits: Who This Plan Will Pay

If a member assigns benefits to his or her dentist, the Plan's dental optional benefit will pay benefits directly to the dentist; otherwise the benefits will be paid to the member.

Overpayments

Recovery of Dental Benefit Overpayments

- The Plan's dental optional benefit has the right to recover any amount that the Claims Administrator determines to be an overpayment for you or for your eligible dependent members.
- An overpayment occurs if the Claims Administrator determines that:
The total amount paid by the Plan's dental optional benefit on a claim for dental benefits or services is more than the total of the benefits due to that member; or
The payment made by the Plan's dental optional benefit should have been made by another group plan.
If such overpayment occurs, the member has an obligation to reimburse the Plan's dental optional benefit.

How The Plan's Dental Optional Benefit Recovers Overpayments
- The Plan's dental optional benefit may recover the overpayment from you by:
  - Stopping or reducing any future benefits payable for dental benefits;
  - Demanding an immediate refund of the overpayment from you; and
  - Taking legal action.
- If the overpayment results from the Plan's dental optional benefit having made a payment to you that should have been made under another group plan, the Plan's dental optional benefit may recover such overpayment from one or more of the following:
  - Any other insurance company;
  - Any other organization; or
  - Any person to or for whom payment was made.

Claims Information

Eligibility
The Claims Administrator verifies eligibility using information provided by the Global Benefits Department. If an employee or his or her dependent is not satisfied with the final determination of eligibility, he or she has the right to a formal review and appeal as described in ADMINISTRATIVE CLAIMS in the PLAN ADMINISTRATION section of this Plan guide.

Claims For Denied Benefits
Many Providers will submit claims directly to the Claims Administrator; a member will generally not be required to file claim forms. If this is not the case, the member can download a claim form by going to www.metlife.com/mybenefits and entering the company name "Gates Corporation".

Complaint and Appeals Procedures

Routine Questions
If there is any question about a claim payment, an explanation may be requested from the Claims Administrator at 1-800-942-0854.

Claim Submission
A member must complete the appropriate claim form and submit the required proof to the address indicated on the claim form.

Initial Determination
After a member submits a claim to the Claims Administrator, the Claims Administrator will review that claim and notify the member of its decision to approve or deny his or her claim.
Such notification will be provided to you within a 30 day period from the date the claim was submitted; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If the Claims Administrator needs such an extension, the Claims Administrator will
notify the member prior to the expiration of the initial 30 day period, state the reason why the extension
is needed, and state when it will make its determination. If an extension is needed because the
member did not provide sufficient information or filed an incomplete claim, the time from the date of
the Claims Administrator's notice requesting further information and an extension until the Claims
Administrator receives the requested information does not count toward the time period the Claims
Administrator is allowed to notify the member as to its claim decision. The member will have 45 days to
provide the requested information from the date you receive the notice requesting further information
from the Claims Administrator.

If the Claims Administrator denies the member's claim in whole or in part, the notification of the claim
decision will state the reason why the claim was denied and references the specific provision(s) in this
guide for the Plan's dental optional benefit on which the denial is based. If the claim is denied because
the Claims Administrator did not receive sufficient information, the claims decision will describe the
additional information needed and explain why such information is needed. Further, if an internal rule,
protocol, guideline, or other criteria was relied upon in making the denial, the claims decision will state
the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other
criteria was relied upon and that the member may request a copy free of charge.

Appealing the Initial Determination

If the Claims Administrator denies a member's claim, the member may make two appeals of the initial
determination. Upon the member's written request, the Claims Administrator will provide the member
free of charge with copies of documents, records, and other information relevant to his or her claim.

The must submit his or her claim appeal to the Claims Administrator at the address indicated on the
claim form within 180 days of receiving the Claims Administrator's decision. Appeals must be in writing
and must include at least the following information:

- Name of member
- The Plan name (that is, Gates Corporation Employee Welfare Benefits Plan)
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why the member is appealing the initial determination

As part of each appeal, the member may submit any written comments, documents, records, or
other information relating to his or her claim.

After the Claims Administrator receives the written request appealing the initial determination or
determination on the first appeal, the Claims Administrator will conduct a full and fair review of the
claim. Deference will not be given to initial denials, and the Claims Administrator's review will look at
the claim anew. The review on appeal will take into account all comments, documents, records, and
other information that the members submits relating to his or her claim without regard to whether such
information was submitted or considered in the initial determination. The person who will review the
member's appeal will not be the same person as the person who made the initial decision to deny his
or her claim. In addition, the person who is reviewing the appeal will not be a subordinate of the
person who made the initial decision to deny the member's claim. If the initial denial is based in whole
or in part on a medical judgment, the Claims Administrator will consult with a health care professional
with appropriate training and experience in the field of dentistry involved in the judgment. This health
care professional will not have consulted on the initial determination, and will not be a subordinate of
any person who was consulted on the initial determination.

The Claims Administrator will notify the member in writing of its final decision within 30 days after the
Claims Administrator's receipt of his or her written request for review, except that under special
circumstances the Claims Administrator may have up to an additional 30 days to provide written
notification of the final decision. If such an extension is required, the Claims Administrator will notify
the member prior to the expiration of the initial 30 day period, state the reason(s) why such an
extension is needed, and state when it will make its determination.
If the Claims Administrator denies the claim on appeal, the Claims Administrator will send the member a final written decision that states the reason(s) why the claim he or she appealed is being denied and references any specific provision(s) in this guide for the Plan's dental optional benefit on which the denial is based. If an internal rule, protocol, guideline, or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that the member may request a copy free of charge. Upon written request, the Claims Administrator will provide the member free of charge with copies of documents, records, and other information relevant to his or her claim.

When the claim has been processed, the member will be notified of the benefits paid. If any benefits have been denied, the member will receive a written explanation.

**Urgent Care Claim Submission**

A small number of claims for dental benefits may be urgent care claims. Urgent care claims for dental benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However a member's dentist may also submit such a claim to the Claims Administrator by telephoning the Claims Administrator and informing the Claims Administrator that the claim is an urgent care claim. Urgent care claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, the Claims Administrator will notify the member of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If a member does not provide the Claims Administrator with enough information to decide the claim, the Claims Administrator will notify the member within 24 hours after it receives the claim of the further information that is needed. The member will have 48 hours to provide the information. If the needed information is provided, the Claims Administrator will then notify the member of the claim decision within 48 hours after the Claims Administrator received the information. If the needed information is not provided, the Claims Administrator will notify the member of its decision within 120 hours after the claim was received.

If a member's claim is denied but he or she receives the care, the member may appeal the denial using the normal claim procedures. If the member's urgent care claim is denied and the member does not receive the care, the member can request an expedited appeal of his or her claim denial by phone or in writing. The Claims Administrator will provide the member with any necessary information to assist him or her with the appeal. The Claims Administrator will then notify the member of its decision within 72 hours of his or her request for an expedited appeal. However, the Claims Administrator may notify the member by phone within the time frames above and then mail the written notice to him or her.

**Vision Optional Benefit**

**General**

The Plan's vision optional benefit coverage is described in this section insured by Vision Service Plan (VSP).

**VSP Coverage Option**

The most current listing of Network Providers is available at www.vsp.com or by calling VSP's Customer
Services Department at 1-800-877-7195. A member must verify at the time of service that a doctor listed in the VSP network directory is still in the network at the time services are rendered.

Schedule of Benefits and Services

This schedule lists the vision care services and eyewear to which a member is entitled, subject to any copays and other conditions, limitations and/or exclusions for this coverage option. Vision care services and eyewear may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether a Network Provider or Out-of-Network Providers.

VSP Doctor Network: VSP Choice

Visit www.vsp.com for more details on your vision benefit and for exclusive savings and promotions for VSP members.

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Your Reimbursement with Out-of-Network Providers
Benefits and Services

The VSP coverage option provides coverage for the following benefits and services subject to limitations and/or qualifications:

**Eye Examination**

A complete initial vision analysis which includes an appropriate exam of the member's visual functions, including the prescription of corrective eyewear where indicated.

**Lenses**

The VSP Network Provider will order the proper lenses necessary for the member's visual welfare. The VSP Network Provider shall verify the accuracy of the finished lenses.

**Frames**

The VSP Network Provider will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.

**Contacts**

Elective contacts are contacts chosen in lieu of glasses. If vision cannot be corrected with glasses, necessary contact lenses are a benefit when specific benefit criteria are satisfied and when prescribed by the member’s Provider. Prior review and approval by VSP are not required for a member to be eligible for the necessary contact lenses benefit under the VSP coverage option.

**Low Vision**

Special assistance is available for a member diagnosed with severe visual problems (that is, partial sight) not corrected with regular lenses, including supplemental testing (including evaluation, diagnosis, and prescription of vision aids where indicated) and supplemental aids. Supplemental testing by a VSP Network Provider is covered in full. Supplemental testing by an Out-of-Network Provider is reimbursed up to $125. Members pay 25% of the cost of supplemental aids. All low vision benefits are subject to a maximum of $1,000 every two years.

The allowance is in addition to a 15% discount on the VSP Network Provider's usual and customary fees for contact lens evaluation and fitting. The Diabetic Eyecare Program provides additional coverage through medical diagnosis and procedure codes for a member with Type 1 diabetes and specific ophthalmological conditions. This benefit provides a diabetic exam for diagnostic services in addition to the routine vision examination covered by the VSP coverage option. Additional services such as retinal photography and other diabetes-related vision tests may apply. A $5.00 copayment is required for each service and office visit. These follow-up diabetic eye care services must be provided by a VSP Network Provider. A member may obtain, free of charge, a schedule of the Diabetic Eyecare Program benefits and services by calling VSP’s Customer Services Department at 1-800-877-7195.
Exclusions and Limitations

The VSP coverage option is a routine vision care coverage option intended to cover visual needs rather than cosmetic materials. If a member selects any of the following extras, the VSP coverage option will pay the basic cost of the allowed lenses and the member will be responsible for the additional cost of the option:

- Optional cosmetic processes.
- Anti-reflective coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

The VSP coverage option provides no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Medical and/or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Corrective vision treatment of an experimental nature such as, but not limited to, RK and PRK Surgery.
- Plano lenses (less than ±.50 diopter power).
- Services rendered after the date that a member’s coverage under the Plan or the VSP coverage option ends, except when service is being rendered to the member as of that termination, the service will be continued to completion, but in no event beyond six months after the termination of the VSP coverage option.
- Replacement of lenses and frames furnished under the VSP coverage option that are lost or broken except at the normal intervals when services are otherwise available under this option.

Procedure for Using the VSP Coverage Option

A member who is enrolled for the VSP coverage option and who wishes to receive benefits and services from a VSP Network Provider, should contact VSP or the VSP Network Provider. If eligible, VSP will provide a benefit authorization to the member or to the VSP Network Provider. The most current listing of VSP Network Providers is available at www.vsp.com or by calling VSP’s Customer Services Department at 1-800-877-7195. This list contains the names, addresses, and telephone numbers of the VSP Network Providers.

The receipt of the benefit authorization and performance of services prior to the expiration date of the authorization, constitutes a claim under the VSP coverage option, even if the qualified employee’s or eligible dependent’s VSP option coverage is terminated. A member who receives services from a VSP Network Provider without a benefit authorization or from an Out-of-Network Provider is responsible for payment in full to that provider and, in each case, must submit an Out-of-Network Reimbursement form to receive an Out-of-Network reimbursement.

A member pays only the copayment (if any) and any overages to the VSP Network Provider for the services covered by the VSP coverage option. VSP will directly pay the VSP Network Provider.

For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the member should contact VSP’s Customer Service Department for assistance. Any such emergency
vision care is subject to the same benefit frequencies, coverage option allowances, copayments, and exclusions for the VSP coverage option.

Claim Payments and Denials

Eligibility

VSP verifies eligibility using information provided by your Human Resources Department/Global Benefits Department. If an employee or his or her dependent is not satisfied with the final determination of eligibility, he or she has the right to a formal review and appeal as described in ADMINISTRATIVE CLAIMS in the PLAN ADMINISTRATION section of this Plan guide.

Initial Determination

All of the vision care services under the VSP coverage option are considered post-service claims. VSP will pay or deny claims for benefits within 30 calendar days of the receipt of the claim from the member or his or her authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than 15 calendar days.

Request for Appeals

If the member's claim for benefits is denied by VSP in whole or in part, VSP will notify the member in writing of the reason or reasons for the denial. Within 180 days after receipt of such notice of denial of a claim, the member may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the member for whom a claim for benefits was denied, including the name and date of birth of the member and his or her identification number, the name of the provider of services, and the claim number. The member may state the reasons he or she believes that the claim denial was in error. The member may also provide any pertinent documents to be reviewed. VSP will review the claim and give the member the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. The member or his or her authorized representative should submit all requests for appeals to:

Vision Service Plan
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
1-800-877-7195

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

If the member disagrees with VSP’s determination, he or she may request a second level appeal within 60 calendar days from the date of the determination. VSP shall resolve any second level appeal within 30 days.

Complaints and Grievances

If a member ever has a question or problem, the first step is to call VSP’s Customer Service Department. The Customer Service Department will make every effort to answer the member's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of the member, he or she may communicate a complaint or grievance to VSP, orally or in writing, by using the complaint form that may be obtained upon request from the Customer Service
Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. A member also has the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP’s review of the complaint or grievance. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution will be achieved as soon as possible, but no later than 120 days after VSP’s receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to the member to indicate VSP’s expected resolution date. Upon final resolution, the member will be notified of the outcome in writing.

In the event of a discrepancy between this document and the VSP plan/policy including any amendments, the terms of the plan policy shall control.

Personal Resilience Program

General

Gates Corporation’s personal resilience program is described in this section.

The personal resilience program is administered by Magellan Healthcare, Inc. or in California, by Magellan Health Services of California — Employer Services. Unless otherwise noted, references in this Plan guide to "Magellan" are to either Magellan Behavioral Health or Magellan Health Services of California — Employer Services depending on where the employee assistance program services are provided. The employee assistance program provides a confidential personal consultation program to help you and your eligible dependents deal with personal problems. This confidential personal consultation program is also available for members of your household.

Magellan will provide, or arrange for a third party to provide, telephone consultation, access to an expanded on-line library of information and tools, and referral services in connection with child care, elder care, parenting issues, children with special needs, schooling and education, teen and young adult issues and adoption assistance, as well as personal convenience services such as pet care, relocation assistance, home or auto repair and improvement, and similar services ("Work-Life Services"). Participants may access Work-Life Services by telephoning the assigned Magellan toll-free telephone number. Work-Life Services are available twenty-four (24) hours per day, seven (7) days per week. When a Participant requests a referral for child care or elder care, a consultant will gather information about the Participant's dependent care needs and send the Participant a packet of educational materials and a list of no fewer than three (3), to the extent available, licensed, certified or registered dependent care providers with confirmed vacancies matching the Participant’s expressed needs. In all cases, the information about, and description of, a particular information agency, resource organization, placement agency, or direct child care or elder care service provider has been provided by the agency, organization, or direct child care or elder care service provider.

Services

Personal Consultation Services

The personal resilience program provides personal consultation services to assist a member to resolve a range of personal problems, including, but not limited to:

- Work-related issues;
- Parenting concerns;
- Marriage and family distress;
• Relationship issues;
• Use and misuse of alcohol and drugs, and co-dependency issues;
• Stress related to financial and legal problems;
• Emotional stress;
• Life crisis; and
• Similar concerns.

The personal consultation services consist of an assessment of the member's problem by a licensed mental health professional, and, as clinically appropriate, brief counseling or referral to a resource in the member's community for treatment. The brief counseling is a problem-focused out-patient counseling with an EAP counselor that: emphasizes skills and strengths and encourages practicing new behaviors; involves setting goals achievable in a one to five month period; involves interpretation, suggestions, and a framework provided by the EAP counselor; and can be utilized by the member alone or together with others who are important to the resolution of the member's problem. If a member is referred for treatment beyond the personal consultation services, with the member's permission, Magellan may follow up to monitor the effectiveness of the assistance received by the member.

In any calendar year, a member can participate in up to five sessions (of 50 minutes each) for each specific problem or set of problems. If the EAP counselor determines after one or two sessions that a member's problem or condition cannot be resolved with brief counseling, the EAP counselor will assist the member to transition out of the employee assistance program to a provider who is appropriate for his or her condition. At that point, no further EAP sessions are available to that member, except in connection with the transition to another provider.

Legal Services

Legal Consultation Services consist of an initial telephonic or in-person consultation lasting up to 60 minutes with a plan attorney located in the Participant’s state of domicile for routine legal needs. During the consultation, a plan attorney will explain the Participant’s rights, identify options, and, if needed, recommend a course of action, which may include referral to a different plan attorney. The Participant will choose whether to retain a plan attorney at his or her expense or adopt an alternative plan of action. Participants who elect to retain legal counsel from a plan attorney after the initial consultation will be entitled to a twenty-five percent (25%) reduction in fees from the plan attorney’s normal hourly rate and/or fee schedule, as applicable. Participants are entitled to one (1) free initial office or telephone consultation with a plan attorney per separate legal matter per Contract Year. Legal Consultation Services include unlimited online access to the legal library, legal tools, forms, and resources. Legal Consultation Services do not include services (i) in connection with employment-related matters, (ii) in connection with disputes or proceedings involving Magellan, its subsidiaries, affiliates or customers, a Participant’s employer, Magellan’s legal and/or financial services vendor(s) or any of its attorneys, or (iii) that are frivolous, harassing, or otherwise involve the violation of ethical rules. Legal Consultation Services are available only to those Participants located within the United States.

Financial Services

Financial Consultation Services include telephonic information and consultation lasting up to 60 minutes on debt management, basic financial planning and budgeting, insurance, retirement, savings and investments, family financial issues and identity theft resolution. Participants are entitled to one (1) free telephone consultation per separate financial matter per Contract Year. Financial Consultation Services are intended to assist Participants in formulating financial planning strategies and to serve as an information resource and planning tool. Financial Consulting Services include unlimited online access to interactive tools (including financial calculators and personal investment tools, financial library, forms, and resources. Financial consultants will not advise nor instruct
Participants as to any course of action, nor be responsible for any decisions made by Participants about their financial planning. Financial Consultation Services are available only to those Participants located within the United States.

Crisis Counseling

In crisis situations a licensed counselor is available to speak with a member about his or her current situation. In this crisis counseling process, the counselor will determine whether an emergency exists and, based on that determination, makes a referral to emergency behavioral health services and care, to community resources, or to an EAP counselor.

Accessing Services

To access the employee assistance program services, a member must call the Magellan toll-free telephone access line 24 hours a day, seven days a week as follows:

<table>
<thead>
<tr>
<th>Toll-Free Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800-424-4268</td>
<td></td>
</tr>
<tr>
<td>1-800-456-4006 (IDD) for speech or hearing impaired assistance</td>
<td></td>
</tr>
</tbody>
</table>

**Personal Consultation Services.** If a member is seeking consultation about a personal problem, the Customer Service representative or care manager will ask him or her to briefly describe that problem. If the member wishes to be seen by an EAP counselor, he or she will be given information about the EAP counselors in the member's area. Or, the member can review the list of EAP counselors at www.MagellanAscend.com before calling the Magellan toll-free access line. The Customer Service representative or care manager will set up an EAP case for the member. The member can then schedule an appointment with the EAP counselor.

**Crisis Services.** In a crisis situation, a member can request immediate employee assistance program services by calling the Magellan toll-free telephone access line as described above.

**EAP Counselors.** The personal resilience program services are only available through a network of independent EAP counselors with whom Magellan has contracted. Each EAP counselor is a psychologist, clinical social worker, marriage, family and child counselor or other professional who is licensed under applicable state law to deliver counseling services. More information is available about the provider network for the employee assistance program services at the Magellan toll-free access line above, on line at www.MagellanAscend.com/member, or by writing to Magellan Healthcare, Inc. Network Department 14100 Magellan Plaza, Maryland Heights, MO 63042.

**Benefits and Services that are Not Covered**

- Medical care, including services for a condition that requires psychiatric treatment (such as a psychosis).
- Inpatient treatment.
- Services by providers who are not part of the Magellan EAP counselor network.
- EAP sessions that were not accessed through the Magellan toll-free number for the particular episode of care.
- Psychological, psychiatric, neurological, education, or IQ testing.
- Remedial and social skills education services, such as evaluation or treatment of learning disabilities, learning disorders, academic skill disorders, language disorders, mental retardation, motor skill disorders, or communication disorders; behavioral training; and cognitive rehabilitation.
Medication, medication management.

Evaluations for fitness for duty or excuses for leaves of absence or time off.

Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), and obtaining any kind of insurance coverage.

Court-mandated counseling, evaluations required by a state or federal judicial officer or other governmental official or agency or to be used in legal actions of any kind (for example, child custody proceedings).

Testimony in legal proceedings, creation of records for legal proceedings, or other preparation for legal proceedings.

Guidance on workplace issues when a member sues, or threatens to sue, the Plan Sponsor or any related entity.

Acupuncture.

Biofeedback and hypnotherapy.

Group counseling.

Services to permit members to fulfill any group health plan prerequisite that EAP services be utilized prior to behavioral health benefits becoming available.

In addition, referrals given in connection with EAP services are not endorsements or guarantees for the programs or providers to which a member is referred. A member is encouraged to discuss any concerns about resources with his or her EAP counselor.

Confidentiality

The employee assistance program is a confidential program. A member's discussions with his or her EAP counselor will not be disclosed to anyone outside the employee assistance program without the member's written consent, except in specific instances required or permitted by law (for example, where child or elder abuse must be reported).

Denials of Eligibility and Benefits and Appeal Procedures

Denial of Eligibility

Your Human Resources Department or Global Benefits Department verifies eligibility for the employee assistance program. If an employee or his or her dependent or household member is not satisfied with the final determination of eligibility, he or she has the right to a formal review and appeal as described in ADMINISTRATIVE CLAIMS in the PLAN ADMINISTRATION section of this Plan guide.

Denial of Benefits

Magellan directly pays all EAP counselors from whom employee assistance program services are available. This means that a member should not make any payment to an EAP counselor. This also means that there are no claims for payments for employee assistance program services. A member who is denied employee assistance program services for reasons other than ineligibility may appeal this adverse determination. The appeal procedures are furnished separately from this Plan guide and can be obtained, without charge, from the Claims Administrator. The contact information for the Claims Administrator is provided in the GENERAL PLAN ERISA FACTS section of the Plan guide under the heading BASIC BENEFITS FACTS.

Grievances and Complaints
A member in California who has any dissatisfaction with Magellan or any EAP counselor in the provider network can make a grievance against Magellan by calling the Magellan toll-free access line (provided above in this section), sending a letter to Comment Coordinator, Magellan Health Services of California – Employer Services 2650 Camino Del Rio North, San Diego, CA 92108, or on line through www.MagellanAscend.com. By calling that toll-free access line, a member can request a grievance form to submit his or her grievance in writing and assistance in completing the form. If a member makes a grievance by telephone or e-mail that cannot be resolved by the next business day or if the grievance relates to employee assistance program services, Magellan will provide the member with a written acknowledgment of his or her grievance within five calendar days. Magellan will resolve the grievance within 30 calendar days of when the grievance is received. A member with a grievance that involves an imminent and serious threat to the health of the member, such as severe pain, potential loss of life, limb, or a major bodily function should call the toll-free access line and request an expedited review for that urgent grievance. Magellan will conduct an expedited review and provide the member with a statement of its resolution within three calendar days of receiving the grievance.

In addition to the grievance process, the member in California may file a complaint with the California Department of Managed Health Care. The Department's toll-free telephone number is 1-888-HMO-2219 and the TDD is 1-877-688-9891 for the speech and hearing impaired. The Department's web site at www.hmohelp.ca.gov includes complaint forms and instructions. A member has the right to immediately contact the Department without participating in the grievance process. A member can call the Department for assistance with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Magellan or a grievance that has remained unsolved for more than 30 days.

**Critical Illness**

**General**

Critical illness insurance is coverage that can help safeguard your finances by providing you with a lump-sum payment—one convenient payment all at once—when you or your family need it most. The extra cash can help you focus on getting back on track—without worrying about finding the money to cover some of your expenses. And best of all, the payment is made directly to you, and is in addition to any other insurance you may have. It’s yours to spend however you like, including for your or your family’s everyday living expenses.

**Coverage Options**

<table>
<thead>
<tr>
<th>Critical Illness Insurance</th>
<th>Initial Benefit</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee</strong></td>
<td>$10,000 or $20,000</td>
<td>Coverage is guaranteed provided you are actively at work.³</td>
</tr>
<tr>
<td><strong>Spouse/Domestic Partner</strong>¹</td>
<td>50% of the employee’s Initial Benefit</td>
<td>Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.³</td>
</tr>
</tbody>
</table>
Benefit Payment

Your Initial Benefit provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit equal to the Initial Benefit for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the Total Benefit and is 3 times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300% or $30,000 or $60,000.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

<table>
<thead>
<tr>
<th>Covered Conditions</th>
<th>Initial Benefit</th>
<th>Recurrence Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Benefit Cancer</td>
<td>100% of Initial Benefit</td>
<td>50% of Initial Benefit</td>
</tr>
<tr>
<td>Partial Benefit Cancer</td>
<td>25% of Initial Benefit</td>
<td>12.5% of Initial Benefit</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>100% of Initial Benefit</td>
<td>50% of Initial Benefit</td>
</tr>
<tr>
<td>Stroke</td>
<td>100% of Initial Benefit</td>
<td>50% of Initial Benefit</td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft</td>
<td>100% of Initial Benefit</td>
<td>50% of Initial Benefit</td>
</tr>
<tr>
<td>Kidney Failure</td>
<td>100% of Initial Benefit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>100% of Initial Benefit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Major Organ Transplant Benefit</td>
<td>100% of Initial Benefit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>22 Listed Conditions</td>
<td>25% of Initial Benefit</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

22 Listed Conditions
MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one payment for each Listed Condition in his/her lifetime.

The Listed Conditions are Addison’s disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig’s disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington’s disease (Huntington’s chorea); Legionnaire’s disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

Example of Initial & Recurrence Benefit Payments
The example below illustrates an employee who elected an Initial Benefit of $10,000 and has a Total Benefit of 3 times the Initial Benefit Amount or $30,000.

<table>
<thead>
<tr>
<th>Illness – Covered Condition</th>
<th>Payment</th>
<th>Total Benefit Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack – first diagnosis</td>
<td>Initial Benefit payment of $10,000 or 100%</td>
<td>$20,000</td>
</tr>
<tr>
<td>Heart Attack – second diagnosis, two years later</td>
<td>Recurrence Benefit payment of $5,000 or 50%</td>
<td>$15,000</td>
</tr>
<tr>
<td>Kidney Failure – first diagnosis, three years later</td>
<td>Initial Benefit payment of $10,000 or 100%</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**SUPPLEMENTAL BENEFITS**

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

**Health Screening Benefit**

After your coverage has been in effect for thirty days, MetLife will provide an annual benefit $50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year.

MetLife will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year.

Eligible screening/prevention measures may include:

- annual physical exam;
- biopsies for cancer;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);
- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- endoscopy;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- lipid panel;
- mammogram;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL or HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STIs);
- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
ultrasound screening of the abdominal aorta for abdominal aortic aneurysms; or
virtual colonoscopy.

INSURANCE RATES
MetLife offers competitive group rates and convenient payroll deduction so you don’t have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Monthly Premium/$1,000 of Coverage

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Employee Only</th>
<th>Employee + Spouse</th>
<th>Employee + Children</th>
<th>Employee + Spouse / Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>$0.29</td>
<td>$0.51</td>
<td>$0.53</td>
<td>$0.74</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.31</td>
<td>$0.53</td>
<td>$0.54</td>
<td>$0.76</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.40</td>
<td>$0.66</td>
<td>$0.63</td>
<td>$0.89</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.55</td>
<td>$0.87</td>
<td>$0.78</td>
<td>$1.11</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.82</td>
<td>$1.27</td>
<td>$1.05</td>
<td>$1.50</td>
</tr>
<tr>
<td>45-49</td>
<td>$1.21</td>
<td>$1.80</td>
<td>$1.44</td>
<td>$2.06</td>
</tr>
<tr>
<td>50-54</td>
<td>$1.79</td>
<td>$2.62</td>
<td>$2.02</td>
<td>$2.85</td>
</tr>
<tr>
<td>55-59</td>
<td>$2.56</td>
<td>$3.67</td>
<td>$2.80</td>
<td>$3.91</td>
</tr>
<tr>
<td>60-64</td>
<td>$3.65</td>
<td>$5.16</td>
<td>$3.86</td>
<td>$5.40</td>
</tr>
<tr>
<td>65-69</td>
<td>$5.40</td>
<td>$7.54</td>
<td>$5.63</td>
<td>$7.77</td>
</tr>
<tr>
<td>70+</td>
<td>$7.52</td>
<td>$10.60</td>
<td>$7.76</td>
<td>$10.83</td>
</tr>
</tbody>
</table>

QUESTIONS & ANSWERS
Employees will enroll through the Oracle self-service portal located on the intranet.

Who is eligible to enroll?
An employee of Gates on U.S. payroll regularly scheduled to work at least 30 hours per week. If you are a qualified employee regularly scheduled to work at least 30 hours per week; you can choose coverage for your eligible dependents for the benefits described in this Plan Summary. No one may qualify as both a dependent and an employee.

How do I pay for coverage?
Coverage is paid through convenient payroll deduction.

What is the coverage effective date?
The coverage effective date is 01/01/2019

If I Leave the Company, Can I Keep My Coverage? 
Under certain circumstances, you can take your coverage with you if you leave. You must make a request in writing within a specified period after you leave your employer. You must also continue to pay premiums to keep the coverage in force.

Who do I call for assistance?
Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.
Please call MetLife directly at 1-855-J O I N-M E T (1-855-564-6638), Monday through Friday from 8:00 a.m. to 8 p.m., EST and talk with a benefits consultant.

Footnotes:
1 Coverage for Domestic Partners, civil union partners and reciprocal beneficiaries varies by state.
Please contact MetLife for more information.

2 Dependent Child coverage varies by state. Please contact MetLife for more information.

3 Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents living overseas. Coverage is guaranteed provided (1) the employee is performing all of the usual and customary duties of your job at the employer's place of business or at an alternate place approved by your employer (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.

4 We will not pay a Recurrence Benefit for a Covered Condition that Recurs during a Benefit Suspension Period. We will not pay a Recurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless the Covered Person has not had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which we paid an Initial Benefit during the Benefit Suspension Period.

5 Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount. For NH-sitused cases and NH residents, there is an initial benefit of $100 for All Other Cancers.

6 In certain states, the covered condition is Severe Stroke.

7 In NJ-sitused cases, the Covered Condition is Coronary Artery Disease.

8 Please review the Outline of Coverage for specific information about Alzheimer's disease.

9 The Occupational HIV benefit is not available with all plans or in all states. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about the Occupational HIV benefit if it is available to you.

10 The Health Screening Benefit is not available in all states. See your certificate for any applicable waiting periods. There is a separate mammogram benefit for MT residents and for cases sitused in CA and MT.

11 Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE’S CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife’s CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. In most plans, there is a preexisting condition exclusion. In most states, after a covered condition occurs there is a benefit suspension period during which most plans do not pay recurrence benefits. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. Rates are subject to change. A more detailed description of the benefits, limitations, and exclusions can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI or GPNP09-CI, or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York.

MetLife’s Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife’s Critical Illness Insurance does not provide reimbursement for such expenses.
Accident Insurance

General

Accident insurance provides a financial cushion for life’s unexpected events. You can use it to help pay costs that aren’t covered by your medical plan. It provides you with a lump-sum payment—one convenient payment all at once—when you or your family need it most. The extra cash can help you focus on getting back on track, without worrying about finding the money to help cover the costs of treatment.

And best of all, the payment is made directly to you, and is in addition to any other insurance you may have. It’s yours to spend however you like, including for your or your family’s everyday living expenses.

Accident Insurance Benefits

With MetLife, you’ll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services.

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Low Plan MetLife</th>
<th>High Plan MetLife</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injuries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractures²</td>
<td>$50 – $3,000</td>
<td>$100 – $6,000</td>
</tr>
<tr>
<td>Dislocations²</td>
<td>$50 – $3,000</td>
<td>$100 – $6,000</td>
</tr>
<tr>
<td>Second and Third Degree Burns</td>
<td>$50 – $5,000</td>
<td>$100 – $10,000</td>
</tr>
<tr>
<td>Concussions</td>
<td>$200</td>
<td>$400</td>
</tr>
<tr>
<td>Cuts/Lacerations</td>
<td>$25 – $200</td>
<td>$50 – $400</td>
</tr>
<tr>
<td>Eye Injuries</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Medical Services &amp; Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>$200 – $750</td>
<td>$300 – $1,000</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Non-Emergency Care</td>
<td>$25</td>
<td>$50</td>
</tr>
<tr>
<td>Physician Follow-Up</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Therapy Services (including physical therapy)</td>
<td>$15</td>
<td>$25</td>
</tr>
<tr>
<td>Medical Testing Benefit</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Medical Appliances</td>
<td>$50 – $500</td>
<td>$100 – $1,000</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>$100 – $1,000</td>
<td>$200 – $2,000</td>
</tr>
<tr>
<td><strong>Hospital³ Coverage (Accident)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission</td>
<td>$1,000 (non-ICU and ICU) per accident</td>
<td>$2,000 (non-ICU and (ICU) per accident</td>
</tr>
<tr>
<td>Confinement</td>
<td>$100 a day (non-ICU) – up to 31 days</td>
<td>$200 a day (non-ICU) – up to 31 days</td>
</tr>
<tr>
<td></td>
<td>$400 a day (ICU) – up to 31 days</td>
<td></td>
</tr>
</tbody>
</table>
Inpatient Rehab
$100 a day, up to 30 days
$200 a day, up to 30 days

Accidental Death
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of
$25,000
$75,000 for common carrier
$50,000
$150,000 for common carrier

Dismemberment, Loss & Paralysis
Dismemberment, Loss & Paralysis $250 – $10,000 per injury $500 - $50,000 per injury

Other Benefits

BENEFIT PAYMENT EXAMPLE - High Plan
Kathy’s daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly’s face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy’s out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

<table>
<thead>
<tr>
<th>Covered Event</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (ground)</td>
<td>$300</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$200</td>
</tr>
<tr>
<td>Physician Follow-Up</td>
<td>$100</td>
</tr>
<tr>
<td>Medical Testing</td>
<td>$200</td>
</tr>
<tr>
<td>Concussion</td>
<td>$400</td>
</tr>
<tr>
<td>Broken Tooth (repaired by crown)</td>
<td>$200</td>
</tr>
<tr>
<td>Benefits paid by MetLife Group Accident Insurance</td>
<td>$1,400</td>
</tr>
</tbody>
</table>

INSURANCE RATES
MetLife offers competitive group rates and convenient payroll deduction so you don’t have to worry about writing a check or missing a payment! Your employee rates are outlined below.

<table>
<thead>
<tr>
<th>Type</th>
<th>Low Plan Monthly</th>
<th>High Plan Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$3.87</td>
<td>$7.46</td>
</tr>
<tr>
<td>Employee * Spouse</td>
<td>$6.87</td>
<td>$13.16</td>
</tr>
<tr>
<td>Employee * Children</td>
<td>$7.37</td>
<td>$14.20</td>
</tr>
<tr>
<td>Employee * Spouse/Children</td>
<td>$9.29</td>
<td>$17.87</td>
</tr>
</tbody>
</table>

QUESTIONS & ANSWERS
How do I enroll?
Employees will enroll through the Oracle self-service portal located on the intranet.

Who is eligible to enroll?
An employee of Gates on U.S. payroll regularly scheduled to work at least 30 hours per week. If you are a qualified employee regularly scheduled to work at least 30 hours per week; you can choose coverage for your eligible dependents for the benefits described in this Plan Summary. No one may qualify as both a dependent and an employee.

How do I pay for my accident coverage?
Premiums will be conveniently paid through payroll deduction, so you don’t have to worry about writing a check or missing a payment.

What happens if my employment status changes? Can I take my coverage with me?
Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Who do I call for assistance?
Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Individuals with a TTY may call 1-800-855-2880. Please call MetLife directly at 1-855-JOIN-MET (1-855-564-6638), Monday through Friday from 8:00 a.m. to 8 p.m., EST and talk with a benefits consultant.

1 Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
2 Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.
3 Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife’s Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
4 The Hospital Sickness benefit may not be available in the following states: NH, VT and WA. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
5 Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details. Be sure to review other information contained in this booklet for more details about plan benefits, monthly rates and other terms and conditions.
6 The lodging benefit is not available in all states. It provides a benefit for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from insured’s primary residence.
7 The Health Screening Benefit is not available in all states. For Texas sitused policies and Texas residents covered under policies sitused in other states, when the Health Screening Benefit is included in an Accident-only plan, the covered screening measures are: physical exam, blood chemistry panel, complete blood count (CBC), chest x-rays, electrocardiogram (EKG), and electroencephalogram (EEG).
8 Benefit amount is based on a sample MetLife plan design. Actual plan design and plan benefits may vary.
9 Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
10 Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.
Prepaid Legal Services Optional Benefit

General

The Plan's prepaid legal services optional benefit coverage is described in this section. The Plan's prepaid legal services optional benefit is provided by Hyatt Legal Plans, Inc. This Plan optional benefit provides personal legal services for you and your eligible dependents through a panel of participating law firms. Lawyers in this network are called Plan Attorneys in this Plan guide.

How to Get Legal Services

Client Service Center

A member may use the Plan's prepaid legal services optional benefit by calling Hyatt Legal Plans' Client Service Center at 1-800-438-6388 Monday through Friday 8 a.m. to 7 p.m. Eastern Time. You or your eligible dependent, as the case may be, should be prepared to give the last four digits of your Social Security Number. The Client Service Representative who answers the call will:

- Verify the member's eligibility for services;
- Make an initial determination of whether and to what extent the member's case is covered (the Plan Attorney will make the final determination of coverage);
- Give the member a case number which is similar to a claim number (the member will need a new case number for each new case the member has);
- Give to the member the telephone number of the Plan Attorney most convenient to the member; and
- Answer any questions the member has about the prepaid legal services optional benefit as administered by Hyatt Legal Plans, Inc.

The member then calls the Plan Attorney to schedule an appointment at a time convenient to the member. Evening and Saturday appointments are available.

If the member chooses, the member may select a non-Plan Attorney. Also, where there are no participating law firms, the member will be asked to select a non-Plan Attorney. In both of these circumstances, Hyatt Legal Plans, Inc. will reimburse the member for these non-Plan attorneys' fees in accordance with a set fee schedule.

For services to be covered the member must have obtained a case number, retained an attorney and the attorney must begin work on the covered legal matter while the member is eligible to participate and is enrolled in the Plan.

Website

You or your eligible dependent may also use the Plan's prepaid legal services optional benefit by visiting the Hyatt Legal Plans, Inc. web site at www.legalplans.com. Once there, chose the Members Login at the top of the page to bring up a secure page that will require entry of the last four digits of the employee member's Social Security Number and the passcode **4360010**. After entering the employee member's Social Security Number, a page that is specific for member services will appear. On this page, the following options will be shown:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
What Services are Covered

The Plan's prepaid legal services optional benefit entitles a member to receive certain personal legal services. The available benefits are comprehensive, but there are limitations and other conditions which must be met. All benefits are available to you and your eligible dependents, unless otherwise noted.

Advice and Consultation

Office Consultation and Telephone Advice

This service provides the member with the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the member's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan's prepaid legal services optional benefit, and will undertake representation if the member so requests. If representation is covered by the Plan's prepaid legal services optional benefit, the member will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Plan, the Plan Attorney will provide a written fee statement in advance. The member may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a member may use this service; however, for a non-covered matter, this service is not intended to provide the member with continuing access to a Plan Attorney in order to seek advice that would allow the member to undertake his or her own representation.

Consumer Protection

Consumer Protection Matters

This service covers the member as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction. The controversy must be evidenced by a written document such as a sales slip, contract, note, or warranty. This service does not include disputes over real estate, construction, insurance, or collection activities after a judgment.

Small Claims Assistance

This service covers counseling the member on prosecuting a small claims action; helping the member prepare documents; advising the member on evidence, documentation, and witnesses; and preparing the member for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.

Personal Property Protection

This service covers counseling the member over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements, or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits, and demand letters.
Debt Matters

Debt Collection Defense
This service provides the member with an attorney’s services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession, or garnishment, up to and including trial if necessary. It does not include vacating a judgment; counter, cross, or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Plan Sponsor or a related entity.

Identity Theft Defense
This service provides the member with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus, and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession, or garnishment, up to and including trial if necessary. The service also provides the member with online help and information about identity theft and prevention. It does not include counter, cross, or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Plan Sponsor or a related entity.

Personal Bankruptcy or Wage Earner Plan
This service covers you and your eligible dependent spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the Plan Sponsor or a related entity, even if you or your eligible dependent spouse chooses to reaffirm that specific debt.

Tax Audits
This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the member’s tax return, negotiating with the agency, advising the member on necessary documentations, and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes, costs of hiring an accountant, or the preparation of any tax returns.

Defense of Civil Lawsuits

Administrative Hearing Representation
This service covers the member in defense of civil proceedings before a municipal, county, state, or federal administrative board, agency, or commission. It does not apply where services are available or are being provided by virtue of a homeowner or vehicle insurance policy. It does not include divorce or post-decree matters, paternity, support, or custody matters, or litigation of a job-related incident.

Civil Litigation Defense
This service covers the member in defense of arbitration proceeding or civil proceeding before a municipal, county, state, or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of
an insurance policy. It does not include divorce or post-decree matters, paternity, support, or custody matters, or litigation of a job-related incident. Services do not include bringing counterclaims, third party, or cross claims, even when this may be part of the defense.

Incompetency Defense

This service covers the member in the defense of any incompetency action, including court hearings when there is a proceeding to find the member incompetent.

Document Preparation

Affidavits

This service covers preparation of any affidavit in which the member is the person making the statement.

Deeds

This service covers the preparation of any deed for which the member is either the grantor or grantee.

Demand Letters

This service covers the preparation of letters that demand money, property, or some other property interest of the member, except an interest that is an excluded service. It also covers mailing demand letters to the addressee and forwarding and explaining any response to the member. Negotiations and representation in litigation are not included.

Document Review

This service covers the review of any personal legal document of the member, such as letters, leases, or purchase agreements.

Elder Law Matters

This service covers counseling the member over the phone or in the office on any personal issues relating to the member's parents as they affect the member. The service includes reviewing documents of the parents to advise the member on the effect on the member. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills, and wills. The service also includes preparing deeds for the parents when the member is either the grantor or the grantee, and preparing promissory notes for the parents when the member is either the payor or the payee.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which the member is the mortgagor. This service does not include documents pertaining to business, commercial, or rental property.

Notes
This service covers the preparation of any promissory note for which the member is the payor or payee.

Family Law

Name Change
This service covers the member for all necessary pleadings and court hearings for a legal name change.

Premarital Agreement
This service covers the preparation of an agreement by you and your fiancé prior to your marriage, outlining how property is to be divided in the event of your separation, divorce, or death. Representation is provided only to you. Your fiancé must have separate counsel or must waive representation.

Uncontested Adoption
This service covers all uncontested governmental agency and stepparent adoptions for you and your eligible dependent spouse. If an adoption becomes contested, your or your eligible dependent spouse must pay all additional legal fees.

Uncontested Guardianship or Conservatorship
This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when you or your eligible dependent spouse is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing, and preparing the initial accounting. If the proceeding becomes contested, your eligible dependent spouse must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings once guardianship or conservatorship has been established.

Immigration Assistance
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents, and helping the member prepare for hearings.

Personal Injury

Personal Injury (25% Network Maximum)
Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the member is the plaintiff) at a maximum fee of 25% of the gross award. It is the member’s responsibility to pay this fee and all costs.
Real Estate Matters

Eviction And Tenant Problems (Primary Residence – Tenant Only)
This service covers the member as a tenant for matters involving leases, security deposits, or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Home Equity Loans (Primary Residence)
This service covers the review or preparation of a home equity loan on the member's primary residence.

Refinancing of Home (Primary Residence)
This service covers the review or preparation, by an attorney representing the member, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation, and taxation), which are involved in the refinancing of a member's primary residence. This benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, or property that is held for any rental, business, investment, or income purpose.

Sale or Purchase of Home (Primary Residence)
This service covers the review or preparation, by an attorney representing the member, of all relevant documents (including construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation, and taxation), which are involved in the purchase or sale of a member's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment, or leases with an option to buy.

Security Deposit Assistance (Primary Residence – Tenant Only)
This service covers counseling the member as a tenant in recovering a security deposit from the member's residential landlord for the member's primary residence, reviewing the lease and other relevant documents, and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the member in prosecuting a small claims action, helping to prepare documents, advising on evidence, documentation, and witnesses, and preparing the member for the small claims trial. This service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.

Traffic and Criminal Matters

Juvenile Court Defense
This service covers the defense of you and your eligible dependent child in any juvenile court matter, provided there is no conflict of interest with the employee member, in which case this service provides
an attorney for you only, including services for parental responsibility.

Restoration Of Driving Privileges
This service covers the member with representation in proceedings to restore the member's driving license.

Traffic Ticket Defense (No DUI)
This service covers representation of the member in defense of any traffic ticket, including traffic misdemeanor offenses, except driving under the influence or vehicular homicide, including court hearings, negotiation with the prosecutor, and trial.

Wills and Estate Planning

Living Wills
This service covers the preparation of a living will for the member.

Powers of Attorney
This service covers the preparation of any power of attorney when the member is granting the power.

Probate (10% Network Discount)
Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the member's responsibility to pay this reduced fee and all costs.

Trusts
This service covers the preparation of revocable and irrevocable trusts for the member. It does not include tax planning or services employed with funding the trust after it is created.

Wills and Codicils
This service covers the preparation of a simple or complex will for the member. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Exclusions
Certain matters are excluded from coverage under the Plan's prepaid legal services optional benefit. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including any employer or statutory benefits;
- Matters involving the Plan Sponsor or related entity, MetLife and affiliates, and Plan Attorneys;
- Matters in which there is a conflict of interest between you and your eligible dependents in
which case services are excluded for your eligible dependents;
 Appeals or class actions;
 Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents;
 Farm and business matters, including rental issues when the member is the landlord;
 Patent, trademark, and copyright matters;
 Costs or fines;
 Frivolous or unethical matters; and
 Matters for which an attorney-client relationship exists prior to the member becoming eligible for benefits under the Plan's prepaid legal services optional benefit.

Confidentiality, Ethics, and Independent Judgment

A member's use of the legal services available under the Plan's prepaid legal services optional benefit is confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about your legal problems or the services you use under the Plan's prepaid legal services optional benefit. The Plan Administrator will have access only to limited statistical information needed for orderly administration of the Plan.

No one will interfere with a Plan Attorney's independent exercise of professional judgment when representing the member. All attorneys' services provided under the Plan's prepaid legal services optional benefit are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to the member. The attorney's relationship is exclusively with the member. Hyatt Legal Plans, Inc., or the law firm providing services under the Plan's prepaid legal services optional benefit is responsible for all services provided by their attorneys.

The Plan has no liability for the conduct of any attorney.

The member has the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan's prepaid legal services optional benefit.

Attorneys will refuse to provide services if the matter is clearly without merit, frivolous, or for the purpose of harassing another person. If the member has a complaint about the legal services received or the conduct of an attorney, he or she can call Hyatt Legal Plans at 800.438.6388 with that complaint. The complaint will be reviewed and the member will receive a response within two business days of the member's call.

The member has the right to retain at his or her own expense any attorney authorized to practice law in the state.

Other Special Rules

In addition to the coverage and exclusions listed, there are certain rules for special situations.

If Other Coverage Is Available

If the member is entitled to receive legal representation provided by any other organization such as a government agency, or if the member is entitled to legal services under any other legal plan, coverage will not be provided under the Plan's prepaid legal services optional benefit. However, if the member is eligible for legal aid or Public Defender services, the member will still be eligible for benefits under the Plan's prepaid legal services option; provided, he or she meets the Plan's eligibility requirements.
If You Are Involved in a Legal Dispute with Your Dependents

You may need legal help with a problem involving your spouse or children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your eligible dependent, only you will be entitled to representation by the Plan Attorney. The dependent will not be covered under the Plan's prepaid legal services optional benefit.

If You Are Involved in a Legal Dispute with Another Employee Member

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

If the Court Awards Attorneys' Fees as Part of a Settlement

If the member is awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for the member's an attorney.

Denials of Eligibility and Benefits and Appeal Procedures

Denial of Eligibility

Hyatt Legal Plans, Inc. verifies eligibility using information provided by your Human Resources Department/Global Benefits Department. When a member calls for services, the member will be advised by Hyatt Legal Plans, Inc. whether he or she is ineligible. If the member is not satisfied with that eligibility determination, the member has the right to a formal review and appeal as described ADMINISTRATIVE CLAIMS in the PLAN ADMINISTRATION INFORMATION section of this Plan guide.

Denial of Coverage

A member will be notified in writing or electronically if Hyatt Legal Plans, Inc. or by any Plan Attorney denies, in whole or in part, coverage for particular legal services. The notice will include: the specific reasons for the denial; reference to the specific Plan provisions on which the denial is based; a description of any additional material or information necessary to process the determination of coverage for particular legal services with an explanation of why this material or information is necessary; and an explanation of and the time limits for the claims review procedure, including the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If the member disagrees with the determination by Hyatt Legal Plans, Inc. or by the Plan Attorney that legal services are not available to him or her under the Plan's prepaid legal services optional benefit, the member may appeal that determination. The member may wish to designate a representative to appeal that determination on his or her behalf. Any such representation is not covered by Hyatt Legal Plan, Inc. To appeal the coverage determination, the member or his or her representative must send a letter to:
The letter should contain the pertinent issues and comments regarding the denial to permit Hyatt Legal Plans, Inc. to examine all the facts and make a final determination with respect to the member's claim for services under the Plan's prepaid legal services optional benefit and must be received by Hyatt Legal Plans, Inc. no later than 60 days after the member received the denial of coverage for legal services. Hyatt Legal Plans, Inc. will provide to the member, upon written request to the address above and free of charge, copies of all documents, records, and other information relevant to the member's claim.

The member's appealed claim must receive a full and fair review by Hyatt Legal Plans, Inc. that takes into account all comments, documents, records, and other information submitted with the member's claim, regardless of whether such information was submitted or considered in the initial denial of coverage. Hyatt Legal Plans, Inc. will issue the Plan's final determination within 60 calendar days of receiving the letter unless special circumstances make a decision within that 60-day period not feasible. In any event, Hyatt Legal Plans, Inc. will decide the member's appealed claim within 120 days after its receipt. If such an extension is required, Hyatt Legal Plans, Inc. will provide a written or electronic notice of the extension to the member prior to the expiration of the 60-day period specifying the circumstances that require the extension and the date upon which a final decision can be expected.

The Director of Administration will provide in writing or electronically the Hyatt Legal Plans, Inc. determination of the member's claim for services under the Plan's prepaid legal services optional benefit. If the determination is adverse, the determination will include the specific reasons for the denial of the reimbursement claim referring the member to the pertinent provisions of the Plan that support the denial. This notice will contain a statement that the member will be provided, upon written request to the Hyatt Legal Plan, Inc. address above and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the member's claim, and a statement regarding the member's right to bring an action under ERISA Section 502(a).

Hyatt Legal Plans, Inc. has the sole discretion to interpret and apply the Plan terms, decide all questions of fact, and determine the time, manner, and amount of benefit payments for the Plan's prepaid legal services optional benefit. Decisions of Hyatt Legal Plans, Inc. in this regard are conclusive and binding.

Flexible Spending and Health Savings Accounts

General

The Plan's general-purpose health flexible spending account, limited-purpose health flexible spending account, dependent care flexible spending account, and health savings account optional benefits are described in this section.

The flexible spending and health savings accounts optional benefits are commonly called pre-tax benefits or accounts.

The Plan offers the following pre-tax accounts:

- Premium expense account;
- Health savings account (HSA);
- General-purpose health flexible spending account (GPHFSA);
- Limited -purpose health flexible spending account (LPHFSA); and
- Dependent care flexible spending account (DCFSA).

The premium expense account lets you pay with pre-tax dollars your share of the annual premiums for the Plan's medical, vision and dental optional benefits for which you and your eligible dependents are enrolled.

If you enroll for the Plan's CDHP medical optional benefit, you can also enroll for the Plan's health savings account optional benefit to help pay the deductible, copays, and co-insurance for medical, prescription, dental, and vision unreimbursable expenses. The general purpose health flexible spending account cannot be elected if you are enrolled in the health savings account. You can enroll in the limited purpose health flexible spending account, if you are enrolled in the Plan's health savings account optional benefit or make contributions to another health savings account. If you enroll in the limited purpose health flexible spending account, you can pay with pre-tax dollars unreimbursed expenses for yourself and your tax-qualified dependents for dental and vision care, as well as medical and prescription fees incurred after you have satisfied the CDHP annual deductible.

If you enroll for the dependent care flexible spending account, you can pay with pre-tax dollars some dependent care expenses that are not otherwise reimbursed.

The portion of your pay that you elect to contribute with your enrollment for the health savings account, the general-purpose or limited purpose health flexible spending account, and/or dependent care flexible spending account plus the portion of your pay that is contributed with your automatic enrollment for the premium expense account for your share of the annual premiums for your elected medical, vision and dental coverage, is not subject to federal income or Social Security/Medicare taxes. In other words, you use tax-free dollars to pay for benefits and expenses that you would otherwise pay with out-of-pocket taxable dollars. As a result, you will have an annual tax savings. Since expenses are paid with your pre-tax dollars, you cannot also claim a federal income tax credit or deduction on your tax return.

Because your taxable compensation is reduced by your contributions for the premium expense account, health savings account, general-purpose or limited purpose health flexible spending account, and/or dependent care flexible spending account, there could be a decrease in your Social Security benefits and other benefits (such as 401(k) plan, pension, disability and life insurance benefits). This is because these other benefits are typically based on your taxable compensation. But the tax savings from your contributions typically will offset any reduction in your other benefits.

**Premium Expense Account**

When you elect enrollment for the Plan's medical, vision and dental optional benefits, you are automatically enrolled in the Plan's premium expense account. This account allows for your share of the annual premiums for the coverage elected for yourself and your eligible dependents for that calendar year to be paid with pre-tax payroll deductions. So your contributions for the premium expense account optional benefit will equal your share of the premiums for the medical, vision and dental optional benefits for which you and your eligible dependents are enrolled. Your pay over the course of the year will be reduced by your premium expense account contributions. If there is any increase or decrease in your premiums for the medical, vision and/or dental optional benefits for which you are enrolled, your premium expense account contributions will be automatically adjusted to reflect the change.
Health Savings Account

Operation

If you enroll for the Plan's CDHP medical optional benefit, you can also enroll for the health savings account optional benefit to help pay copays, deductibles, and co-insurance for medical, prescription, dental, and vision unreimbursable expenses with pre-tax dollars. A health savings account enables you to save, invest, and spend funds for qualified medical expenses on a tax-advantaged basis. Your funds grow tax-free and unused funds roll over from year to year. Once the account is opened, it is always your account, even if you leave Gates. The health savings account is a convenient way to save for future medical expenses.

The Plan’s health savings account optional benefit consists solely for the ability to make pre-tax contributions to the health savings account. This health savings account is administered by Optum Health/UHC. Neither the Plan Sponsor, the Plan Administrator, nor Optum Health/UHC has any authority or control over your health savings account. If you are enrolled in the Plan’s CDHP medical optional benefit and otherwise eligible to contribute to a health savings account under Code Section 223, you are not required to enroll for the health savings account optional benefit. The Plan Sponsor does not endorse the health savings account. For example, you can instead choose a provider other than Optum Health/UHC for your health savings account, but you cannot make pre-tax payroll contributions to that other health savings account through the Plan.

For each calendar year after your first enrollment for the health savings account, you must again enroll for this optional benefit: your enrollment for this optional benefit does not continue from one calendar year to the next.

Eligibility

Not everyone enrolled in the CDHP is eligible to contribute to a health savings account. Internal Revenue Section 223, states the following employee categories are not eligible to contribute to a health savings account:

- Enrolled in Medicare Parts A and/or B
- Eligible to be claimed as a dependent on another individual’s tax return
- Non-US residents
- A veteran who has received veteran’s benefits within the last three months
- Active military
- Enrolled in another medical plan (such as Gates’ PPO or your spouse’s plan) unless the plan is a qualified high deductible plan.

Consult with your tax advisor and Internal Revenue Section 223 for more information including health savings account eligibility requirements, tax treatment, and distributions refer to the Internal Revenue Service Publication 969 Health Savings Accounts and Other Tax-Favored Health Plans. For general information about the administration, contributions and distributions from your health savings account and the terms and conditions of this account see the materials provided to you by Optum Health/UHC when you enrolled in the health savings account optional benefit.

Contributions

When you enroll in the health savings account optional benefit, you will also choose how much to contribute for that particular benefit. You will make this choice based on what you expect to spend for the expenses covered by this optional benefit because your contributions will be used later to pay for those expenses from your account balance as they arise during the calendar year or years beyond.
For a calendar year, this contribution amount cannot exceed the statutory maximum amount that applies for the CDHP optional benefit coverage that you have elected (that is, single or family coverage). For the 2019 calendar year, the statutory maximum contribution for single coverage is $3,500 and $7,000 for family coverage. You can make an additional $1,000 catch-up contribution, if you are age 55 or older in the 2019 calendar year. The maximum annual contribution can be made even if you become eligible after your tax year begins, as long as you are covered under the CDHP on the first day of December and remain in the CDHP for the following 12 months. See IRS publication 969 for additional details. During the Plan year, you may enroll in the health savings account, change your payroll deduction, or end payroll deductions. The amount that you elect to contribute to the health savings account optional benefit for the calendar year will be deducted from your pay over the course of that year. Assuming you have activated your account, as soon as administratively possible, funds will be electronically transmitted to your account.

If your Plan coverage ends due to your ineligibility, you may not continue to make pre-tax payroll contributions under the Plan to your health savings account. But if you are still eligible under Internal Revenue Code Section 223 to make health savings account contributions, you can make them to your health savings account outside the Plan on an after-tax basis. In all cases, your health savings account contributions are not forfeited and you will keep your health savings account if your Plan coverage ends due to your ineligibility.

If you do not remain eligible to contribute to a health savings account under the requirements of Internal Revenue Code Section 223, your contributions for the health savings account optional benefit when you were ineligible to make them should be included in your Federal tax filing gross income and subject to a 10% penalty tax, in most instances.

Distributions

The balance of funds in your health savings account can be used for qualified medical expenses such as prescriptions, dental, vision, medical services, equipment and chiropractic care. Only expenses for “medical care” as defined under Internal Revenue Code Section 213(d) for you and your eligible dependents should be distributed from the health savings account. A general list of medical care expenses that can be distributed from your health savings account is available free of charge from Optum Health/UHC at www.myuhc.com. This information is not tax advice; so, you may wish to consult a tax advisor.

When you activate your health savings account, you can pay for qualified expenses from the balance in your account as follows:

- Use your Optum Health/UHC debit card wherever debit cards are accepted
- Use Optum Health/UHC’s online bill payment to pay your provider directly when the bill arrives
- Order paper checks and pay your provider directly when services are provided

Limits That Apply to Distributions

You may only withdraw funds from your health savings account that are available in your account. You cannot deduct for federal income tax purposes any medical care expense for which you take a distribution from your health savings account. Generally you will not be taxed on the distributions that you receive from your health savings account for your qualified medical care expenses. The Plan Sponsor does not guarantee any specific tax consequences for your health savings account or ineligible distributions, so you may wish to consult a tax advisor. If you use your health savings account funds for expenses that are not qualified by the IRS, you will want to include these funds in your taxable income when filing your annual federal tax return. Health savings account withdrawals made for non-qualified expenses are subject to ordinary income tax and IRS penalties may be applicable. State taxes may also apply. Consult with your tax advisor for details.
Recordkeeping for Tax Purposes

You are responsible for balancing and managing your health savings account. Retain your monthly health savings account statements as well as all receipts for distributions for seven years in the event you are audited by the Internal Revenue Service. The Optum Health/UHC will mail you the following tax forms annually:

- 1099 SA - Postmarked by January 31 showing your annual distributions for the last plan year
- 5498 SA – Postmarked by May 31 showing your annual contributions

Health Flexible Spending Accounts

General-Purpose Health Flexible Spending Account Operation

If you enroll in the general-purpose health flexible spending account, you can pay with pre-tax dollars out-of-pocket medical, prescription, dental, and vision expenses for yourself and your tax qualified dependents that are not reimbursed elsewhere. You are not eligible to participate in the general-purpose health savings account if you are enrolled in the Plan's health savings account optional benefit. You may enroll for the general-purpose health flexible spending account during the Plan's annual open enrollment or as a newly hired or rehired qualified employee. You must again enroll in this optional benefit: your enrollment in this optional benefit does not continue from one calendar year to the next.

If you enroll in the general-purpose health flexible spending account, a recordkeeping account will be set up in your name to keep a record of your contributions and available reimbursements. This account is just a recordkeeping device and is not funded and does not earn any interest. All reimbursements from your health flexible spending account are paid from the Plan Sponsor's general assets. During the last quarter of the calendar year and again during the first 90 days of the next year, Optum Health/UHC will send to you a statement reflecting the balance in your general-purpose health flexible spending recordkeeping account. This statement will be sent to your e-mail address on file with Optum Health/UHC or to your street address, if Optum Health/UHC does not have an e-mail address for you on file. At the same time that it is sent to you, the statement will be posted to your on-line account with Optum Health/UHC at www.myuhc.com.

Limited-Purpose Health Flexible Spending Account Operation

The limited-purpose health flexible spending account is offered to those enrolled in a health savings account. If you enroll in the limited-purpose health flexible spending account, you can pay with pre-tax dollars out-of-pocket qualified dental and vision expenses for yourself and your tax qualified dependents that are not reimbursed elsewhere, and medical and prescription expenses incurred after you have satisfied the CDHP medical plan annual deductible. You may enroll in the limited-purpose health flexible spending account during the Plan's annual open enrollment or as a newly hired or rehired qualified employee. If you are enrolled in the Plan's health savings account optional benefit or make contributions to another health savings account, you can only enroll in the limited-purpose health flexible spending account rather than the general purpose health flexible spending account. For each calendar year after your first enrollment, you must again enroll for this optional benefit: your enrollment for this optional benefit does not continue from one calendar year to the next.
If you enroll for the limited-purpose health flexible spending account, a recordkeeping account will be set up in your name to keep a record of your contributions to and available reimbursements from them. This account is just a recordkeeping device and is not funded and does not earn any interest. All reimbursements from your health flexible spending account are paid from the Plan Sponsor's general assets. During the last quarter of the calendar year and again during the first 90 days of the next year, Optum Health/UHC will send to you a statement reflecting the balance in your general-purpose or limited-purpose health flexible spending recordkeeping account. This statement will be sent to your e-mail address on file with Optum Health/UHC or to your street address, if Optum Health/UHC does not have an e-mail address for you on file. At the same time that it is sent to you, the statement will be posted to your on-line account with Optum Health/UHC at www.myuhc.com.

Contributions

When you enroll for the Plan's general-purpose or limited-purpose health flexible spending account, you will also choose how much to contribute for this optional benefit. In the 2019 calendar year, you can contribute from as little as $260 up to $2,650 to your health flexible spending account. The Internal Revenue Service may change annually the maximum contribution. You choose the amount of your contribution based on what you expect to spend for the expenses covered by the general-purpose health flexible spending account or limited-purpose health flexible spending account. Your contributions will be used later to pay for those expenses as they arise during the calendar year. The amount that you elect to contribute to the general-purpose or limited-purpose health flexible spending account will be deducted from your pay on a pre-tax basis over the course of the year.

Your general purpose and limited purpose health flexible spending account reimbursements are paid by your pre-tax payroll contributions. The full amount of this election (less any prior reimbursements made for the same year) will be available for reimbursement regardless of the amount that you have contributed when you submit your reimbursement request for a particular expense.

Reimbursable Expenses

For an expense to be reimbursable from your general-purpose or limited-purpose health flexible spending account for a particular calendar year, the expense must be incurred during that year. An expense is incurred when the service that gives rise to the expense is provided, not when the expense is paid. An expense that is incurred before the effective date of your election for a calendar year is not reimbursable. Unless you or your eligible dependents has the right to elect COBRA coverage (as described in the CONTINUATION OF COVERAGE section of this guide), an expense that is incurred after your health care flexible spending account terminates is not reimbursable.

General-Purpose Health Flexible Spending Account Reimbursements

Only expenses for "medical care" as defined under Internal Revenue Code Section 213(d) for you and your eligible dependents can be reimbursed by the general-purpose health flexible spending account. Some expenses are not reimbursable, even if they are medical care expenses deductible under Internal Revenue Code Section 213(d). For example, health insurance premiums for any other plan or long-term care expenses are not a medical care expense reimbursable by the general-purpose health flexible spending account. A general list of medical care expenses that can be reimbursed by the general-purpose health flexible spending account is available free of charge from Optum Health/UHC at www.myuhc.com. This information is not tax advice, so, you may wish to consult a tax advisor.

Limited-Purpose Health Flexible Spending Account Reimbursements

Expenses under Internal Revenue Code Section 213(d) for you and your eligible dependents for dental and vision care can be reimbursed by the limited-purpose health flexible spending account, as well as medical and prescription costs incurred after you have satisfied the CDHP annual deductible. A
general list of expenses that can be reimbursed by the limited health flexible spending account is available from Optum Health/UHC at www.myuhc.com. This information is not tax advice so you may wish to consult a tax advisor.

**Limitations That Apply to Reimbursements**

You cannot deduct for federal income tax purposes any medical care expense for which you are reimbursed from your general-purpose or limited-purpose health flexible spending account.

Generally you will not be taxed on the reimbursements that you receive from your general-purpose or limited-purpose health flexible spending account for qualified expenses. The Plan Sponsor does not guarantee any specific tax consequences for your general-purpose or limited-purpose flexible spending account so, you may wish to consult a tax advisor. If you are reimbursed for an expense that is later determined not to be a reimbursable expense, you will be required to repay this amount to the Plan and this amount may be subject to federal income taxes.

**Dependent Care Flexible Spending Account**

**Operation**

If you enroll for the dependent care flexible spending account, you can pay with pre-tax dollars out-of-pocket work-related child and/or adult dependent care expenses that are not reimbursed elsewhere. For example, you cannot be reimbursed for the same expense from your spouse's dependent care flexible spending account that is provided by his or her employer.

You may enroll for the dependent care flexible spending account during the Plan's annual open enrollment or as a newly hired or rehired qualified employee. The amount that you elect to contribute to the dependent care flexible spending account for the year will be deducted on a pre-tax basis from your pay over the course of that year. For each calendar year after your first enrollment for the dependent care flexible spending account, you must again enroll for this optional benefit. Your enrollment for this optional benefit does not continue from one calendar year to the next.

If you enroll for the dependent care flexible spending account, an account will be set up in your name to keep a record of your contributions and reimbursements. This account is just a recordkeeping device and is not funded and does not earn any interest. All reimbursements from your dependent care flexible spending account are paid from the Plan Sponsor's general assets. During the last quarter of the calendar year and again during the first 90 days of the next year, Optum Health/UHC will send to you a statement reflecting the balance in your dependent care flexible spending account. This statement will be sent to your e-mail address on file with Optum Health/UHC or to your street address, if Optum Health/UHC does not have an e-mail address for you on file. At the same time that it is sent to you, the statement will be posted to your on-line account with Optum Health/UHC at www.myuhc.com.

**Contributions**

When you enroll in the Plan's dependent care flexible spending account, you will also choose how much to contribute for this optional benefit. For the 2019 calendar year, you can contribute from as little as $260 up to $5,000 (or, if less, the maximum amount that you have reason to believe when you make your choice will be excludible from your income under Internal Revenue Code Section 129 for that year). The Internal Revenue Service may change annually the maximum contribution. You choose the amount of your contribution based on what you expect to spend for the expenses covered by the dependent care flexible spending account for the calendar year. Your contributions will be used later to pay for those expenses as they arise during the calendar year.
You are eligible to enroll in the dependent care flexible spending account if you have qualified expenses for a tax-qualified dependent and:

- You are married and file with your spouse a joint federal income tax return;
- You are married and file a separate federal income tax return and (1) maintain as your home a household that is (for more than half of the calendar year) the principal place of abode for a qualifying individual (that is, the dependent for whom you can receive reimbursements under the Plan's dependent care flexible spending account); (2) you furnish over half of the cost of maintaining that household during the calendar year; and (3) during the last six months of the calendar year, your spouse is not a member of such household (that is, he or she maintained a separate residence) or;
- You are single or the head of the household for federal income tax purposes
- You are married and reside with your spouse but you file a separate federal income tax return.

Your dependent care flexible spending account funds are paid by your pre-tax payroll contributions. The amount in your account at any time will not exceed the balance in your dependent care flexible spending account.

**Nondiscrimination Testing**

Under the tax code and related federal regulations, the Plan Sponsor must test participation in the dependent care flexible spending account to ensure the Plan does not provide an unfair advantage to highly compensated employees. Depending on the results of the annual tests, contributions of certain employees may be reduced or returned. You will be notified if this affects you.

**Reimbursable Dependent Care Expenses**

The balance of funds in your dependent care flexible spending account can be used for qualified child and adult care expenses. For a dependent care expense to be reimbursable from your dependent care flexible spending account for a particular calendar year, the expense must be incurred during that year. An expense is incurred when the service that gives rise to the expense is provided, not when the expense is paid. A dependent care expense that is incurred before the effective date of your election for a calendar year is not reimbursable. A dependent care expense that is incurred in the same year after your dependent care flexible spending account terminates is reimbursable if there are funds in your account.

**Qualifying Individual**

Only dependent care expenses incurred on behalf of a qualifying individual can be reimbursed under the dependent care flexible spending account. A qualifying individual is:

- A person under age 13 who is your qualifying child under Internal Revenue Code Section 152. In general, this person must have the same principal place of abode as you for more than half of the calendar year, is your child or stepchild (by blood or adoption), foster child, sibling, or stepsibling or a descendent of any of them, and does not provide more than half of his or her own support for that year;
- Any other person (except your spouse) who is your qualifying relative under Internal Revenue Code Section 152. In general, this person must be physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year and is your tax dependent under Internal Revenue Code 152 (but without regard to whether he or she is a dependent of another Code Section 152 dependent, married and filing a joint return, or the gross income limitations for a qualifying relative); or
- Your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the calendar year.

If you are divorced and are the primary custodial parent of your child, he or she is a qualifying
individual even if the child’s noncustodial parent is entitled to claim the federal income tax
dependency exemption for that child.

More information about which of your eligible dependents is a qualifying individual is available from
Optum Health/UHC at www.myuhc.com. This information is not tax advice so you may wish to consult a
tax advisor.

Examples of Reimbursable Dependent Care Expenses

Reimbursable dependent care expenses include:

- Expenses incurred on behalf of your qualifying individual to enable you and your spouse, if
  you are married, to be gainfully employed, which generally means working or looking for
  work. If your spouse is not working or looking for work when the expenses are incurred, he or
  she must be a full-time student or be physically or mentally incapable of self-care. The
  expenses can also be incurred while you are working and your spouse is sleeping (or vice
  versa), if one of you works during the day and the other works at night and sleeps during
  the day.
- Expenses incurred for household services that are attributable to the care of your qualifying
  individual.
- Expenses incurred outside of your household for the care of your qualifying individual under
  age 13 or for your qualifying individual who is age 13 or older and who spends at least
  eight hours per day in your household.
- Expenses incurred for services provided to your qualifying individual by a dependent day
  care center (a facility, including a day camp) that receives payment for providing care to
  more than six nonresident individuals on a regular basis and that complies with all applicable
  state and local laws.
- Expenses for a day camp or similar program to care for your qualifying individual, even if the
  camp specializes in a particular activity (soccer or computers, for example), but
  excluding any separate expense or charge for equipment.
- Expenses for nursery school, preschool, or other similar programs for your qualifying individual.
- Expenses to transport your qualifying individual to or from a place where care is provided
  to him or her when that transportation is provided by the care provider.
- Expenses such as application fees, agency fees, and deposits that related to but are not
  directly the care your qualifying individual, if you must pay the expenses to obtain the
  related care and the related care is provided.

The person who provides the care cannot be your spouse, a parent of your qualifying individual under
age 13 (such as your former spouse who is the child’s noncustodial parent), or a person for whom you
or your spouse are entitled to claim a personal exemption under Internal Revenue Code Section
151(c). If your child provides the care, he or she must be age 19 or older at the end of the calendar
year when the expenses are incurred.

A list of expenses that can be reimbursed by the dependent care flexible spending account is
available from, free of charge, from Optum Health/UHC at www.myuhc.com. This information is not
legal advice; so, you may wish to consult a tax advisor.
Limits on Reimbursements

You cannot claim any other federal tax benefit for the amount of your contributions from your dependent care flexible spending account. But your dependent care expenses in excess of the amount of those contributions may be eligible for the federal dependent care tax credit.

The law limits the tax-free reimbursements from your dependent care flexible spending account for a calendar year to the smallest of the following amounts:

- $5,000 (if you are married and file a joint return or you are a single parent) or $2,500 (if you are married and file a separate return);
- Your taxable compensation for the calendar year; or
- If you are married on the last day of the calendar year, your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself or herself and has the same principal place of abode as you for more than half of that calendar year has deemed monthly earned income of $200 if there is one qualifying individual or $400 for two or more qualifying individuals in your household).

Generally you will not be taxed on the reimbursements that you receive from your dependent care flexible spending account for your dependent care expenses. To qualify for this tax-free treatment, you will be required to include a completed Form 2441 (Child and Dependent Care Expenses) with your annual federal income tax return that you file with the Internal Revenue Service. On the Form 2441 you must list the names and taxpayer identification numbers of any dependent care providers for whose services you claimed reimbursement from your dependent care flexible spending account. If you receive reimbursements from your dependent care flexible spending account in excess of the amount to which you are limited by the tax laws for a calendar year, the reimbursement will be taxable to you. If you are reimbursed for an expense that is later determined not to be a reimbursable dependent care expense, you will be required to repay this amount to the Plan. And this amount may be subject to federal income taxes.

In some cases, you may have more tax savings by including all of your dependent care flexible spending account reimbursements in your income and claiming the dependent care tax credit. For more information about the dependent care tax credit, see IRS Publication No. 503 (Child and Dependent Care Expenses). The Plan Sponsor does not guarantee any specific tax consequences for your dependent care flexible spending account so you may wish to consult a tax advisor.

Flexible Spending Accounts - Distributions

Debit Cards

When you enroll for either or both of the Plan's health or dependent care flexible spending accounts, you will receive a debit card to pay for your medical care and/or dependent care expenses incurred during the plan year. Debit cards can only be used to pay providers that have an eligible merchant code. More information about your debit card is available from Optum Health/UHC or at www.myuhc.com.

Payment of Expenses

You can pay for your qualified expenses with money from your own pocket or with your debit card if the provider has an eligible merchant code and the service was incurred in the plan year.

Flexible Spending Account Claim Form

Whether you pay for your medical and dependent care expenses with money from your own pocket or with your debit card, in most instances you must submit by fax or e-mail a flexible spending account
claim form for each expense. You can obtain this form from Optum Health/UHC or at www.myuhc.com.

For a reimbursable medical care expense, you must include with the flexible spending account claim form the explanation of benefits sent by your medical plan to substantiate deductibles, co-payments, co-insurance, or other expense that is not reimbursed elsewhere, itemized receipts from medical care providers that substantiate the date of service, type of service, cost of service, and name and phone number of the provider. For an over-the-counter medicine or drug expense, you must submit the itemized receipt for the expense with a written prescription from the with the name of the person legally authorized to prescribe that medication in the state where the expense is incurred, or an itemized receipt that contains the state issued RX number if the over-the-counter medication or drug is dispensed by the pharmacist as a prescription.

For a reimbursable dependent care expense, you must include with the flexible spending account claim form itemized receipts that substantiate the date of care, the provider’s tax ID, amounts paid for the care, and the name of the care provider or have this provider sign the certification on the flexible spending account claim form.

Within the time period described below, your completed flexible spending account claim form with any required documents to substantiate the claimed expense, as described above, must be submitted to Optum Health/UHC, see www.myuhc.com for details.

**Time Period for Making Reimbursement Claims**

You may submit reimbursement claims for qualified medical care and/or dependent care expenses that you incur in the calendar year at any time during the calendar year when the expense is incurred and for the first 90 days after the end of that year. At the end of this 90-day period, any contributions that remain in your general purpose or limited purpose health flexible spending account or your dependent care flexible spending account will be forfeited.

If your Plan coverage ends due to your ineligibility, you may submit reimbursement claims for medical care and/or dependent care expenses incurred prior to that termination coverage until the end of the 90-day period immediately following the calendar year when your coverage ends. Also until the end of that 90-day period, you may submit reimbursement claims for dependent care expenses incurred by you for the remainder of the calendar year when your coverage ends. You may only submit reimbursement claims for medical care expenses for the remainder of the calendar year when your Plan coverage ends due to ineligibility, if you are entitled to and do elect continuation of coverage for your general purpose or limited-purpose health flexible savings account optional benefit under the COBRA coverage rules described in this Plan guide.

**Forfeitures of Contributions**

At the end of the 90-day period immediately following the calendar year when your election ends, any contributions that remain in your health flexible spending account or your dependent care flexible spending account will be forfeited. However, if you or your eligible dependent has a timely-filed pending claim for reimbursement at the end of that 90-day period, any contributions that remain in your flexible spending account to which the claim pertains will not be forfeited until, and consistent with, the Plan Administrator's final determination of that claim.

**Flexible Spending Accounts - Claims and Appeals**

**Denial of Eligibility**

The Claims Administrator verifies eligibility using information provided by your Global Benefits
Department. If the member is not satisfied with that determination of eligibility, the member has the right to a formal review and appeal as described ADMINISTRATIVE CLAIMS in the PLAN ADMINISTRATION INFORMATION section of this Plan guide.

Time Frames for Processing Reimbursement Claims

Typically, the Claims Administrator will process a flexible spending account reimbursement claim within the 48 hours after the claim is received. Absent matters beyond the Plan's control, a flexible spending account reimbursement claim will be processed no later than 30 calendar days after the claim is received by the Claims Administrator. If matters beyond the Plan's control prevent processing your claim within those 30 days, the Claims Administrator will notify you in writing of this fact within the 30 calendar days after your reimbursement claim is received and that the period for processing the claim will be extended 15 calendar days. If your reimbursement claim is incomplete, within the 30 calendar days after the claim is received the Claims Administrator will notify you in writing of the information required to complete your claim. You will have 45 calendar days from the date of the Claims Administrator's notice to provide the information described in that notice to complete your reimbursement claim. Once the additional information is received by the Claims Administrator or, if later, at the expiration of the 45-day period, the Claims Administrator will process your reimbursement claim within 15 calendar days.

Dependent Care Flexible Spending Account/Denial of Coverage

A member will be notified in writing or electronically if his or her dependent care flexible spending account reimbursement claim is denied, in whole or in part, by the Claims Administrator. The notice will include: the specific reasons for the denial; reference to the specific Plan provisions on which the denial is based; a description of any additional material or information necessary to process the reimbursement claim with an explanation of why this material or information is necessary; and an explanation of and the time limits for the claims review procedure.

If the member disagrees with the Claims Administrator's determination of his or her claim for reimbursement, the member may appeal that determination. The member may wish to designate a representative to appeal that determination on his or her behalf. To appeal the Claims Administrator's determination, the member or his or her representative must send a letter to the Plan Administrator.

Vice President of Total Rewards
Gates Corporation
1144 Fifteenth Street
Denver, CO 80202

The letter should contain the pertinent issues and comments regarding the denial to permit the Plan Administrator to examine all the facts and make a final determination with respect to the member's claim for dependent care flexible spending account benefits and must be received by the Plan Administrator no later than 60 days after the member received the Claims Administrator's denial of his or her dependent care flexible spending account reimbursement claim. The Plan Administrator will provide to the member, upon written request to the address above and free of charge, copies of all documents, records, and other information relevant to the member's claim.

The member's appealed claim must receive a full and fair review by the Plan Administrator that takes into account all comments, documents, records, and other information submitted with the member's claim, regardless of whether such information was submitted or considered in the initial denial of coverage. The Plan Administrator will issue the Plan's final determination within 60 calendar days of receiving the letter unless special circumstances make a decision within that 60-day not feasible. In any event, the Plan Administrator will decide the member's appealed claim within 120 days after its receipt. If such an extension is required, the Plan Administrator will provide a written or electronic
notice of the extension to the member prior to the expiration of the regular 60-day period specifying the circumstances that require the extension and the date upon which a final decision can be expected.

The Plan Administrator will provide in writing or electronically the Plan's determination of the member's claim for reimbursement to him or her. If the determination is an adverse one, the determination will include the specific reasons for the denial of the reimbursement claim referring the member to the pertinent provisions of the Plan that support the denial. This notice will contain a statement that the member will be provided, upon written request to the Plan Administrator and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the member's claim.

The Plan Administrator has the sole discretion to interpret and apply the Plan terms, decide all questions of fact, and determine the time, manner, and amount of benefit payments for the Plan's dependent flexible spending account optional benefit. Decisions of the Plan Administrator are conclusive and binding.

General and Limited Purpose Health Flexible Spending Accounts/Denial of Coverage

All general and limited purpose health flexible spending accounts claims are considered post-service claims.

A member will be notified in writing or electronically if his or her general or limited purpose health spending account reimbursement claim is denied, in whole or in part, by the Claims Administrator. The notice will include:

- The specific reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to process the reimbursement claim with an explanation of why this material or information is necessary;
- An explanation of the member's right to obtain free of charge and upon written request copies of all documents, records, and other information relating to his or her reimbursement claim, and other information relevant to the claim;
- An explanation of and the time limits for the claims review procedure, including the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- An explanation of the member's right to obtain upon written request the name of any medical or vocational expert whose advice was obtained in connection with the benefit determination, regardless of whether the expert's advice was relied upon for that benefit determination; and
- A statement disclosing any internal rule, guideline, protocol, or other similar criterion that was relied upon for the adverse benefit determination (or a statement disclosing that such rule, guideline, protocol, or other similar criterion was relied upon and that such information will be provided free of charge upon request).

If the member disagrees with the Claims Administrator's determination of his or her claim for reimbursement, the member may appeal that determination. The member may wish to designate a representative to appeal that determination on his or her behalf. To appeal the Claims Administrator's determination, the member or his or her representative must send a letter to the Plan Administrator.

Vice President of Total Rewards
Gates Corporation
1144 Fifteenth Street

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The letter should contain the pertinent issues and comments regarding the denial to permit the Plan Administrator to examine all the facts and make a final determination with respect to the member's claim for health flexible spending account benefits and must be received by the Plan Administrator no later than 180 days after the member received the Claims Administrator's denial of his or her health flexible spending account reimbursement claim.

The member's appealed claim must receive a full and fair review by the Plan Administrator that takes into account all comments, documents, records, and other information submitted with the member's claim, regardless of whether such information was submitted or considered by the Claims Administrator for its initial denial of coverage, and without giving deference to the Claims Administrator's initial benefit decision. If the Plan Administrator's determination on appeal is based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in that medical judgment and who was neither consulted nor a subordinate of any such individual who was consulted for the initial benefit determination.

The Plan Administrator will issue the Plan's final determination within 60 calendar days of receiving the letter with the member's claim appeal.

The Plan Administrator will provide to the member in writing or electronically the Plan's written determination of his or her claim for reimbursement. If the determination is an adverse one, the written determination will include:

- The specific reasons for the denial of the reimbursement claim referring the member to the pertinent provisions of the Plan that support the denial;
- A statement that the member will be provided, upon written request to the Plan Administrator's address above and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the member's claim;
- A statement disclosing any internal rule, guideline, protocol, or other similar criterion that was relied upon for the adverse benefit determination (or a statement disclosing that such rule, guideline, protocol, or other similar criterion was relied upon and that such information will be provided free of charge upon written request by the member); and
- A statement of the member's right to bring a suit under ERISA Section 502(a).

The Plan Administrator has the sole discretion to interpret and apply the Plan terms, decide all questions of fact, and determine the time, manner, and amount of benefit payments for the Plan's general and limited purpose health spending accounts optional benefit. Decisions of the Plan Administrator are conclusive and binding.

Subrogation and Reimbursement

The subrogation and reimbursement provisions in this section of the Plan guide apply in the absence of specific subrogation and reimbursement provisions for a particular Plan benefit.

The member has the obligation to return or refund to the Plan the amount of any benefits paid by the Plan to the member or on the member's behalf if:

- The Plan determines or finds that such benefits were paid in error, or
- A third party is liable for such benefits.

If the member receives benefits under the Plan which arose or were incurred as a result of the negligence or other tortuous or wrongful act of a third party, the Plan shall be subrogated to the member's rights against any such third party or that third party's insurer, and the member must repay the Plan for the benefits received from any amount of money that the member receives from the third
party or the third party's insurer. The repayment will be to the extent of the benefits paid by the Plan, but will not exceed the amount of the payment received by the member from the third party or the third party's insurer. Failure to pay such sums over to the Plan may result in the termination of the member's benefits under the Plan with no opportunity for reinstatement. Upon request, the member must execute and deliver any document required by the Plan to carry out the obligations of this provision. Finally, the Plan may assert a lien or offset the member's entitlement to future benefits in order to protect its rights under the Plan.

The Plan's share of the amount received from the third party or the third party's insurer will not be reduced because the member did not receive the full damages claimed, including attorney's fees and other expenses, unless the Plan agrees in writing to a reduction. Upon the member's written request, the Plan may, in its sole discretion, agree that the amount of reimbursement due to the Plan be reduced by a portion of the reasonable expenses, including attorneys' fees and costs, incurred in prosecuting the claim against the third party, or the third party's insurer. To be effective and enforceable, any such agreement regarding any reduction in the amount of reimbursement owed to the Plan must be confirmed in writing and be signed by an authorized representative of the Plan.

The member's obligation to reimburse the Plan for benefits received will be binding upon the member, the member's heirs and the member's legal representatives regardless of whether:

The payment received from the third party, or its insurer, is the result of:

- A judgment entered in a court of law; or
- An arbitration award; or
- A compromise settlement; or
- Any other arrangement under which the member's claims or demands against the third party or its insurer are compromised, settled, or otherwise resolved; or
- The third party, or its insurer, has admitted liability for the payment; or
- The benefits paid by the Plan are itemized as part of the payment or consideration paid by the third party, or its insurer, or
- The payment received from the third party or the third party's insurer is sufficient to make the member whole pursuant to state law or otherwise; or
- The payment received from the third party was reduced for attorney's fees or other expenses incurred by the member in connection with the recovery against the third party or the third party's insurer.

**No-Fault Automobile Insurance.** If a member owns and operates a motor vehicle on the public highways as defined by the applicable law, the member is required to carry no-fault insurance in states where no-fault laws apply. No-fault insurance covers certain medical and rehabilitation expenses the member may incur in the event the member is injured in an automobile accident.

The Plan is permitted by law to coordinate its coverage with no-fault automobile insurance. If a member is injured in an automobile accident, the automobile insurance must pay all expenses and exhaust coverage before the Plan will become liable for any expenses. The Plan will always be secondary to benefits payable under any automobile insurance, including no-fault insurance and personal protection insurance, under which the member is eligible for benefits. This rule for coordinating benefits with automobile insurance supersedes all other rules in the Plan for coordinating benefits.

The Plan provides coverage only to the extent no-fault insurance is insufficient to pay all the medical expenses and only up to the maximum allowable under the Plan. For this purpose it will be assumed that the minimum state required coverage, or the minimum coverage offered by the insurer (whichever is greater), is in place.

If the member does not have no-fault insurance on the member's vehicle when no-fault insurance is required and the member is injured while riding in or driving the vehicle, benefits under the Plan will be reduced to the extent of the minimum benefits required by the no-fault law.
If a member is involved in an accident as a non-owner operator or a passenger or a pedestrian, the Plan will provide coverage for the member's medical expenses only to the extent any coverage provided under any available automobile insurance is insufficient to pay all of the member's medical expenses and only up to the maximum benefits provided under the Plan.

The member should not waive any rights under any automobile insurance or resulting from an accident, or sign any waivers related to the member's rights under any automobile insurance or resulting from an accident until the member talks to the Plan Administrator. If the member could have received benefits as a result of an accident from any another source but waived the opportunity to do so, the Plan will not pay any of the member's medical expenses that would have been covered by the other source of benefits.

The Plan requires proof that any available no-fault automobile insurance policy has paid all benefits required by law before the Plan makes any payments.

If there is more than one automobile insurance policy that may provide the member with benefits as the result of an accident, the Plan will pay benefits only after all benefits under the no-fault policies are coordinated and paid in accordance with current rules and regulations for automobile no-fault coverage as set forth by state law.

In states where no-fault laws do not apply, the coordination of benefits provisions stated above will apply to the extent permitted by state law and ERISA. The subrogation and reimbursement provisions of the Plan, described elsewhere in this Plan guide, apply in all situations, where a member makes or is entitled to make any recovery under automobile insurance, including no-fault insurance and personal protection insurance.

Workers’ Compensation and Related Employment Coverage

The workers’ compensation and related employment coverage provisions in this section of the Plan guide apply in the absence of specific workers’ compensation and related employment coverage provisions for a particular Plan benefit. If workers’ compensation is mandatory in the member's state of residence, the Plan will make no payment for occupational or work-related illness or injury. This exclusion applies to expenses resulting from occupational injuries or illnesses covered under:

- Occupational disease laws;
- Employer’s liability laws;
- Municipal, state or federal laws; or
- Workers' compensation Acts.

In order to recover benefits from work-related illness or injury, a member must pursue his/her rights under the applicable workers’ compensation act or any of the other sources of payment listed above which may apply to his/her illness or injury.

The Plan will not pay for a work-related injury or illness even if:

- The member fails to file a claim within the filing period allowed by the law.
- The member obtains care which is not authorized by Workers' Compensation.
- The member's company fails to carry the required workers' compensation insurance. In this case, the member's company may be liable for any work related illness or injury expenses.
- The member fails to comply with any other provisions of the law.
Coordination of Benefits

General

The coordination of benefits provisions in this section of the Plan guide apply in the absence of specific coordination of benefits provisions for a particular Plan benefit.

When the employee member or dependent members are covered by more than one plan, "coordination of benefits" rules determine two things:

- Which plan pays first; and
- How much each plan pays.

The following rules establish the order in which benefits will be paid:

- The first coordination rule is that the Plan will always be secondary to benefits payable under any automobile insurance, including no-fault insurance and personal protection insurance, under which the member is eligible for benefits.
- A plan with no coordination of benefits rules will pay benefits before the Plan does.
- The plan that covers the person other than as a dependent, for example as an employee member, subscriber, or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - Secondary to the plan covering the person as a dependent;
  - Primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefit is reversed so that the plan covering the person as an employee member, subscriber, or retiree is secondary and the other plan is primary.
- A plan that covers a person as an employee member who is neither laid off nor retired (or as that employee member's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under the immediately preceding paragraph.
- If an employee member is covered by another active employee plan, the plan under which the employee has been covered for the longest will be deemed to pay its benefits first.
- A plan of a company other than Gates Corporation or any related entity that covers a person as a retiree (or dependent of the retiree) will pay benefits before the Plan if the person retired from the other company after retiring from Gates Corporation or any related entity.
- Subject to the above, if there is more than one medical plan for a family, and both the employee member and spouse cover the dependent children, then the dependent children will be covered first under the plan of the parent or guardian whose birthday comes first in a calendar year. This is called the "birthday rule." The years of the employee member's birth and the spouse's birth do not impact this. So, if one parent has a birthday of March 13 and the other has a birthday of June 27, the plan of the parent whose birthday is March 13 pays medical benefits for the dependents first. If a plan does not have this birthday provision, then the plan which covers the father will pay benefits before the plan which covers the mother, regardless of whether or not the father and mother are married to each other.
- When the person for whom claim is made is a dependent child whose parents are legally separated or divorced:
  - If any court decree has established which parent has the financial responsibility for the child's medical care expenses, then that parent's medical plan takes precedence over any other policy or plan which covers the child as a dependent.
  - If there is no court decree establishing financial responsibility:
    - The medical plan of the parent with custody takes precedence over the plan of the parent who does not have custody.
• If the parent with custody of the child remarries, then the child will be covered first under the plan of the parent with custody and second under the plan of the stepparent.
• If the child is covered as a dependent of the parent without custody, the Plan will pay benefits last.
• If the other plan is the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Plan is primary.
• If the other plan is COBRA continuation coverage for the spouse or child, the Plan is primary.

Medicare

If the member is an employee and eligible for Medicare, the Plan is primary over Medicare for the employee member and enrolled dependents, unless the employee or a dependent suffers from end stage renal disease (ESRD) and becomes eligible for Medicare. In that event, the Plan is primary only for an initial period of time from the first dialysis treatment. If Medicare is primary, the benefits from Medicare will be taken into account, and the benefits will be coordinated between the plans to provide benefits up to the amount the Plan would pay if it were the only source of coverage. Medicare is primary for all Medicare eligible retirees and enrolled dependents.

Recovery of Excess Benefits

If the Plan pays a benefit it wasn't required to make, then the Plan has the right to recover that excess benefit based upon the actual payment made or offset the amount of the overpayment from a future claim payment. Recovery may be sought from among one or more of the following as the Plan shall determine: any person to, for, or with respect to whom such payments were made; any insurance company; health care plan; or other organization. This right of recovery shall be the Plan's alone, and is at its sole discretion. If deemed necessary, the member (or his or her legal representative if a minor or legally dependent) upon request, shall execute and deliver such instruments and papers required and do whatever else is necessary to secure the Plan's rights hereunder.

Miscellaneous

Highly Compensated and Key Employees

In some instances, the Internal Revenue Code limits the pre-tax contributions and benefits for qualified employee members who are highly paid officers and other key employees. If you are within these categories, the amount of pre-tax contributions and/or benefits for you and your eligible dependents may be limited for a particular year so that the Plan as a whole does not unfairly favor qualified employee members who are highly paid and their eligible dependents. Plan experience will dictate whether the pre-tax contributions and/or benefits limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

Tax Consequences

The Plan Sponsor does not guarantee any specific tax consequences for any Plan benefit or for the amounts that you or another member contributes or otherwise pays for any Plan benefit.

Severability

If any term, provision, covenant, or condition of the Plan is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.
No Implied Waiver

Failure by Gates or any related entity or a member to avail itself of a right conferred by the Plan shall in no event be construed as a waiver of its right to enforce said right in the future.

Administrative Policies

The Plan Sponsor may adopt reasonable policies, procedures, and rules that promote orderly administration of the Plan.

Access to Information to Provider Services

The Plan is entitled to receive from any provider who renders service to a member all information reasonably necessary to fulfill the terms of the Plan. Subject to applicable confidentiality requirements, members hereby authorize any provider rendering service hereunder to disclose all facts pertaining to such care and treatment; also, to render reports pertaining to such care or physical condition and permit copying of records by the Plan.

Applications, Statements, Etc.

Members or applicants for membership shall complete and submit such applications, forms or statements as the Plan may reasonably request. Members warrant that all information shown in such applications, forms, or statements is true, correct, and complete. All rights to Plan benefits are subject to the condition that all such information is true, correct, and complete. There is no obligation for coverage if enrollment is incomplete, late, or submitted without proper supporting documentation.

Identification Cards

Cards issued to a member are for identification only. Possession of a card confers no right to services or other benefits under the Plan.

Benefits Do Not Guarantee Employment

Participation in the Plan is not a guarantee of your present or continued employment with Gates. This Plan guide is not a contract for, or a guarantee of, present or continued employment of you by Gates.

Right to Change

The Plan Sponsor has the absolute right in its sole discretion to amend or terminate the Plan or any Plan provision in whole or in part at any time, including any cost sharing arrangements. The Plan Administrator will notify you if an amendment or termination of the Plan or any Plan provision substantially affects your Plan benefits.

The “Hearsay” Disclaimer

Gates is not responsible for Plan information communicated by an employee, or any Claims Administrator or other party who assists with the administration or operation of the Plan, which is contrary to the information in this Plan guide and any other document that governs the terms of this Plan.
General

The Plan's medical, dental, vision, general purpose and limited purpose health flexible spending account, prepaid legal services optional benefit, and the Plan's Personal Resilience Program are subject to the requirements of a federal law called the Employee Retirement Income Security Act of 1974 or "ERISA" for short.

Receive Information About the Plan and Benefits

Under the Plan's Personal Resilience Program and any of the Plan's medical, dental, vision, and general-purpose or limited-purpose health care flexible spending account optional benefits for which you have enrolled, you shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain on written request to the Plan Administrator copies of all documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and an updated Plan document and summary description. The Plan Administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each member with a copy of the Plan's annual report.

Continue Group Health Plan Coverage

Under COBRA, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage with a qualified event under the Plan's Personal Resilience Program, medical, dental, or vision optional benefits for which you have enrolled. In limited situations, COBRA continuation coverage may also be available for you, your spouse or dependents if there is a loss of coverage under the Plan's general-purpose or limited-purpose health flexible spending account. You or your dependents may have to pay for any COBRA continuation coverage. You should review the Plan's COBRA continuation coverage rules in this Plan guide.

Prudent Actions by Plan Fiduciaries

In addition to creating rights under the Plan for you, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries, have a duty to do so prudently and in the interest of you and Plan participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied, 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 provided in the specific claims procedures for the Plan's medical, dental, vision, prepaid legal services, general-purpose or limited-purpose health flexible spending account optional benefits and for the Plan's Personal Resilience Program.

Under ERISA there are steps you can take to enforce the preceding rights. For instance, if you request...
in writing a copy of Plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the claims procedures specified for the Plan's medical, dental, vision, prepaid legal services, and health care flexible spending arrangement optional benefits and the Plan's Personal Resilience Program. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that you are discriminated against for asserting your rights, or the Plan fiduciaries misuse the Plan’s money, you may seek assistance from the U.S. Department of Labor. You also 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 claims is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 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.

Plan Administration Information

General

This section describes the general administration of the Plan. The Plan Administrator is responsible for the general administration of the Plan and is the named fiduciary to the extent not otherwise specified in this Plan guide, any other Plan document or an insurance contract. Unless otherwise specified in this Plan guide or another Plan document or insurance contract, the Plan Administrator has the discretionary authority to construe and interpret the Plan provisions and make factual determinations regarding all aspects of the Plan.

Administrative Claims

There are two types of claims under the Plan: administrative claims and benefits claims. A claim that is not for the payment of a specific plan benefit or service under the Plan, such as an eligibility or enrollment claim, is treated as an administrative claim. A benefits claim is a claim for the payment of a specific benefit or service under the Plan. Claims for the payment of benefits and appeals of denied benefit claims are described in the section of the Plan guide that contains the description of the coverage for the particular claimed benefit.

A claim that is not a claim for the payment of a specific benefit or service under the Plan is treated as an administrative claim. For example, a member who believes that he or she was charged too much for an optional benefit (by incorrect payroll deductions, for example) may make an administrative claim. Also, for example, a claim regarding eligibility and enrollment for the employee assistance program or any optional benefit under the Plan, including disputes due to failure to provide documentation substantiating dependent eligibility and eligibility and enrollment for COBRA coverage, is an administrative claim as is a claim that involves a Plan change or amendment.
All administrative claims must be submitted in writing to:

Vice President of Total rewards  
Gates Corporation  
1144 Fifteenth Street  
Denver, CO 80202

Within 60 days after a written administrative claim is received, the claimant will receive a written notice of the decision. If the claim is denied, in whole or in part, the Plan Administrator will further notify the claimant of his or her right to additional review of the denied claim. If the claimant's request for review is denied in whole or in part and he or she still disagrees with the decision, within 60 days of the date when he or she receive written notice, the claimant must deliver to the Plan Administrator a written request for a final claim determination at the above address. A request for a final claim determination should include any documentation supporting your claim. The claimant will receive written notice of the final claim determination.

For claim disputes relating to a dependent's eligibility for coverage due to failure to provide documentation substantiating his or her eligibility, the claimant should include the documentation that will prove the dependent is eligible (see DOCUMENTATION OF DEPENDENT ELIGIBILITY in the ENROLLMENT section of this Plan guide) along with his or her letter. If approved, coverage will begin retroactively from the date that the appeal was submitted in this event, if your coverage level changed, premiums for coverage will be collected from the date coverage was reinstated. If denied, coverage under the Plan for which you have enrolled the dependent will automatically end at 12:01 a.m. on the first day after the final claim determination.

For claim disputes relating to a dependent's eligibility for coverage due to his or her disability under the Plan's employee assistance program basis benefit and all optional benefits other than the dental optional benefit for a qualified employee of Gates and his or her eligible dependents, the Claims Administrator for the medical optional benefit will determine whether the dependent is disabled under the Plan terms. For claim disputes relating to a dependent's eligibility for coverage due to his or her disability under the Plan's dental optional benefit for a qualified employee of Gates, the Claims Administrator for that dental optional benefit will determine whether the dependent is disabled under the Plan terms.

As to any administrative claim, the Plan Administrator has the ultimate authority and sole discretion to interpret and apply the Plan terms and to determine all questions of fact and eligibility.

General Plan ERISA Facts

| Employer/Plan Sponsor | Gates Corporation *  
|------------------------|----------------------  
| 1144 Fifteenth Street  
| Denver, CO 80202 |
| Employer Identification Number | 84-0857401 |
| Type of Plan | Employee welfare benefit plan providing medical (including major medical, surgical, hospital, pharmacy, dental, vision, health flexible spending account, wellness, personal resilience, critical illness and accident insurance benefits) and prepaid legal services |
| Type of Administration | Plan Administrator, contract administration, and insurer administered |
| Plan Administrator | Vice President of Total Rewards  
| Gates Corporation  
| 1144 Fifteenth Street  
| Denver, CO 80202  
| 1-303-744-5958 |
Agent for Service of Legal Process  | General Counsel  
| Gates Corporation  
| 1144 Fifteenth Street  
| Denver, CO 80202  
| Service of legal process may also be made at the same address upon the Plan Administrator.  

Plan Year End  | December 31. Plan records are kept on a calendar year basis  
Plan Number  | 599  

* Gates Corporation as the Plan Sponsor pays for and is directly liable for the cost of coverage under the Plan's basic and optional benefits as described in the BASIC BENEFIT FACTS AND OPTIONAL BENEFIT FACTS under this PLAN ADMINISTRATION section of the Plan guide.

Basic Benefit Facts

| Employee Assistance Program  | The cost of coverage is paid by the Plan Sponsor from its general assets.  
| Source of contributions and funding |  
| Service Provider | Magellan Behavioral Health, Inc.  
| | 14100 Magellan Plaza Drive  
| | Maryland Heights, MO 63402  
| | 1-800-218-6786  
| | or  
| | Magellan Health Services of California, Inc. — Employer Services  
| | 300 Continental Blvd., Ste 240  
| | El Segundo, CA 90245  
| | 1-800-424-1565 (option 7)  
| | and  
| | www.MagellanAscend.com  

| Claims Administrator/Benefits | Magellan Behavioral Health, Inc.  
| | 14100 Magellan Plaza Drive  
| | Maryland Heights, MO 63402  
| | 1-800-218-6786  
| | or  
| | Magellan Health Services of California, Inc. — Employer Services  
| | 300 Continental Blvd., Ste 240  
| | El Segundo, CA 90245  
| | 1-800-424-1565 (option 7)  
| | and  
| | www.MagellanHealth.com  

| Claims Administrator/Administrative Claims | See ADMINISTRATIVE CLAIMS under PLAN ADMINISTRATION INFORMATION  

| COBRA Administrator | See COBRA ADMINISTRATOR under CONTINUATION OF COVERAGE  

Optional Benefits Facts

| Medical Optional Benefit  | The cost of coverage is paid by qualified employees who are enrolled for this optional benefit generally with pre-tax payroll deductions and by the Plan Sponsor from its general assets. The Plan Sponsor provides the majority of the cost of coverage.  
| Source of contributions and funding |  
| Claims Administrator/Benefits | United Healthcare  
| | P.O. Box 30555  
| | Salt Lake City, UT 84130  
| | 1-866-787-6864  

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<table>
<thead>
<tr>
<th>Claims Administrator/Administrative</th>
<th>See ADMINISTRATIVE CLAIMS under PLAN ADMINISTRATION INFORMATION</th>
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<tbody>
<tr>
<td>COBRA Administrator</td>
<td>See COBRA ADMINISTRATOR under CONTINUATION OF COVERAGE</td>
</tr>
</tbody>
</table>

**Dental Optional Benefit**

<table>
<thead>
<tr>
<th>Source of contributions and funding</th>
<th>The cost of coverage is paid by qualified employees who are enrolled for this optional benefit generally with pre-tax payroll deductions and by the Plan Sponsor from its general assets.</th>
</tr>
</thead>
</table>
| Claims Administrator/Benefits       | MetLife Dental Claims  
El Paso, TX 79998-1282 |
| Claims Administrator/Administrative | See ADMINISTRATIVE CLAIMS under PLAN ADMINISTRATION INFORMATION |
| COBRA Administrator                | See COBRA ADMINISTRATOR under CONTINUATION OF COVERAGE |

**Vision Optional Benefit**

<table>
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<tr>
<th>Source of contributions and funding</th>
<th>The cost of coverage is paid by qualified employees who are enrolled for this optional benefit with pre-tax payroll deductions. Benefits are fully insured by Vision Service Plan Insurance Company. The only source of recovery is from this insurer.</th>
</tr>
</thead>
</table>
| Claims Administrator/Benefits       | Vision Service Plan (VSP)  
333 Quality Drive  
Rancho Cordova, CA 95670  
1-800-877-7195  
www.vsp.com |
| Claims Administrator/Administrative | See ADMINISTRATIVE CLAIMS under PLAN ADMINISTRATION INFORMATION |
| COBRA Administrator                | See COBRA ADMINISTRATOR under CONTINUATION OF COVERAGE |

**Prepaid Legal Services Optional Benefit**

| Claims Administrator/Benefits       | Hyatt Legal Plans, Inc.  
Director of Administration  
Eaton Center  
1111 Superior Ave., Ste 800  
Cleveland, OH 44114-2507 |
| Claims Administrator/Administrative | See ADMINISTRATIVE CLAIMS under PLAN ADMINISTRATION INFORMATION |

**General Purpose And Limited Purpose Health Flexible Spending Accounts**

<table>
<thead>
<tr>
<th>Source of contributions and funding</th>
<th>The benefit is paid by qualified employees who have enrolled for this optional benefit with pre-tax payroll deductions.</th>
</tr>
</thead>
</table>
HIPAA Privacy

General

This Plan guide was amended to comply with the HIPAA privacy requirements. The required amendment immediately follows in this Plan guide section. The amendment is written in technical language to comply with the HIPAA privacy requirements and sets forth obligations between the Plan and Gates as the Plan Sponsor. The amendment does not provide any rights to you or any member under the Plan. Your rights and those of any member under the HIPAA privacy requirements are set forth in a document entitled "Notice of Privacy Practices" which is not a part of this Plan guide.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan administration purposes, the Plan Sponsor agrees to:
Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

Report to the Plan an PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

Make its internal practices, books and records, relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

- Plan Administrator
- Accounting/Finance analysts
- Finance Management staff
- Retirement Department staff
- Legal Department employees
- Global Benefits staff
- Audit staff
- Health, Safety, Environmental staff

The access to and use of PHI by the individuals described above shall be restricted to the Plan administration functions that the Plan Sponsor performs for the Plan. "Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision, dental, and health flexible spending accounts. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

Any person or class of persons described above, who obtains access to or uses PHI in a manner that is contrary to the requirements of this section, shall be subject to the Plan Sponsor's disciplinary policies and procedures up to and including termination of employment. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall modify or revoke any person's access to or use of PHI.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor.
that (a) the Plan documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan and their enrollment status in the available medical options offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Plan's Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers, or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards. These are the restrictions that apply to the Plan Sponsor's storage and transmission of a member's electronic protected health information. The Plan Sponsor has in place appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity and availability of a member's electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the Plan Sponsor described above have access to use or disclose a member's electronic protected health information in accordance with the HIPAA regulations. If the Plan Sponsor discloses any of a member's electronic protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations. The Plan Sponsor will report to the Plan any security incident of which it becomes aware in accordance with the HIPAA regulations.
Medical Optional Benefit

This Summary Plan Description (SPD) describes the benefits under the Plan's coverage options of two Consumer Driven Health Plan (CDHP1 and CDHP2) and preferred provider organization (PPO), including their limitations and exclusions. By learning how coverage works, you can help make the best use of the Plan's medical optional benefit for which you, or you and your eligible dependents elect to participate. The Plan is intended to be compliant with the Patient Protection and Affordable Care Act (PPACA or ACA).

UnitedHealthcare Concierge - Your Medical Plan Concierge

UnitedHealthcare Concierge provides resources that can help you improve your health, while also more effectively addressing the continuing rising costs of health care. This service is available to all enrolled employees and dependents to help you understand your medical plan and help you make the most of it. This service is part of your medical plan and helps you:

- Understand your care options and coverage
- Make decisions about treatment options for you and your family members
- Find a doctor that's right for you
- Resolve your billing and claims issues
- Make sense of your health risks and lab results, and create an action plan for the future

For more information or to utilize this benefit contact UHC at the phone number on back of your UHC ID card.

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-866-755-2648 or 866-787-6864.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800.

Gates Corporation 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 Gates Corporation Employee Welfare Benefit Plan. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
Your rights and responsibilities under the Plan.

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.

**IMPORTANT**
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, Glossary.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Gates Corporation 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 subject to any collective bargaining agreements between the Employer and various unions, if applicable. 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.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare’s goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Gates Corporation is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how Gates Corporation Employee Welfare Benefit Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.
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 find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.

■ 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.

■ Gates Corporation is also referred to as Company.

■ 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

What this section includes:
- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility
You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse, as defined in Section 14, Glossary.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under Gates Corporation Employee Welfare Benefit Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under Gates Corporation Employee Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, Other Important Information.

Cost of Coverage
You and Gates Corporation share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.
Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Gates Corporation reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll
To enroll, call Human Resources within 30 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

**Important**
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins
Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 30 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 30 days of the birth, adoption, or placement.
If You Are Hospitalized When Your Coverage Begins

If you 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 that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify UnitedHealthcare of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
• Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.

• Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).

• You or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).

• You or your Dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your Dependent may enroll in other individual market coverage, through or outside of a Marketplace.

• A strike or lockout involving you or your Spouse.

• A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 30 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

**Note:** Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.
Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Gates Corporation's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Gates Corporation's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:
- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment (PPO coverage only).
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing 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 Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, Plan Highlights. When Designated Network Benefits apply, they are included in and subject to the
same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a Primary Care Physician or PCP.

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 Emergency room Physician, radiologist, anesthesiologist or pathologist.

**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. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare’s Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, Glossary, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

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.
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 when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of healthcare professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use 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 at the number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Gates Corporation or 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.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.
If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Providers
If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers
If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single
Network Physician to provide and coordinate all of your future Covered Health Services.

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

**Eligible Expenses**

Gates Corporation has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Designated Network Benefits and 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 UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

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

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare'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 UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

**For Non-Network Benefits**, Eligible Expenses are based on either of 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 UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.

- If rates have not been negotiated, then one of the following amounts:

  - Eligible Expenses are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following:

    - 50% of CMS for the same or similar laboratory service.
    - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

    - When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
      - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

      - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

      - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

      - For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for
Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

UnitedHealthcare 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 providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

### Don't Forget Your ID Card
Remember to show your 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.

**Annual Deductible**
The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

**Copayment (PPO coverage only)**
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 count toward the Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. 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.
Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar 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 calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

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 (PPO coverage only)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Payments toward the Annual Deductible</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments, except for those Covered Health Services identified in the Section 5, Plan Highlights table that do not apply to the Out-of-Pocket Maximum</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Charges for non-Covered Health Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION 4 - PERSONAL HEALTH SUPPORT and PRIOR AUTHORIZATION

What this section includes:
■ An overview of the Personal Health Support program.
■ Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

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.

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. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support 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 the number on your ID card.

**Prior Authorization**

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section 6, Additional Coverage Details.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization.
before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

**To obtain prior authorization, call the number on the back of your ID card.** This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 6, Additional Coverage Details, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

**Special Note Regarding Medicare**

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, Coordination of Benefits (COB). You are not required to obtain authorization before receiving Covered Health Services.
# Section 5 - Plan Highlights

**What this section includes:**
- Payment Terms and Features.
- Schedule of Benefits.

## Payment Terms and Features for the PPO Coverage

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>Network Amounts</th>
<th>Non-Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture.</td>
<td>$35</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Dental Services-Accident Only.</td>
<td>$35</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Physician's Office Services - Primary Physician.</td>
<td>$35</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Physician's Office Services - Specialist.</td>
<td>$65</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Rehabilitation Services.</td>
<td>$65/$35</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Urgent Care Center Services.</td>
<td>$75</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Virtual Visits.</td>
<td>$35</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Copays do not apply toward the Annual Deductible.
Copays do apply toward the Out-of-Pocket Maximum.

**Annual Deductible**
- Individual. $750 $1,500
- Family (cumulative Annual $1,500 $3,000
The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

### Annual Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th></th>
<th>Network Amounts</th>
<th>Non-Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (single coverage).</td>
<td>$3,500</td>
<td>$12,000</td>
</tr>
<tr>
<td>Family (cumulative Out-of-Pocket Maximum).</td>
<td>$7,900</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

### Lifetime Maximum Benefit

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></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.

Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:
Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).

Schedule of Benefits for the PPO coverage
This table 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>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td>100% after you pay a Copayment of $35 per visit</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Ground and/or Air Ambulance 80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Emergency Ambulance.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Non-Emergency Ambulance. Ground or air ambulance, as the Claims Administrator determines appropriate.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>(The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td><strong>Cancer Services</strong></td>
<td></td>
</tr>
<tr>
<td>For Network Benefits, oncology</td>
<td>Depending upon where the Covered Health Service is provided, Benefits</td>
</tr>
<tr>
<td>services must be received by a</td>
<td>will be the same as those stated under each Covered Health Service</td>
</tr>
<tr>
<td>Designated Provider.</td>
<td>category in this section.</td>
</tr>
<tr>
<td>Depending upon the Covered</td>
<td></td>
</tr>
<tr>
<td>Health Service, Benefit limits</td>
<td></td>
</tr>
<tr>
<td>are the same as those stated</td>
<td></td>
</tr>
<tr>
<td>under the specific Benefit</td>
<td></td>
</tr>
<tr>
<td>category in this section.</td>
<td></td>
</tr>
<tr>
<td>See Cancer Resource Services (CRS) in Section 6, Additional Coverage Details.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cellular and Gene Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>For Network Benefits, Cellular</td>
<td>Depending upon where the Covered Health Service is provided, Benefits</td>
</tr>
<tr>
<td>or Gene Therapy services must be</td>
<td>will be the same as those stated under each Covered Health Service</td>
</tr>
<tr>
<td>received from a Designated</td>
<td>category in this section.</td>
</tr>
<tr>
<td>Provider.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td></td>
</tr>
<tr>
<td>Depending upon the Covered</td>
<td>Depending upon where the Covered Health Service is provided, Benefits</td>
</tr>
<tr>
<td>Health Service, Benefit limits</td>
<td>will be the same as those stated under each Covered Health Service</td>
</tr>
<tr>
<td>are the same as those stated</td>
<td>category in this section.</td>
</tr>
<tr>
<td>under the specific Benefit</td>
<td>category in this section.</td>
</tr>
<tr>
<td>Benefits are available when the</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services are</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>(The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td><strong>Non-Network</strong></td>
</tr>
<tr>
<td>provided by either Network or non-Network providers.</td>
<td>under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td></td>
</tr>
<tr>
<td>Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section. Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section.</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services - Accident Only</strong></td>
<td></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>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>
</tr>
<tr>
<td></td>
<td>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>
</tr>
<tr>
<td>Diabetes Self-Management Items</td>
<td>Benefits for diabetes equipment will be the same as those stated under Durable Medical Equipment in this section.</td>
</tr>
<tr>
<td>■ Diabetes equipment.</td>
<td>Benefits for diabetic supplies may be covered under your Pharmacy Plan.</td>
</tr>
<tr>
<td>■ Diabetes supplies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See Durable Medical Equipment in Section 6, Additional Coverage Details, for limits.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME), Orthotics and Supplies</strong></td>
<td></td>
</tr>
<tr>
<td>■ Physician’s Office</td>
<td>100%</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>■ All other Places of Service</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

See Durable Medical Equipment in Section 6, Additional Coverage Details, for limits.

**Emergency Health Services - Outpatient**

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% after you meet the Annual Deductible</td>
<td>Same as Network</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td>Network</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Gender Dysphoria</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits.</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>See Section 6, Additional Coverage Details, for limits. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider UnitedHealthcare identifies.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Hospital - Inpatient Stay</strong></td>
<td></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Diagnostics - Outpatient</strong></td>
<td></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

- Lab Testing - Outpatient.
<table>
<thead>
<tr>
<th>Covered Health Services: X-Ray and Other Diagnostic Testing - Outpatient.</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
</tr>
<tr>
<td></td>
<td>meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient**  
  ■ Outpatient | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
|  ■ Therapeutic prophylactic injections | 100% | 60% after you meet the Annual Deductible |
|  ■ Freestanding center only | 100% after you pay a $200 Copay | 60% after you meet the Annual Deductible |
| **Mental Health Services**  
  ■ Inpatient. | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
|  ■ Outpatient. | 100% after you pay a Copayment of $35 per visit | 60% after you meet the Annual Deductible |
|  ■ Cognitive Behavioral Therapy (provided by AbiTo) | 100% | 60% after you meet the Annual Deductible |
| **Neurobiological Disorders - Autism Spectrum Disorder Services**  
  ■ Inpatient. | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>Deductible</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a Copayment of $35 per visit</td>
</tr>
<tr>
<td>■ Cognitive Behavioral Therapy (provided by AbilTo)</td>
<td>100%</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Ostomy Supplies</strong></td>
<td></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details for limits.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Pharmaceutical Products - Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td>■ Depo-Provera injection</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td></td>
</tr>
<tr>
<td>■ Physician’s Office</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Specialist Physician.</td>
<td>100% after you pay a $35 Copay</td>
</tr>
<tr>
<td><strong>Physician's Office Services - Sickness and Injury</strong></td>
<td></td>
</tr>
<tr>
<td>■ Primary Physician.</td>
<td>100% after you pay a Copayment of $35 per visit</td>
</tr>
<tr>
<td>■ Specialist Physician.</td>
<td>100% after you pay a Copayment of $65 per visit</td>
</tr>
</tbody>
</table>
In addition to the Copayments stated in this section, the Copayments and or Deductible and Coinsurance 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 under Lab, X-Ray and Diagnostics - Outpatient.
- Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.
- Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Outpatient surgery procedures described under Surgery - Outpatient.
- Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.

<table>
<thead>
<tr>
<th>Covered Health Services1</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Pregnancy – Maternity Services</td>
<td>100% after you pay a Copayment of $35 for the first prenatal care then 80% after</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>the Annual Deductible for all other services (including delivery)</td>
</tr>
<tr>
<td></td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>100%</td>
</tr>
<tr>
<td>■ Physician Office Services.</td>
<td></td>
</tr>
<tr>
<td>■ Lab, X-ray or Other Preventive Tests.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Breast Pumps.</td>
<td>100%</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td>Depending upon where the Covered Health Service is</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
</tr>
<tr>
<td>Provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
<td>provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</strong></td>
<td>100% after you pay a Copayment of $65 per visit 100% after you pay a Copayment of $35 per visit</td>
</tr>
<tr>
<td>■ Cardiac and Pulmonary Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>■ All other Rehabilitation Therapy</td>
<td></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for visit limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Scopnic Procedures - Outpatient Diagnostic and Therapeutic</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders Services</td>
<td></td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>100% after you pay a Copayment of $35 per visit</td>
</tr>
<tr>
<td>Surgery - Outpatient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Therapeutic Treatments - Outpatient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td></td>
</tr>
<tr>
<td>For Network Benefits, transplantation services must be received by a Designated Provider. The Claims Administrator does not require that cornea transplants be performed by a Designated Provider in order for you to receive Network Benefits.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Urgent Care Center Services</strong></td>
<td></td>
</tr>
<tr>
<td>In addition to the Copayment stated in this section, the Copayment, Deductible and Coinsurance for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</td>
<td>100% after you pay a Copayment of $75 per visit</td>
</tr>
<tr>
<td>■ Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostics - Outpatient.</td>
<td>60% after you meet the Annual Deductible</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>
</tr>
<tr>
<td>■ Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic.</td>
<td></td>
</tr>
<tr>
<td>■ Outpatient surgery procedures described under Surgery - Outpatient.</td>
<td></td>
</tr>
<tr>
<td>■ Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</td>
<td></td>
</tr>
</tbody>
</table>

**Urgent, non-routine after hours care:**
100% after you pay a Copayment of $75 per visit, then 80% of eligible expenses after satisfying the Annual Deductible to apply to all ancillary services (any services billed outside of a visit charge).
Covered Health Services

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td>Virtual Visits</td>
<td></td>
</tr>
<tr>
<td>Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card.</td>
<td>100% after you pay a Copayment of $35 per visit</td>
</tr>
<tr>
<td>Wigs</td>
<td>100%</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
</tbody>
</table>

1Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 6, Additional Coverage Details.

Payment Terms and Features for the CDHP1 coverage

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Designated Network and Network Amounts</th>
<th>Non-Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Premium Provider</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Tier 2 Non Premium Provider</td>
<td>70% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Plan Features</strong></td>
<td><strong>Designated Network and Network Amounts</strong></td>
<td><strong>Non-Network Amounts</strong></td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Individual.</td>
<td>Network $1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>■ Family (cumulative Annual Deductible).</td>
<td>Network $3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Designated Network and Network Amounts</th>
<th>Non-Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Individual (single coverage).</td>
<td>Network $4,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>■ Family (cumulative Out-of-Pocket Maximum).</td>
<td>Network $7,150</td>
<td>$24,000</td>
</tr>
<tr>
<td>The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>Designated Network and Network Amounts</td>
<td>Non-Network Amounts</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Schedule of Benefits for the CDHP1 coverage**
This table 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>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
<th>Designated Network and Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Services</td>
<td></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Ground and/or Air Ambulance 80% after you meet the Annual Deductible</td>
<td>Ground and/or Air Ambulance Same as Network</td>
<td>Ground and/or Air Ambulance Same as Network</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
</tbody>
</table>

1. See Section 6, Additional Coverage Details, for limits.

- Emergency Ambulance.
- Non-Emergency Ambulance. Ground or air ambulance, as the Claims Administrator determines appropriate.

For Network Benefits, oncology services must be received by a Designated Provider.

Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section.

See Cancer Resource Services (CRS) in Section 6, Additional Coverage Details.
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td><strong>Cellular and Gene Therapy</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Designated Network and Network</strong></td>
</tr>
<tr>
<td>(CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
</tr>
<tr>
<td>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section.</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services - Accident Only</strong></td>
<td><strong>80% after you meet the Annual Deductible</strong></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td><strong>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care</strong></td>
</tr>
<tr>
<td>Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Designated Network and Non-Network</td>
</tr>
<tr>
<td></td>
<td>ot care will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diabetes Self-Management Items</td>
<td></td>
</tr>
<tr>
<td>■ Diabetes equipment.</td>
<td>Benefits for diabetes equipment will be the same as those stated under Durable Medical Equipment in this section.</td>
</tr>
<tr>
<td>■ Diabetes supplies.</td>
<td>Benefits for diabetic supplies may be covered under your Pharmacy Plan.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Orthotics and Supplies</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Office</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient Professional</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>If you are admitted as an</td>
<td>Same as Network</td>
</tr>
</tbody>
</table>

See Durable Medical Equipment in Section 6, Additional Coverage Details, for limits.
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>Inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Gender Dysphoria</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

See Section 6, Additional Coverage Details, for limits.

To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider UnitedHealthcare identifies.
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
<th>Designated Network and Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details, for limits.</td>
<td>Deductible</td>
<td>Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital - Inpatient Stay</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Diagnostics - Outpatient</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Lab testing - Outpatient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ X-ray and Other Diagnostic Testing - Outpatient.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Cognitive Behavioral therapy - (AbilTo)</td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Neurobiological Disorders - Autism Spectrum Disorder Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
<td></td>
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<tr>
<td>--------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
<td></td>
</tr>
<tr>
<td>■ Cognitive Behavioral therapy - (AbilTo)</td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
<td>Deductible 100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>-------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td><strong>Ostomy Supplies</strong></td>
<td>See Section 6, Additional Coverage Details for limits.</td>
<td>80% 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></td>
<td>80% 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></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Physician's Office Services - Sickness and Injury</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Tier 1 - Premium Provider.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Tier 2 - Non - Premium Provider.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Office:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Tier 1 - Premium Provider.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
<td></td>
</tr>
<tr>
<td>■ Tier 2 - Non - Premium Provider.</td>
<td>70% after you meet the Annual Deductible</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
<td></td>
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<tr>
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<td>------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy - Maternity Services</strong></td>
<td>Designated Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td>100% 60% after you meet the Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician Office Services.</td>
<td>100% 60% after you meet the Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Lab, X-ray or Other Preventive Tests.</td>
<td>100% 60% after you meet the Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Breast Pumps.</td>
<td>100% 60% after you meet the Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services 1</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td><strong>Reconstructive Procedures</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See Section 6, Additional Coverage Details, for visit limits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scopic Procedures - Outpatient Diagnostic and Therapeutic</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
<td></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td><strong>Substance-Related and Addictive Disorders Services</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Cognitive Behavioral therapy – (AbilTo)</td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery - Outpatient</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Therapeutic Treatments - Outpatient</strong></td>
<td>80% after you meet the Annual Deductible</td>
<td>60% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Transplantation Services</strong></td>
<td>Depending upon where the Covered Health Service is provided,</td>
<td>Non-Network Benefits are not available</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
<td>Non-Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Health Services

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit</th>
<th>Designated Network and Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center Services</td>
<td>Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</td>
<td>80% after you meet the Annual Deductible</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Virtual Visits</td>
<td>Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card.</td>
<td>80% after you meet the Annual Deductible</td>
<td>Non-Network Benefits are not available.</td>
</tr>
<tr>
<td>Wigs</td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

1Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 6, Additional Coverage Details.

### Payment Terms and Features for the CDHP2 coverage

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Designated Network and Network Amounts</th>
<th>Non-Network Amounts</th>
</tr>
</thead>
</table>

179
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Designated Network and Network Amounts</th>
<th>Non-Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Individual.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Family (cumulative Annual Deductible).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Network</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Plan Features</td>
<td>Designated Network and Network Amounts</td>
<td>Non-Network Amounts</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Individual (single coverage).</td>
<td><strong>Network</strong> $6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>■ Family (cumulative Out-of-Pocket Maximum).</td>
<td><strong>Network</strong> $12,000</td>
<td>$48,000</td>
</tr>
<tr>
<td>The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>Designated Network and Network Amounts</td>
<td>Non-Network Amounts</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Schedule of Benefits for the CDHP2 coverage**

This table 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>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>(The Amount Payable by the Plan based on Eligible Expenses)</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Ground and/or Air Ambulance</td>
</tr>
<tr>
<td>■ Emergency Ambulance.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Non-Emergency Ambulance.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Ground or air ambulance, as the Claims Administrator determines appropriate.</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer Services</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>For Network Benefits, oncology services must be received by a Designated Provider.</td>
<td></td>
</tr>
<tr>
<td>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section.</td>
<td></td>
</tr>
<tr>
<td>See Cancer Resource Services (CRS) in Section 6, Additional Coverage Details.</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
</tr>
<tr>
<td><strong>Cellular and Gene Therapy</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td></td>
<td>Non-Network Benefits are not available</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>50% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>(CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.</td>
<td></td>
</tr>
<tr>
<td>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section.</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Services - Accident Only</strong></td>
<td></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td><em>(The Amount Payable by the Plan based on Eligible Expenses)</em></td>
</tr>
<tr>
<td></td>
<td><strong>Designated Network and Network</strong></td>
</tr>
<tr>
<td></td>
<td>ot care will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Covered Health Services*</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Diabetes Self-Management Items</strong></td>
<td></td>
</tr>
<tr>
<td>■ Diabetes equipment.</td>
<td>Benefits for diabetes equipment will be the same as those stated under Durable Medical Equipment in this section.</td>
</tr>
<tr>
<td>■ Diabetes supplies.</td>
<td>Benefits for diabetic supplies may be covered under your Pharmacy Plan.</td>
</tr>
<tr>
<td></td>
<td>See Durable Medical Equipment in Section 6, Additional Coverage Details, for limits.</td>
</tr>
</tbody>
</table>

| **Durable Medical Equipment (DME), Orthotics and Supplies** | | |
| ■ Office | 80% after you meet the Annual Deductible | 50% after you meet the Annual Deductible |
| ■ Outpatient Professional | 80% after you meet the Annual Deductible | 50% after you meet the Annual Deductible |
| | See Durable Medical Equipment in Section 6, Additional Coverage Details, for limits. | |

<p>| <strong>Emergency Health Services - Outpatient</strong> | <strong>Benefit</strong> (The Amount Payable by the Plan based on Eligible Expenses) |
| If you are admitted as an | | |
| | 80% after you meet the Annual Deductible | Same as Network |</p>
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Non-Emergency</td>
<td></td>
</tr>
<tr>
<td>Gender Dysphoria</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>See Section 6, Additional Coverage Details, for limits. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider UnitedHealthcare identifies.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>See Section 6, Additional Coverage</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Designated Network and Network</strong></td>
</tr>
<tr>
<td>Details, for limits.</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Hospital - Inpatient Stay</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Diagnostics - Outpatient</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Lab testing - Outpatient.</td>
<td></td>
</tr>
<tr>
<td>■ X-ray and Other Diagnostic Testing - Outpatient.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>■ Inpatient.</td>
</tr>
<tr>
<td></td>
<td>■ Outpatient.</td>
</tr>
<tr>
<td></td>
<td>■ Cognitive Behavioral therapy - (AbilTo)</td>
</tr>
<tr>
<td>Neurobiological Disorders - Autism Spectrum Disorder Services</td>
<td>■ Inpatient.</td>
</tr>
<tr>
<td></td>
<td>■ Outpatient.</td>
</tr>
<tr>
<td>Covered Health Services 1</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td></td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Cognitive Behavioral therapy – (AbilTo)</td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Ostomy Supplies</strong></td>
<td>See Section 6, Additional Coverage Details for limits.</td>
</tr>
<tr>
<td><strong>Pharmaceutical Products - Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physician's Office Services - Sickness and Injury</strong></td>
<td></td>
</tr>
<tr>
<td>■ Tier 1 - Premium Provider.</td>
<td></td>
</tr>
<tr>
<td>■ Tier 2 - Non - Premium Provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Office:</strong></td>
<td></td>
</tr>
<tr>
<td>■ Tier 1 - Premium Provider.</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>■ Tier 2 - Non - Premium Provider.</td>
<td>70% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>50% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>

1 Tier 2 - Non - Premium Provider.
### Covered Health Services

**Benefit**  
(The Amount Payable by the Plan based on Eligible Expenses)

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Designated Network and Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnancy - Maternity Services</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. | **Designated Network**  
Benefits will be the same as those stated under each Covered Health Service category in this section.  
**Network**  
Benefits will be the same as those stated under each Covered Health Service category in this section. | |
<p>| <strong>Preventive Care Services</strong> | | |
| ■ Physician Office Services. | 100% | 50% after you meet the Annual Deductible |
| ■ Lab, X-ray or Other Preventive Tests. | 100% | 50% after you meet the Annual Deductible |
| ■ Breast Pumps. | 100% | 50% after you meet the Annual Deductible |</p>
<table>
<thead>
<tr>
<th>Covered Health Services¹</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Designated Network and Network</strong></td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td><strong>Reconstructive Procedures</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for visit limits.</td>
<td></td>
</tr>
<tr>
<td><strong>Scopic Procedures - Outpatient Diagnostic and Therapeutic</strong></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services¹</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>(The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Substance-Related and Addictive Disorders Services</strong></td>
<td></td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td></td>
<td>80% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td></td>
</tr>
<tr>
<td>■ Cognitive Behavioral therapy – (AbilTo)</td>
<td>100% for initial consultation; thereafter 100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Surgery - Outpatient</strong></td>
<td></td>
</tr>
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<td>80% after you meet the Annual Deductible</td>
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<tr>
<td><strong>Therapeutic Treatments - Outpatient</strong></td>
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<td></td>
<td>80% after you meet the Annual Deductible</td>
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<tr>
<td><strong>Transplantation Services</strong></td>
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<td></td>
<td>Depending upon where the Covered Health Service is provided,</td>
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<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
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<td></td>
<td><strong>Designated Network and Network</strong></td>
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<td></td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
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<thead>
<tr>
<th>Covered Health Services¹</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
<th>Designated Network and Network</th>
<th>Non-Network</th>
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<tbody>
<tr>
<td><strong>Urgent Care Center Services</strong>&lt;br&gt;Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</td>
<td>80% after you meet the Annual Deductible</td>
<td>80% after you meet the Annual Deductible</td>
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<tr>
<td><strong>Virtual Visits</strong>&lt;br&gt;Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card.</td>
<td>80% after you meet the Annual Deductible</td>
<td>Non-Network Benefits are not available.</td>
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<tr>
<td><strong>Wigs</strong>&lt;br&gt;See Section 6, Additional Coverage Details, for limits.</td>
<td>100%</td>
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¹Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 6, Additional Coverage Details.
SECTION 6 - ADDITIONAL COVERAGE DETAILS

**What this section includes:**
- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that for which you should obtain prior authorization 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 obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, Exclusions and Limitations.

**Acupuncture Services**

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

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

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Any combination of Network Benefits and Non-Network Benefits is limited to 15 visits per calendar year.
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 non-Emergency 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.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain prior authorization as soon as possible before transport.

Cancer Resource Services (CRS)
The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider 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 the Claims Administrator or a Personal Health Support Nurse.

Call CRS at 1-866-936-6002.


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

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

**Note:** The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with cancer-related services received by a Designated Provider.

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 Provider performing the services (even if you self-refer to a provider in that Network).

**Cellular and Gene Therapy**

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician’s office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

**Prior Authorization Requirement**

For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid.
Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

- Other diseases or disorders 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 qualifying 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 Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
- 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.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI)).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to
meet both of the following criteria:

- Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

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<th>Prior Authorization Requirement</th>
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<tr>
<td>You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises.</td>
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**Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of Fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under Physician Fees for Surgical and Medical Services.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:
- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at www.myoptumhealthcomplexmedical.com.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

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

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

**Note:** The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.
Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization from the Claims Administrator as required

Dental Services - Accident Only
Dental services are covered by the Plan when all of the following are true:

■ Treatment is necessary because of accidental damage.
■ Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
■ The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.)

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

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 immunosuppressive (medication used to reduce inflammation and suppress the immune system).
■ Direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services to repair the damage caused by accidental Injury must conform to the following time-frames: Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care). Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury limited to the following:
■ Emergency examination.
■ Necessary diagnostic X-rays.
■ Endodontic (root canal) treatment.
■ Temporary splinting of teeth.
■ Prefabricated post and core.
■ Simple minimal restorative procedures (fillings).
■ Extractions.
■ Post-traumatic crowns if such are the only clinically acceptable treatment.
■ Replacement of lost teeth due to the Injury by implant, dentures or bridges.

The Plan provides benefits for Dental anesthesia inpatient and outpatient hospital charges including professional services for x-ray, lab and anesthesia while in the hospital if the covered person is a child under 18 or is severely disabled or has a medical condition that requires hospitalization or general anesthesia for dental care treatment that is deemed medically necessary. Dental care for a covered Dependent child who:

■ has a physical, mental or medically compromising condition.
■ Has dental needs for which local anesthesia is not effective because of acute infection, anatomic variation or allergy.
■ Is extremely uncooperative, unmanageable, uncommunicative or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred.
■ Has sustained extensive orofacial and dental trauma.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care
Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies.
- Blood glucose meters, including continuous glucose monitors.

Benefits for diabetic supplies may be covered under the Pharmacy Plan. Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.
**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

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**Durable Medical Equipment (DME), Orthotics and Supplies**

The Plan pays for Durable Medical Equipment (DME), Orthotics and Supplies that are:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.
- Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type beds.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services in this section.
■ Shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics when prescribed by a Physician.

■ 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. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. See Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section.

■ 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. Dental braces are excluded from coverage.

■ Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

Benefits include lymphedema stockings for the arm as required by the Women's Health and Cancer Rights Act of 1998.

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.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Service.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.

Benefits do not include:

■ Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered
Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.

- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.
- Powered exoskeleton devices.

UnitedHealthcare will decide if the equipment should be purchased or rented.

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

This limit does not apply to wound vacuums.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are included in the limits stated above.

To receive Network Benefits, you must purchase, rent, or obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or purchase it directly from the prescribing Network Physician.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment or orthotic once every zero calendar years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every 3 calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.
**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).

**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.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 24 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. 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, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under Eligible Expenses in Section 3, How the Plan Works.

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

**Note:** If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 24 hours or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

**Gender Dysphoria**
Benefits for the treatment of Gender Dysphoria limited to the following services:
Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services in your SPD.

Cross-sex hormone therapy:
- Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under Pharmaceutical Products – Outpatient in your SPD.

Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.

Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

**Male to Female:**
- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchietomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

**Female to Male:**
- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

**Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:**

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria.
The assessment must document that the Covered Person meets all of the following criteria:
- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Prior Authorization Requirement for Surgical Treatment
You must obtain prior authorization as soon as the possibility of surgery arises.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

Home Health Care
Covered Health Services are services that a Home Health Agency 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.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, Glossary for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services.

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<th>Prior Authorization Requirement</th>
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<td>For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods, or as soon as is reasonably possible.</td>
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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 hospice care is received from a licensed hospice agency, which can include a Hospital.

The Plan does not provide benefits for bereavement counseling.

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<tr>
<td>For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.</td>
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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).
- 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 - Outpatient Diagnostic and Therapeutic, and Therapeutic Treatments - Outpatient, respectively.

### Prior Authorization Requirement
For Non-Network Benefits, for:
- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

### 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.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.
Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

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.

**Prior Authorization Requirement**

For Non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization from the Claims Administrator 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.
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

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

**Prior Authorization Requirement**

For Non-Network Benefits for CT, PET scans, MRI, MRA, nuclear medicine, including nuclear cardiology, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received.
Mental Health Services
Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission.

- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.
In addition, for Non-Network Benefits you must obtain prior authorization from the Claim Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Neurobiological Disorders - Autism Spectrum Disorder Services
The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

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

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

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Prior Authorization Requirement**

For Non-Network Benefits for:
- A scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

**Ostomy Supplies**

Benefits for ostomy supplies are limited to:
- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

**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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

**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, Alternate Facility or for Physician house calls.
Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

Covered Health Services include Genetic Counseling.

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 Benefits for the analysis or testing of a lab, radiology/X-rays or other diagnostic service, whether performed in or out of the Physician's office, are described under Lab, X-Ray and Diagnostics - Outpatient.

Prior Authorization Requirement

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing - BRCA.

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

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

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

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

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

**Healthy moms and babies**
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, Clinical Programs and Resources, for details.

**Preventive Care Services**
The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:
Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, Plan Highlights, under Covered Health Services.

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

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

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

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices
Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the Women’s Health and Cancer Rights Act of 1998. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. 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 will 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.

Benefits are available for repairs and replacement, except as described in Section 8, Exclusions and Limitations, under Devices, Appliances and Prosthetics.

**Note:** Prosthetic devices are different from DME - see Durable Medical Equipment (DME) in this section.

**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices 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 a 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 at the number on your ID card 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.

Prior Authorization Requirement

For Non-Network Benefits for you must obtain prior authorization from the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.

Habilitative Services

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

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
■ It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
■ It requires clinical training in order to be delivered safely and effectively.
■ It is not Custodial Care.

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

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

■ The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
■ The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under Durable Medical Equipment and Prosthetic Devices.
Benefits are limited to:

- **30 visits per calendar year for physical therapy.**
- **30 visits per calendar year for occupational therapy.**
- **30 visits per calendar year for speech therapy.**
- **15 visits per calendar year for Manipulative Treatment.**

There are no visit limits for cardiac, pulmonary, cognitive and post-cochlear implant aural therapy.

**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 diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- 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 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.

Benefits that apply to certain preventive screenings are described in this section under Preventive Care Services.

**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:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
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 both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be 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.
- 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.
Any combination of Network Benefits and Non-Network Benefits is limited to 120 days per calendar year.

**Prior Authorization Requirement**
For Non-Network Benefits for a scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission, or as soon as is reasonably possible for non-scheduled admissions.

Substance-Related and Addictive Disorders Services
Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Prior Authorization Requirement**
For Non-Network Benefits for:
■ A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator prior to the admission.

■ A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

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 certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

■ The facility charge and the charge for supplies and equipment.

■ 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.

Prior Authorization Requirement

For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant, blepharoplasty, uvulopalatopharyngoplasty, vein procedures and sleep apnea surgery, cochlear implant and orthognathic surgeries you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.
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.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Prior Authorization Requirement

For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal
or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with transplant services received by a Designated Provider.

Prior Authorization Requirement
For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed by a Designated Provider, Network Benefits will not be paid.

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 quality treatment centers 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's Office Services - Sickness and Injury.

Virtual Visits
Virtual visits for Covered Health Services that include 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. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.

**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.

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

**Wigs**

The Plan pays Benefits for wigs and other scalp hair prosthesis only for the temporary loss of hair resulting from treatment of malignancy.

Any combination of Network Benefits and Non-Network Benefits is limited to $500.00 per calendar year.
SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

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

Gates Corporation believes in giving you tools to help you be an educated health care consumer. To that end, Gates Corporation 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.
- 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 more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Gates Corporation 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, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Health Survey
You are invited to learn more about 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.
NurseLine<sup>SM</sup>

NurseLine<sup>SM</sup> is a 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 to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that Gates Corporation has available that may 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 drug products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine<sup>SM</sup> gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine<sup>SM</sup> is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

**Note:** If you have a medical emergency, call 911 instead of calling NurseLine<sup>SM</sup>.

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

Call NurseLine<sup>SM</sup> any time, 24 hours a day, seven days a week. You can count on NurseLine<sup>SM</sup> to help answer your health questions.

With NurseLine<sup>SM</sup>, you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help 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**.
Decision Support

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

This program offers:

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

Conditions for which this program is available include:

■ Back pain.
■ Knee & hip replacement.
■ Prostate disease.
■ Prostate cancer.
■ Benign uterine conditions.
■ Breast cancer.
■ Coronary disease.

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 the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium Physician, log onto www.myuhc.com or call the number on your ID card.
UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. www.myuhc.com opens the door to a wealth of health information and self-service tools.

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLineSM.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- 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 on www.myuhc.com, simply go to www.myuhc.com and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copays and Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- 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 and supports a Covered Person who has 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 help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies 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 the number on the back of your ID card or call the program directly at 1-866 936-6002.

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

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

These programs offer:

■ Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.

■ Access to educational and self-management resources on a consumer website.

■ An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

- Education about the specific disease and condition.
- Medication management and compliance.
- Reinforcement of on-line behavior modification program goals.
- Preparation and support for upcoming Physician visits.
- Review of psychosocial services and community resources.
- Caregiver status and in-home safety.
- Use of mail-order pharmacy and Network providers.

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 the number on the back of your ID card.

**HealtheNotesSM**

UnitedHealthcare provides a service called HealtheNotesSM. HealtheNotesSM provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotesSM report may include health tips and other wellness information.

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information 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 HealtheNotesSM 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 information UnitedHealthcare provides. 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 the number on the back of your ID card.

**Travel and Lodging Assistance Program**

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility.
Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

**Travel and Lodging Expenses**
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 qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.

- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.

- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.

- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.

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

- The cancer and congenital heart disease programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

**Lodging**

- A per diem rate, up to $50.00 per day, for the patient (when not in the Hospital) or the caregiver.

- Per diem is limited to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation
- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Wellness Programs

Healthy Pregnancy Program
If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.
- 24-hour access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 16 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.
As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: 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 following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited 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 limited 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.
2. Rolfing.
3. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) 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.

4. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

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.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:
- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
- Extractions (including wisdom teeth), restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described
under Dental Services - Accident Only 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. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

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 when prescribed by a Physician as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 6, Additional Coverage Details.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

4. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

5. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

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.

7. Oral appliances for snoring.

**Drugs**

1. Prescription drug products 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. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain specialty medications ordered by a Physician through Caremark.

7. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, Additional Coverage Details.

8. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

10. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

11. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

12. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

13. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

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

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:
- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.

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.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes.
5. Shoe orthotics.
6. Shoe inserts.
7. Arch supports.

**Gender Dysphoria**

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies
1. Prescribed or non-prescribed medical and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment or prosthetics devices for which Benefits are provided as described under Durable Medical Equipment and Prosthetic Devices in Section 6, Additional Coverage Details. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details.
   - Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 6, Additional Coverage Details.

2. Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 6 Additional Coverage Details.

3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.

4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services

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

1. Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion does not apply to medical education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

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

3. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.

4. Foods that are not covered include:

- Enteral feedings and other nutritional and electrolyte formulas, including when administered using a pump, infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). 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.
- Other dietary and electrolyte supplements.

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

Personal Care, Comfort or Convenience
1. Television.
2. Telephone.
4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

- Air conditioners, air purifiers and filters and dehumidifiers.
- Batteries and battery chargers.
- Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.)
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
- Exercise equipment and treadmills.
- Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, Glossary. 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.
- Scar or tattoo 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.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 6, Additional Coverage Details.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prostheses regardless of the reason for the hair loss except for loss of hair resulting from hair loss resulting from treatment of malignancy, in which case the Plan pays up to a maximum of $500 per Covered Person per calendar year.

6. 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.

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


5. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain injury or cerebral vascular accident.
6. Speech therapy to treat stuttering, stammering, or other articulation disorders.

7. Rehabilitation services for speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in Section 6, Additional Coverage Details.

8. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

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

10. Chelation therapy, except to treat heavy metal poisoning.

11. 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.

12. The following treatments for obesity:
   - Non-surgical treatment of obesity, even if for morbid obesity.
   - Surgical treatment of obesity even if there is a diagnosis of morbid obesity.

13. Medical and surgical treatment of excessive sweating (hyperhidrosis).

14. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

15. 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.

16. Helicobacter pylori (H. pylori) serologic testing.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

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

5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

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, or similar legislation if you could elect it, or could have it elected for you.

3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
4. While on active military duty.

5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants
1. Health services for organ and tissue transplants except those described under Transplantation Services in Section 6, Additional Coverage Details unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel
1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging Assistance Program in Section 7, Clinical Programs and Resources. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 6, Additional Coverage Details.

Types of Care
1. Custodial Care or maintenance 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.

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.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

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.

4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

5. Eye exercise or vision therapy.

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.
   - 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.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.

6. In the event a Non-Network provider waives, does not pursue, or fails to collect the Copayment, Coinsurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the Copayment, Coinsurance and/or deductible are waived.

7. Foreign language and sign language interpretation services offered by or required to be provided by a Network or non-Network provider.

8. Long term (more than 30 days) storage of blood, umbilical cord or other material.

9. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, Glossary. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this SPD under Section 6, Additional Coverage Details and in Section 5, Plan Highlights.
   - Not otherwise excluded in this SPD under this Section 8, Exclusions and Limitations.
10. 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.

11. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:

- Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details.
- Related to judicial or administrative proceedings or orders.
- 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.
■ 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 at the phone number on your ID card 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.

If Your Provider Does Not File Your Claim
You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting Human Resources. 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.
■ The number as shown on your ID card.
■ The name, address and tax identification number of the provider of the service(s).
■ A diagnosis from the Physician.
■ The date of service.
■ An itemized bill from the provider that includes:
- A description of, and the charge for, each service.
- The date the Sickness or Injury began.
- 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.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. 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.

Payment of Benefits
You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider without UnitedHealthcare’s consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare’s consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well.
payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 10, Coordination of Benefits.

Form of Payment of Benefits
Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements
Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at 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)
You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. 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 the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 14, Glossary, for the definition of Explanation of Benefits.
**Important - Timely Filing of Non-Network Claims**

All claim forms for non-Network services must be submitted within 12 months after the date of service. 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 at the number on your ID card 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.

**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 below, 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.
- 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 740816  
Atlanta, Georgia 30374-0816

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.
Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:
- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal
UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:
- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

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.

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 their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

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 Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- 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 the number on your ID card 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.
- 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.
- 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.
- 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.
- 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.
- 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 as new 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 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.

- 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 as new 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 at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations
Separate schedules apply to the timing of claims 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.
- **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.
- **Post-Service** - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process.
Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

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

<table>
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<tr>
<th>Type of Request for Benefits or Appeal</th>
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<tbody>
<tr>
<td>UnitedHealthcare must notify you of the appeal decision within:</td>
<td><strong>72 hours</strong> after receiving the appeal</td>
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</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>
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<tbody>
<tr>
<td>If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:</td>
<td><strong>5 days</strong></td>
</tr>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td><strong>15 days</strong></td>
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<tr>
<td>You must then provide completed request for Benefits information to UnitedHealthcare within:</td>
<td><strong>45 days</strong></td>
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<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
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<tr>
<td>■ if the initial request for Benefits is complete, within:</td>
<td><strong>15 days</strong></td>
</tr>
<tr>
<td>■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:</td>
<td><strong>15 days</strong></td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td><strong>180 days</strong> after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td><strong>15 days</strong> 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><strong>60 days</strong> after receiving the first level appeal decision</td>
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</table>
### Pre-Service Request for Benefits*  

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

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
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</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>
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<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 days after receiving the first level appeal</td>
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Post-Service Claims

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<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
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<tbody>
<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 Gates Corporation 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 Gates Corporation 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 Gates Corporation or the Claims Administrator.

You cannot bring any legal action against Gates Corporation 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 Gates Corporation 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 Gates Corporation 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.
- 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.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

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 the toll-free number on your ID card 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

Order of Benefit Determination Rules
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.
- 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.

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 allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

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 allowable expense.

**Determining the Allowable Expense If This Plan is Secondary**

**What is an allowable expense?**

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this plan.
Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the 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 (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge - often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely
enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

**Medicare Crossover Program**
The Plan offers a Medicare Crossover 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 Dependent will also have this automated Crossover, 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 crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) and to expenses under Part B (Physician office visits) and DME Medicare expenses or 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 the telephone number listed on the back of your ID card.

**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 the Plan 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 Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company 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.
- 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 refund is due from the Covered Person and the Covered Person 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, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in
part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will 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

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

**Subrogation - Example**

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

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.
**Reimbursement - Example**

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

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

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

■ The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

■ The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

■ Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or

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characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

■ Benefits paid by the Plan may also be considered to be Benefits advanced.

■ If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

■ By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

■ The Plan's rights to recovery will not be reduced due to your own negligence.

■ By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

■ The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any 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. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- 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.

- 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 any 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.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery
The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

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.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.
SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- 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, Gates Corporation 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.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends.
- The date the Plan ends.
- 12:01 a.m. on the first unpaid day, if the premium payment (including any grace period) for the coverage is not paid in full by the due date.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from Gates Corporation to end your coverage, or the date requested in the notice, if later.
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- 12:01 a.m. on the first unpaid day, if the premium payment (including any grace period) for the coverage is not paid in full by the due date.
- The last day of the month UnitedHealthcare receives written notice from Gates Corporation to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.
Other Events Ending Your Coverage

The Plan will provide at least thirty days' 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and Gates Corporation find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Gates Corporation has the right to demand that you pay back all Benefits Gates Corporation paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond the limiting age if both of the following are true regarding the enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on you for support.

Coverage will continue as long as the enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.

The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. However, the Plan will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan's request as described above, coverage for that child will end.
Continuing Coverage Through COBRA
If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, Glossary.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and Gates Corporation.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCOS)
A qualified medical child support order (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.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCOS from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Gates Corporation
In order to make choices about your health care coverage and treatment, Gates Corporation believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in
which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you 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.

- 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.

Gates Corporation and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Gates Corporation and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Gates Corporation and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Gates Corporation, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Gates Corporation’s agents or employees, nor are they agents or employees of UnitedHealthcare. Gates Corporation and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

Gates Corporation and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Gates Corporation and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare’s credentialing process confirms public information about the providers’ licenses and other credentials, but does not assure the quality of the services provided. They are not Gates Corporation’s employees nor are they employees of UnitedHealthcare. Gates Corporation and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Gates Corporation and UnitedHealthcare are not liable for any act or omission of any provider.
UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Gates Corporation is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You 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.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Gates Corporation is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

Gates Corporation and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.
Gates Corporation and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Gates Corporation may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Gates Corporation does so in any particular case shall not in any way be deemed to require Gates Corporation to do so in other similar cases.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, 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.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare’s reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare’s Network through UnitedHealthcare’s provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare’s reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare’s reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare’s reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by OptumInsight and/or a third party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health
Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare’s website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Information and Records
Gates Corporation and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Gates Corporation and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Gates Corporation and UnitedHealthcare will keep this information confidential. Gates Corporation and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Gates Corporation and UnitedHealthcare with all information or copies of records relating to the services provided to you. Gates Corporation and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee’s enrollment form. Gates Corporation and UnitedHealthcare agree that such information and records will be considered confidential.

Gates Corporation and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Gates Corporation is required to do by law or regulation. During and after the term of the Plan, Gates Corporation and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Gates Corporation recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.
If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, Gates Corporation and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers
Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You
Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but Gates Corporation recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions.
Additional information may be found in Section 7, Clinical Programs and Resources.

Rebates and Other Payments
Gates Corporation and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Gates Corporation and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays or Coinsurance.

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.

Future of the Plan
Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

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 Company 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 the Company and others as may be required by any applicable law.

Plan Document
This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is
available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

**Medicare Eligibility**

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, Coordination of Benefits, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.
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.
- Rehabilitative, laboratory, diagnostic or therapeutic services.
An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

**Amendment** - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

**Annual Deductible (or Deductible)** - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, Plan Highlights.

**Autism Spectrum Disorder** - 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.
Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Gates Corporation. 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.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United HealthCare) and its affiliates, who 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 charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works.

Company - Gates Corporation.

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.
- 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 charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

**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 the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, Plan Highlights and 6, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 2, Introduction.
- Not otherwise excluded in this SPD under Section 8, Exclusions and Limitations.

Covered Person - either the Employee or an enrolled Dependent, but this term applies only while the person is 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 are any of the following:
- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).

- Health-related services that 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.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Deductible** - see Annual Deductible.

**Definitive Drug Test** - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

**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 Network Benefits** - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that the Claims Administrator has identified as Designated Network providers. Refer to Section 5, Plan Highlights, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

**Designated Provider** - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or

- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.
You can find out if your provider is a Designated Provider by contacting the Claims Administrator at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Designated Physician** - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Designated Virtual Network Provider** - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

**DME** - see Durable Medical Equipment (DME).

**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:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

**Eligible Expenses** - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, How the Plan Works.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare'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.

■ As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

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

■ Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

■ Serious impairment to bodily functions.

■ Serious dysfunction of any bodily organ or part.

**Emergency Health Services** - with respect to an Emergency, both of the following:

■ A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.

■ Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

**Employee** - a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under Eligibility in Section 2, Introduction. An Employee must live and/or work in the United States.

**Employee Retirement Income Security Act of 1974 (ERISA)** - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

**Employer** - Gates Corporation.
**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 the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not 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.)

- 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, the Claims Administrator 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, the Claims Administrator 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.
■ The reason(s) why the service or supply was not covered by the Plan.

**Freestanding Facility** - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

**Gender Dysphoria** - A disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

■ Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

■ Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

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.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

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 and that meets both of the following:

- It 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.
- It 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 nursing home, convalescent home or similar institution.

**Hospital-based Facility** - an outpatient facility that performs services and submits claims as part of a Hospital.

**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 Behavioral Therapy (IBT)** - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include Applied Behavior Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI).

**Intensive Outpatient Treatment** - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding 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.
- 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** - Therapeutic application of chiropractic and/or osteopathic 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.

**Medically Necessary** - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

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

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card, and to Physicians and other health care professionals on [UHCprovider.com](http://UHCprovider.com).
Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by Gates Corporation who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

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** - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, Plan Highlights to determine whether or not your Benefit plan offers Network Benefits and Section 3, How the Plan Works, for details about how Network Benefits apply.

**New Pharmaceutical Product** - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

**Non-Network Benefits** - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, Plan Highlights to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, How the Plan Works, for details about how Non-Network Benefits apply.

**Open Enrollment** - the period of time, determined by Gates Corporation, during which eligible Employees may enroll themselves and their Dependents under the Plan. Gates Corporation determines the period of time that is the Open Enrollment period.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar 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.

**Partial Hospitalization/Day Treatment** - a structured ambulatory program that may be a freestanding 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 Product(s)** - U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

**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** - Gates Corporation Medical Plan.

**Plan Administrator** - Gates Corporation or its designee.

**Plan Sponsor** - Gates Corporation.

**Pregnancy** - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

**Prescription Drug List (PDL) Management Committee** - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

**Presumptive Drug Test** - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

**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** - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:
- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

**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** - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.
**Retired Employee** - an Employee who retires while covered under the Plan.

**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** - a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, 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.
- They are not Custodial Care, as defined in this section.

**Skilled Nursing Facility** - a Hospital or 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** - an individual to whom you are legally married.

**Substance-Related and Addictive Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

**Transitional Living** - Mental health services and substance-related and addictive disorder services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**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.

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.

**Urgent Care** - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

**Urgent Care Center** - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.
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 medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, Glossary. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator
Gates Corporation is the Plan Sponsor and Plan Administrator of Gates Corporation Employee Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator - Medical Plan
Gates Corporation
1144 Fifteenth Street
Denver, CO 80202
(303) 744-4780

Claims Administrator
UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

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:
Legal process may also be served on the Plan Administrator.

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.

<table>
<thead>
<tr>
<th><strong>Plan Name:</strong></th>
<th>Gates Corporation Employee Welfare Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Number:</strong></td>
<td>501</td>
</tr>
<tr>
<td><strong>Employer ID:</strong></td>
<td>84-0857401</td>
</tr>
<tr>
<td><strong>Plan Type:</strong></td>
<td>Welfare benefits plan</td>
</tr>
<tr>
<td><strong>Plan Year:</strong></td>
<td>January 1 - December 31</td>
</tr>
<tr>
<td><strong>Plan Administration:</strong></td>
<td>Self-Insured</td>
</tr>
<tr>
<td><strong>Source of Plan Contributions:</strong></td>
<td>Employee and Company</td>
</tr>
<tr>
<td><strong>Source of Benefits:</strong></td>
<td>Assets of the Company</td>
</tr>
</tbody>
</table>

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.
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. Requests for available plan documents should be sent to the address provided under “How to Appeal a Denied Claim” in Section 9, Claims Procedures.

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. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

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 the plan document 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 $147 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 NW 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 1-866-444-3272.

The Plan's Benefits are administered by Gates Corporation, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Gates Corporation 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 Gates Corporation 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 at the number on the back of your ID card.

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 at the number on the back of your ID card.
HEALTH CARE REFORM: REQUIRED LEGAL NOTICE

The Affordable Care Act (ACA) requires Gates Corporation (Gates) provide you with the following information about the new health insurance marketplaces. A “health insurance marketplace” is an online, government-sponsored shopping site where you can buy and compare private health insurance if you are not eligible for Medicare.

THE INDIVIDUAL MANDATE AND WHERE TO GO FOR MEDICAL COVERAGE

Starting January 1, 2014, nearly everyone in the U.S. will be required to have medical coverage or pay a tax penalty. (Certain exceptions apply in cases where you earn below a certain threshold, the cost of coverage is unaffordable, your gap in coverage is less than three continuous months in a year, etc.) This requirement is called the individual mandate.

If you’re eligible for medical coverage through Gates and you enroll in one of our medical plans, you will meet the individual mandate.

If you’re not eligible for a Gates medical plan, or if you’re eligible but don’t want to enroll in a Gates plan, you can get medical coverage through a number of other sources and still satisfy the individual mandate. Other sources may include:

| Your Spouse/ domestic Partner or Parent’s Plan | If your spouse or partner’s employer offers coverage, consider this option. If you’re under age 26, you can also consider your parents’ employers’ coverage, if available. |
| Government-Sponsored Programs | If you meet certain age, disability, income or other qualifications, you may be eligible for a U.S. government-funded medical program, such as Medicare or Medicaid. Find out if you qualify at www.cms.gov. |
| Health Insurance Marketplace or Individual Marketplace | In general, there are 3-4 different levels of health insurance to choose from — each with different levels of cost sharing. Unless you qualify for a subsidy, you’ll pay for 100% of your premiums when you enroll in a marketplace plan. You can visit the federal government’s health care website (www.HealthCare.gov) for a list of the available federal and state marketplaces and to see if you qualify for a subsidy. |

You also have the option to not enroll in health insurance. However, if you choose to be uninsured for any portion of the year you will pay a tax penalty when you file your taxes. (To determine your potential tax penalty, go to www.HealthCare.gov or call 800-318-2596).

What Are the Marketplaces?

To help satisfy the individual mandate, the federal government and many U.S. states have launched public health insurance marketplaces (also known as exchanges). A “health insurance marketplace” is an online public shopping site where you can compare and buy health insurance that meets ACA requirements.

The health insurance marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit (subsidy) that lowers your monthly premium right away.

You’ll hear a lot about the marketplaces from mailings and in the news. You’ll hear many different messages in these advertisements, so remember: Coverage through the marketplace is, in most instances, best suited for people who don’t have access to medical coverage through their employer.

About Gates Coverage:

› Gates will offer medical coverage to regular employees on U.S. payroll scheduled to work 30 hours or more per week.

› Gates offers medical coverage to you and your eligible dependents.

› Gates medical coverage for active employees meets the minimum value and affordability standards required by the ACA.

COBRA Coverage

If you are enrolled in a Gates medical plan under COBRA, that coverage will meet the individual mandate. You should, however, evaluate all available plan options, including marketplace coverage, to determine the most affordable option for you and your family.

ELIGIBILITY FOR A MARKETPLACE SUBSIDY

At least one of Gates medical plans meets the minimum value standard under the ACA and the cost of coverage under this plan is intended to be affordable for active employees. If you are not eligible to participate in Gates medical plans or if the cost of the cheapest Gates medical plan that would cover you (and not other members of your family) is more than 9.5% of your household income for the year, you may be eligible to receive a subsidy for coverage purchased through the Marketplace. In this case, eligibility for a subsidy will depend on your family size, household income and its relation to the federal poverty level.

Note: If you purchase a health plan through the marketplace instead of accepting health coverage offered by Gates, then you will lose the employer contribution toward the cost of medical coverage that is provided to active employees. That’s because you pay the full cost of plans purchased through a marketplace. Additionally, employer contributions — as well as your contribution toward employer-offered coverage — is often excluded from income for federal and state income tax purposes, so you lose the benefit of these tax-favored contributions. Your payments for coverage through the marketplace are made on an after-tax basis.

GATES MEDICAL COVERAGE AND YOU

If You’re Eligible for Gates Medical Coverage

If you’re eligible for a Gates medical plan and you enroll for coverage, you will satisfy the individual mandate. This coverage may be your best medical coverage option because Gates pays for a large portion of the cost for your coverage, and you pay only a small percentage. If you choose to enroll in a medical plan through the marketplace, you won’t have the Gates employer contribution, so you’ll pay 100% of the cost. In addition, at least one of the Gates coverage options for active employees meets the ACA minimum value standard and is intended to be affordable. You may only be eligible to receive government assistance in paying for coverage through the marketplace if the cost of the cheapest Gates medical plan for employee-only coverage is more than 9.5% of your household income for the year.

If You’re Not Eligible for Gates Medical Coverage

If you’re not eligible for medical coverage through Gates and decide to buy medical coverage through the marketplace, you may qualify for a subsidy. Qualifying for a subsidy depends on your family size and your household income. You can apply for medical coverage on a public marketplace website.

Information about health coverage offered by Gates

If you decide to complete an application for coverage in the health insurance marketplace, you’ll be asked to provide the following information:

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gates Corporation</td>
<td>84-0857401</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Address</th>
<th>Employer Phone Number</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1144 Fifteen Street</td>
<td>303-744-4318</td>
<td>Denver</td>
<td>CO</td>
<td>80202</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who can we contact about employee health coverage at this job?</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Benefits Department</td>
<td><a href="mailto:benefitssupport@gates.com">benefitssupport@gates.com</a></td>
</tr>
</tbody>
</table>

An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

This page acts as the legally required notice regarding Health Insurance Marketplaces. Please read it carefully.
FREQUENTLY ASKED QUESTIONS (FAQS)
Here are some questions you may have about health care reform and the answers that we have for them.
Keep in mind, federal guidance on some key areas of this legislation may change, so some answers may change.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I thought everyone is covered under health care reform. Do I need to do anything?</td>
<td>Health care reform gives everyone access to medical coverage, but coverage isn’t automatic or free. If you’re not enrolled in a medical plan and you want to avoid paying a penalty, you must take action and enroll.</td>
</tr>
<tr>
<td>What if I don’t have medical coverage?</td>
<td>You may have to pay a penalty when you file your federal income taxes.</td>
</tr>
<tr>
<td>How much is the penalty if I don’t have medical coverage?</td>
<td>Go online to <a href="http://www.healthcare.gov">www.healthcare.gov</a> or call 1-800-318-2596 for this year’s penalty.</td>
</tr>
<tr>
<td>Can I sign up for medical coverage through Gates?</td>
<td>You’ll be notified if you’re eligible to sign up for medical coverage through Gates.</td>
</tr>
<tr>
<td>If I sign up for medical coverage through Gates, how much will it cost?</td>
<td>The amount you’ll pay generally depends on who you cover and which plan option you select.</td>
</tr>
<tr>
<td>How much will I pay for medical coverage if I get it through the health insurance marketplace?</td>
<td>The cost you pay for coverage through the marketplace will be based on different factors, including your family size, your age(s), your household income, whether you smoke and the plan level you want. For example, cost can vary depending on which deductible and coinsurance levels you choose. You also may be eligible to apply for a subsidy from the federal government.</td>
</tr>
<tr>
<td>Is it true I can get help paying for medical coverage through the health insurance marketplace?</td>
<td>Some people will qualify for subsidies to help them buy medical coverage through the marketplace. If you and your dependents are eligible for medical coverage from Gates, then you will only be eligible for a subsidy through the marketplace if the cost of the cheapest Gates medical plan that would cover you (and not other members of your family) is more than 9.5% of your household income for the year. If you’re not eligible for medical coverage through Gates, your eligibility for a subsidy depends on your family size, household income, and the federal poverty level.</td>
</tr>
<tr>
<td>How do I estimate my household income to see if I qualify for the subsidy?</td>
<td>You may be eligible for the premium subsidy if your household income is below a certain amount. If you apply for coverage in the Marketplace, you’ll learn if you’re eligible for the subsidy and savings on out-of-pocket costs at that time. Visit <a href="http://www.HealthCare.gov">http://www.HealthCare.gov</a> for more information.</td>
</tr>
<tr>
<td>Where do I go to find out about my state’s marketplace?</td>
<td>For more information about the plans being offered through your state’s marketplace, go to <a href="http://www.HealthCare.gov">http://www.HealthCare.gov</a> and click What is the Marketplace in my state? At the bottom of the homepage or call 800-318-2596.</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION
If you have additional questions about how the ACA affects you as a Gates employee, please contact the Global Benefits Department at benefitssupport@gates.com or call 303-744-5794. If you have general questions about the ACA or the exchanges, visit http://www.healthcare.gov or call 800-318-2596.
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.gateshealth.com or call www.gateshealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 866-787-6864 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: $750 Individual / $1,500 Family Non-Network: $1,500 Individual / $3,000 Family per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as “No Charge”.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive Care and categories with copay are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No, there are no other deductibles.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
</tbody>
</table>

### What is the out-of-pocket limit for this plan?

Medical- Network: $3,500 Individual / $7,900 Family Non-Network: $12,000 Individual / $24,000 Family per calendar year

The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must be met.

### What is not included in the out-of-pocket limit?

Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.

Even though you pay these expenses, they don’t count toward the out-of-pocket.
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See myuhc.com or call 866-787-6864 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$35 Copay/visit</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$35 Copay/visit</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$65 Copay/visit</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
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<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% Coinsurance 20% Coinsurance</td>
<td>You pay 20% after deductible for all other services</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance 20% Coinsurance</td>
<td>In/Out of Ntwk- Covered person pays 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 Copay/visit 40% Coinsurance</td>
<td>You pay $75 Copay and 20% after deductible for all other services</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$35 Copay/visit then 0% Coinsurance 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coinsurance 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$35 Copay/initial visit only 40% Coinsurance</td>
<td>Routine prenatal care covered at no charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
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<td>Childbirth/delivery facility services</td>
<td>20% Coinsurance</td>
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<tr>
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<td>Home health care</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
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<td></td>
<td>Rehabilitation services</td>
<td>$35 Copay/visit</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
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<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
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<tr>
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<td>Hospice services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Excluded Services &amp; Other Covered Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</td>
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<td>• Hearing aids</td>
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<td>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</td>
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Does this plan provide Minimum Essential Coverage? Yes
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Language Access Services:
Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwiijigo holne' 866-787-6864.

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About these Coverage Examples:

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<table>
<thead>
<tr>
<th>Peg is Having a Baby  (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes  (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture  (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ The plan’s overall deductible</td>
<td>▪ The plan’s overall deductible</td>
<td>▪ The plan’s overall deductible</td>
</tr>
<tr>
<td></td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td>▪ Specialist copayment</td>
<td>▪ Specialist copayment</td>
<td>▪ Specialist copayment</td>
</tr>
<tr>
<td></td>
<td>$65</td>
<td>$65</td>
</tr>
<tr>
<td>▪ Hospital (facility) coinsurance</td>
<td>▪ Hospital (facility) coinsurance</td>
<td>▪ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>▪ Other coinsurance</td>
<td>▪ Other coinsurance</td>
<td>▪ Other coinsurance</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Example Cost</td>
<td>$12,800</td>
<td>$7,400</td>
</tr>
<tr>
<td>In this example, Peg would pay:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$750</td>
<td>$107</td>
</tr>
<tr>
<td>Copayments</td>
<td>$70</td>
<td>$410</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,480</td>
<td>$27</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$96</td>
<td>$6,041</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$3,396</td>
<td>$6,585</td>
</tr>
</tbody>
</table>
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.gateshealth.com or call www.gateshealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 866-787-6864 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: $750 Individual / $1,500 Family Non-Network: $1,500 Individual / $3,000 Family per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as “No Charge”.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive Care and categories with copay are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No, there are no other deductibles.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Medical-Network: $3,500 Individual / $7,900 Family Non-Network: $12,000 Individual / $24,000 Family per calendar year</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must be met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket.</td>
</tr>
<tr>
<td>Important Questions</td>
<td>Answers</td>
<td>Why This Matters:</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See myuhc.com or call 866-787-6864 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

⚠️ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least) $35 Copay/visit</td>
<td>Out-of-Network Provider (You will pay the most) 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$65 Copay/visit</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Virtual visit - In network $25 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>none</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>----------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic Drugs (Tier 1)</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.caremark.com">www.caremark.com</a></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: N/A Mail Order: N/A</td>
<td>Retail: N/A Mail Order: N/A</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Retail: N/A Mail Order: N/A</td>
<td>Retail: N/A Mail Order: N/A</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>Retail: N/A Mail Order: N/A</td>
<td>Retail: N/A Mail Order: N/A</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
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<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 Copay/visit</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
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<tr>
<td></td>
<td>Physician/surgeon fees</td>
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<td>40% Coinsurance</td>
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<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$35 Copay/visit</td>
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<td>Inpatient services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
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<td>If you are pregnant</td>
<td>Office visits</td>
<td>$35 Copay/initial visit only</td>
<td>40% Coinsurance</td>
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<td>20% Coinsurance</td>
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<td>Not Covered</td>
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- Bariatric Surgery
- Child dental check-up
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- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
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- Private-duty nursing
- Weight loss programs

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible $750
- Specialist copayment $65
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$70</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,480</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $96

The total Peg would pay is $3,396

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible $750
- Specialist copayment $65
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$107</td>
</tr>
<tr>
<td>Copayments</td>
<td>$410</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$27</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $6,041

The total Joe would pay is $6,585

Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible $750
- Specialist copayment $65
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$335</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$276</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $0

The total Mia would pay is $1,361

The plan would be responsible for the other costs of these EXAMPLE covered services.
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.gateshealth.com or call www.gateshealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 866-787-6864 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | **Network**: $1,500 Individual / $3,000 Family  
**Non-Network**: $3,000 Individual / $6,000 Family per calendar year. *Deductibles cross-apply  
Does not apply to services listed below as “No Charge”. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive Care is covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No, there are no other deductibles. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | **Medical-Network**: $4,000 Individual / $7,150 Family  
**Non-Network**: $12,000 Individual / $24,000 Family per calendar year  
*Out-of-pockets cross-apply | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must be met. |
<p>| <strong>What is not included in the out-of-pocket limit?</strong> | Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services. | Even though you pay these expenses, they don’t count toward the out-of-pocket. |</p>
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See myuhc.com or call 866-787-6864 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Virtual visit - In network 20% co-ins [after deductible] by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>40% Coinsurance</td>
<td>Includes preventive health services specified in the health care reform law. You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic Drugs (Tier 1)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% <strong>Coinsurance</strong></td>
<td>20% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% <strong>Coinsurance</strong></td>
<td>20% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% <strong>Coinsurance</strong></td>
<td>20% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>Routine prenatal care covered at no charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you need help</td>
<td>Home health care</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
<td>120 day visit limit annually</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------------------</td>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>30 visits per cal year combined In/out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>120 day visit limit annually</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Acupuncture
- Chiropractic care
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov/ or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your
Does this plan provide Minimum Essential Coverage?  Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards?  Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dinek'ehgo shika a'tohwol ninisingo, kwiijigo holne' 866-787-6864.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
**About these Coverage Examples:**

*This is not a cost estimator.* Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $1,500
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**Total Example Cost**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$1,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $96

**The total Peg would pay is**: $4,096

---

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $1,500
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits *(including disease education)*
- Diagnostic tests *(blood work)*
- Prescription drugs
- Durable medical equipment *(glucose meter)*

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$740</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$740</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$240</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Joe would pay is**: $7,021

---

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $1,500
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$1,305</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,305</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$385</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $1,690

---

The **plan** would be responsible for the other costs of these EXAMPLE covered services.
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

#### Coverage Period:
01/01/2019 - 12/31/2019

#### Coverage for: Employee/Family | Plan Type: PS1

---

#### Important Questions | Answers | Why This Matters:

**What is the overall deductible?**
- **Network**: $1,500 Individual / $3,000 Family
- **Non-Network**: $3,000 Individual / $6,000 Family per calendar year.
  - Deductibles cross-apply
  - Does not apply to services listed below as “No Charge”.

**Why This Matters:**
- Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.

**Are there services covered before you meet your deductible?**
- Yes. Preventive Care is covered before you meet your deductible.

**Why This Matters:**
- This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at [www.healthcare.gov/coverage/preventive-care-benefits/](http://www.healthcare.gov/coverage/preventive-care-benefits/)

**Are there other deductibles for specific services?**
- No, there are no other deductibles.

**Why This Matters:**
- You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

**What is the out-of-pocket limit for this plan?**
- **Medical-Network**: $4,000 Individual / $7,150 Family
- **Non-Network**: $12,000 Individual / $24,000 Family per calendar year
  - Out-of-pockets cross-apply

**Why This Matters:**
- The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must be met.

**What is not included in the out-of-pocket limit?**
- Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.

**Why This Matters:**
- Even though you pay these expenses, they don’t count toward the out-of-pocket.

---

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

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## Important Questions | Answers | Why This Matters:
--- | --- | ---
**Will you pay less if you use a network provider?** | Yes. See myuhc.com or call 866-787-6864 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.  

**Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral.  

---

⚠️ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
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<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>Network Provider</strong> (You will pay the least) 20% Coinsurance</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td></td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic Drugs (Tier 1)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.caremark.com">www.caremark.com</a></td>
<td>Mail Order: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Retail: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs (Tier 4)</td>
<td>Retail: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mail Order: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% <strong>Coinsurance</strong></td>
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</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% <strong>Coinsurance</strong></td>
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</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% <strong>Coinsurance</strong></td>
<td>20% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% <strong>Coinsurance</strong></td>
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</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
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<td>Physician/surgeon fees</td>
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<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td>If you need help</td>
<td>Home health care</td>
<td>20% <strong>Coinsurance</strong></td>
<td>40% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>120 day visit limit annually</td>
</tr>
</tbody>
</table>

*Note: **Coinsurance** indicates the percentage of cost you will pay as determined by your policy.*
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
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<tr>
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<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 visits per cal year combined In/out-of-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>120 day visit limit annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
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<td></td>
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- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
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Language Access Services:
Navajo (Dine): Dine'ehgo shika a'tohwol ninisingo, kwii'jigo holne' 866-787-6864.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby  
(9 months of in-network pre-natal care and a hospital delivery) | Managing Joe’s type 2 Diabetes  
(a year of routine in-network care of a well-controlled condition) | Mia’s Simple Fracture  
(in-network emergency room visit and follow up care) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
</tr>
<tr>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>■ Specialist coinsurance</td>
<td>■ Specialist coinsurance</td>
<td>■ Specialist coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost** $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $96
- The total Peg would pay is $4,096

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$740</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$240</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $6,041
- The total Joe would pay is $7,021

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1305</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$385</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $0
- The total Mia would pay is $1,690

---

The plan would be responsible for the other costs of these EXAMPLE covered services.
CDHP2 Premium Tiering Plan

Coverage Period: 01/01/2019-12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

Coverage for: Employee/Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.gateshealth.com or call www.gateshealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 866-787-6864 to request a copy.

Important Questions | Answers | Why This Matters:
--- | --- | ---
**What is the overall deductible?** | Network*: $3,000 Individual / $6,000 Family  Non-Network*: $6,000 Individual / $12,000 Family per calendar year. *Deductibles cross-apply  Does not apply to services listed below as “No Charge” | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.

**Are there services covered before you meet your deductible?** | Yes. Preventive Care is covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.

**Are there other deductibles for specific services?** | No, there are no other deductibles. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

**What is the out-of-pocket limit for this plan?** | Medical- Network*: $6,000 Individual / $12,000 Family  Non-Network*: $12,000 Individual / $48,000 Family per calendar year *Out-of-pockets cross-apply | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

**What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services. | Even though you pay these expenses, they don’t count toward the out-of-pocket.
## Important Questions | Answers | Why This Matters:
--- | --- | ---
**Will you pay less if you use a network provider?** | Yes. See myuhc.com or call 866-787-6864 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
**Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

---

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least) 20% Coinsurance</td>
<td>Out-of-Network Provider (You will pay the most) 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Virtual visit - In network 20% co-ins [after deductible] by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.

Includes preventive health services specified in the health care reform law. You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
<table>
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<tr>
<td></td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic Drugs (Tier 1)</td>
<td>Retail: N/A</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
</tr>
<tr>
<td></td>
<td>Mail Order: N/A</td>
<td>Retail: N/A</td>
<td>Facility fee (e.g., hospital room)</td>
</tr>
<tr>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
<td>Physician/surgeon fees</td>
</tr>
<tr>
<td></td>
<td>Mail Order: N/A</td>
<td>Retail: N/A</td>
<td>Physician/surgeon fees</td>
</tr>
<tr>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
<td>Physician/surgeon fees</td>
</tr>
<tr>
<td></td>
<td>Mail Order: N/A</td>
<td>Retail: N/A</td>
<td>Physician/surgeon fees</td>
</tr>
<tr>
<td>Specialty drugs (Tier 4)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
<td>Physician/surgeon fees</td>
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<tr>
<td></td>
<td>Mail Order: N/A</td>
<td>Retail: N/A</td>
<td>Physician/surgeon fees</td>
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<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
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<td>Facility fee (e.g., hospital room)</td>
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<td></td>
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<td>If you need immediate medical attention</td>
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<td>Emergency medical transportation</td>
<td>20% Coinsurance</td>
<td>Emergency medical transportation</td>
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<td></td>
<td>Urgent care</td>
<td>20% Coinsurance</td>
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<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
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<td>Physician/surgeon fees</td>
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<td>Outpatient services</td>
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<td></td>
<td>Inpatient services</td>
<td>50% Coinsurance</td>
<td>Inpatient services</td>
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<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% Coinsurance</td>
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<td></td>
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<td>-------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
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</tr>
<tr>
<td>recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>Network Provider (You will pay the least)</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
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Language Access Services:
Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwiijigo holne' 866-787-6864.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Specialist coinsurance</td>
<td>Specialist coinsurance</td>
<td>Specialist coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
<td>$740</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,520</td>
<td>$240</td>
</tr>
</tbody>
</table>

*What isn’t covered*

Limits or exclusions $96

The total Peg would pay is $5,616

**Total Example Cost** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$740</td>
<td>$1,305</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$240</td>
<td>$385</td>
</tr>
</tbody>
</table>

*What isn’t covered*

Limits or exclusions $6,041

The total Joe would pay is $7,021

**Total Example Cost** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,305</td>
<td>$1,305</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$385</td>
<td>$385</td>
</tr>
</tbody>
</table>

*What isn’t covered*

Limits or exclusions $0

The total Mia would pay is $1,690

The plan would be responsible for the other costs of these EXAMPLE covered services.
## CDHP2 Plan

**Coverage Period:** 01/01/2019-12/31/2019

### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

**Coverage for:** Employee/Family | **Plan Type:** PS1

---

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.gateshealth.com or call www.gateshealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 866-787-6864 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network*: $3,000 Individual / $6,000 Family Non-Network*: $6,000 Individual / $12,000 Family per calendar year. *Deductibles cross-apply Does not apply to services listed below as “No Charge”.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive Care is covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No, there are no other deductibles.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Medical- Network*: $6,000 Individual / $12,000 Family Non-Network*: $12,000 Individual / $48,000 Family per calendar year *Out-of-pockets cross-apply</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket.</td>
</tr>
</tbody>
</table>
**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
Will you pay less if you use a network provider? | Yes. See myuhc.com or call 866-787-6864 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist? | No | You can see the specialist you choose without a referral.

---

**Important Information:**

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% Coinsurance</td>
<td>Includes preventive health services specified in the health care reform law. You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic Drugs (Tier 1)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>Retail: N/A</td>
<td>Retail: N/A</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>If you need help</td>
<td>Home health care</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**

- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):

- Acupuncture
- Chiropractic care
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your
Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.
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### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $3,000
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,520</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $5,616

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $3,000
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$740</td>
</tr>
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<table>
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<tr>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $7,021

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $3,000
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,305</td>
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<table>
<thead>
<tr>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $1,690

The plan would be responsible for the other costs of these EXAMPLE covered services.
We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español** (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Y: Nếu quý vị nói tiếng **Việt** (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và địa thoại bảo hiểm (Summary of Benefits and Coverage, SBC) này.
알림: 한국어 (Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyong at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of

تنبيه: إذا كنت تتحدث العربية (Arabic) فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー ダイヤルにてお電話ください。
توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می‌باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Benefits and Coverage, SBC) تماس بگیرید.

وارد عامه‌پرست: این متن به‌عکس همه‌گانه (Hindi) می‌باشد، بنابراین می‌توانید به شماره تلفن رایگان ذکر شده در این خلاصه لایحه و پوشش (Summary of Benefits and Coverage, SBC) که در اینجا به طور کامل ارائه شده، تماس بگیرید.

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

Phnom Penh: ប្រសិនបើមានបញ្ហានោះ (Khmer) ដែលមានបញ្ហាតាមបញ្ហារបស់អ្នក ឬបញ្ហាដែលអ្នកមាន សិស្សដែលមានបញ្ហាតាមបញ្ហារបស់អ្នក ឬបញ្ហាដែលអ្នកមាន (Summary of Benefits and Coverage, SBC) ឬជាមួយ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóó'tí'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'ěasti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'i biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).
ATTACHMENT III - LEGAL NOTICES

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 under the Plan 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.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any 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 obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT IV – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words “Claims Administrator” in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.
United HealthCare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**ATTACHMENT V – GETTING HELP IN OTHER LANGUAGES OR FORMATS**

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translated Taglines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Albanian</td>
<td>Ju keni të drejtë të mëngë ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numër që gjendet në kartën e planit tuaj shëndetësor, shypni 0. TTY 711.</td>
</tr>
<tr>
<td>2 - Amharic</td>
<td>የታConstructed text in Amharic for translation purposes.</td>
</tr>
<tr>
<td>3 - Arabic</td>
<td>تل أحق في الحصول على المساعدة والمعلومات بلغتك دون تكلفة، أي تكلفة. تطلب مترجم فوري، اتصل بقم الهاتف المحمول الخاص بالإعضاء المدرج ببطاقة تعرف العضوية الخاصة بطلق الصمية، واضغط على 0. الهاتف (TTY 711)</td>
</tr>
<tr>
<td>4 - Armenián</td>
<td>Հասարակական ինֆորմացիա և ծանոթություն, որը կարողանում է ամփոփել ինքնուրույն առաջարկություն (ID) անվճար ցանկացած լեզուն եկամտ. Ասեն: հեռախոսակարգումով միջազգային ծանոթություն, սակայն 0•TTY 711</td>
</tr>
<tr>
<td>5 - Bantu-Kinundu</td>
<td>Usa fise uburenganzira bwo kuronka ubufasha n'amakuru mu-rumirimwe ku bantu. Kugana usabe umwumuzi, hamaga inomero y' ubufasha y' ubantu yagenwe abanywanyi iki k' utonde ku karangamintu w' umugambi wawe w' ubusima, fyonda 0. TTY 711.</td>
</tr>
<tr>
<td>6 - Bisayan Visayan (Cebuano)</td>
<td>Aduna kaya katungod nga mangaro og tabang ug impormasyon sa imong lengguwa nga walay bayad. Aton mohangro og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID card sa plano sa panglawas, pindota ang 0. TTY 711.</td>
</tr>
<tr>
<td>7 - Bengali-Bangla</td>
<td>অনুষ্ঠানের অনুসারে পাবলিক পরিকল্পনার আইডি কার্ড ও ট্যাঙ্কিং শীর্ষ অফিস থেকে পরিবহন অথবা কেনাক করা।</td>
</tr>
<tr>
<td>8. → Burmese</td>
<td>စာပေဖြင့် ဖော်ပြပါမည်။ ကြမ်းချင်သော အချက်အလက်များအား ဖော်ပြသည်။ ကြည့်ရှုရန် TTY 711 ဖြင့် သိမ်းရန်။</td>
</tr>
<tr>
<td>9. → Cambodian- Mon - Khmer</td>
<td>ដែលបានប្រការតាម ទឹកកក្កត្ត ការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានការព្យូករដ្ឋ ប្រភេទផ្សេងៗនោះ និងទឹកកក្កត្ត ដែលមានក�... 0... TTY 711</td>
</tr>
<tr>
<td>10. Choctaw</td>
<td>ḌO ĐOĆ DĆP IĆZP IĆAĆO CTWP ĆOĆP ĆR ĆJAAĆ ĆAĆOĆAĆ ĆĆOĆIT, ĆOĆOĆOĆ 0... TTY 711</td>
</tr>
<tr>
<td>11. Chinese</td>
<td>您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言障礙服務專線 711</td>
</tr>
<tr>
<td>12. Cushitic-Oromo</td>
<td>Kaffalti male afaan keessanii oodee fannoofi deeggass argachuu misgaa ni qabdu. Turjumaana gaafachuufis sarara bibilaa kan bilisaa waraaga tenyummaa karoora fayya keematti tareeke fahmaa bilbiilo, 0- tuqi. TTY 711</td>
</tr>
<tr>
<td>13. Dutch</td>
<td>U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringkaart treft, druk op 0. TTY 711</td>
</tr>
<tr>
<td>14. French</td>
<td>Vous avez le droit d’obtenir gratuitement de l’aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d’affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711</td>
</tr>
<tr>
<td>15. French Creole - Haitian Creole</td>
<td>Ou gen dwa pou nde ak enfòmisyon nan lang-natif moun anpil gratis. Pou mande yon entéprè, rele mwen eo gratis manm lan ki endikite sou kaj ID plan sante ou, peze 0. TTY 711</td>
</tr>
<tr>
<td>16. German</td>
<td>Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an.</td>
</tr>
<tr>
<td>Language</td>
<td>Text</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>Greek</td>
<td>Έγετε το δίκαιο να λάβει δικαιοσύνη και πληρωθεί στη γλώσσα σας: μιας χρήσης. Τι να ζητήσετε δημιουργήσε, καλέστε το δωρεάν κριτικό τηλεφώνου που βρίσκεται στην καρτή μέλους χορηγήσε, παρήγγελτο 0-ΤΤΥ:711.</td>
</tr>
<tr>
<td>Gujarati</td>
<td>તમે નિંદા મુક્યે પણ અંદર તમારી સંપર્કમાં મેલ્ટરની મેલ્ટરની વાતાવરણ, તમારા ઇન્ડિયન ઐડ પાનેય સુખ્યા આહેહ, પેસ્ટ-કે મેયરને કેનળક-નબર તુંપ કેલ થયે, 0 આયરલ-TTTY:711</td>
</tr>
<tr>
<td>Hawaiian</td>
<td>He pono ke kōkua ‘ana aku ia ‘oe maka maopo ‘ana o keia ‘ike ma loko o kau ‘ole pono ‘i me ka aku ‘ole ‘ana. E kamā ‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu keleponakāki ‘ole ma kou kaleaka olakino, e ko kūm o ia helu 0. TTTY:711.</td>
</tr>
<tr>
<td>Hindi</td>
<td>क्षण के पास अपनी भाषा में सहयोग एवं जानकारी मुंकय प्राप्त करने का अधिकार है। दुःखित-के के परिपुर्तिकरण करने के लिए, अपने हैल्थ फ्लैन ID-कार्ड पर सुविधा दोल-का नंबर पर जोन करें। 0 दुखित।TTTY:711</td>
</tr>
<tr>
<td>Hmong</td>
<td>Koj muaj cai tau kev pab thiab tau coov ntaub ntawv sau va koj hom-lus pub dawb. Yog xav tau ib tug neeg thiab, huv tuh coov tooj tau stawv cuab hu dawb uas sau muaj nyob ntawm koj daim xua them ngi kho mob, nias 0. TTTY:711.</td>
</tr>
<tr>
<td>Ibo</td>
<td>Inwere ikiike inweta enyemaka nakwa imuta asusu gi n’efu n’akwughiugwo. Maka ikpoturu onye nsughari okwu, kpoo akara ekweni ni diknakvukiwo ajinmara gi nke eمص maka ahuis gi, pia 0. TTTY:711.</td>
</tr>
<tr>
<td>Ilocano</td>
<td>Adda karbangam nga makaala ti tulong-ken impormasyon-it: pagsasam nga libre. Tapno agdawat iti maysa nga agipatarus, tuma wagiti toll-free nga numero ti telefono nga para kadagii kang nga nakalista ayan ti ID cardmo para ti piano ti salun-at, ipindutt ti 0. TTTY:711.</td>
</tr>
<tr>
<td>Indonesian</td>
<td>Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penceremah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID-rencana kesehatan Anda, tekan 0. TTTY:711.</td>
</tr>
<tr>
<td>Italian</td>
<td>Ha il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTTY:711</td>
</tr>
<tr>
<td>27. Japanese</td>
<td>ご希望の言語でサポートを受けたり、情報を入手したりすることができるです。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。</td>
</tr>
<tr>
<td>28. Korean</td>
<td>귀하는 도움과 정보를 귀하의 언어로 이용 부담없이 업을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY:711</td>
</tr>
<tr>
<td>29. Kru-Bassa</td>
<td>Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yukwel ni Koboi mahal seblana, soho ni sebel numa I ni tehe mu I ticket I docta I nan, bep 0. TTY:711</td>
</tr>
<tr>
<td>30. Kurdish-Sorani</td>
<td>مانچی لوت بیک هیپیریس. بریمبی و زلاوی پورتی به زبانی جوت و مورگیت. نیوراکی، فارسی بوشهری، و پیتروکاپیکی. بی‌شماری به‌طور گسترده‌ای در روانشناسی و روان‌پزشکی نیز به‌کار می‌رود. TTY:711</td>
</tr>
<tr>
<td>31. Laotian</td>
<td>ຜ້ານ້ານທ້າຍນ້ານອົບການຈາກແຮ້້ານຄຸມ້ອງສາຍໜານສາຂາຮັບຄວາມໝາຍຂອງການນະຄອນນານະຄອນ. ຜ້ານ້ານໃຫ້ໜານທ້າຍນ້ານອົບການຈາກແຮ້້ານຄຸມ້ອງສາຍໜານສາຂາຮັບຄວາມໝາຍຂອງການນະຄອນນານະຄອນ. TTY:711</td>
</tr>
<tr>
<td>32. Marathi</td>
<td>अपलव्यान अपलव्यान अपलव्यान विश्वसनीय मदत आणि उपक्रमातील संधिरूसारखी आदर्श आहेत. नेचन कायदा दिवसीय करण्यासाठी आपल्या आरोग्य योजना: औद्योगिक जागरूकता सूचीबद्ध केल्या सदस्यांना विश्वसनीय पोल नवरारं संग्रह करण्यासाठी दाऊ. TTY:711</td>
</tr>
<tr>
<td>33. Marshallese</td>
<td>Eor am maro-i'nan bok iipa'i im melele iilo kajin eo am iilo ejjok: won'ania. Nan kajitok nanjuon ni ukok, kudoj negba eo emo'i an jeje iilo kaat in ID in karok in zimour eo am, jipep 0. TTY:711</td>
</tr>
<tr>
<td>34. Micronesian - Pohnpeian</td>
<td>Komw ahene manaman unse komwi en alehi sawas oh: menghtik ni pein omwi tungoal lokaia ni soh isep. Pwen peki sawas es soun-kawehwe, eker dele groh nempem oeng-towe rkan me soh isep me ntinghi ni pein omwi doarogwe me pid-koasoandi en kehl, padik 0. TTY:711</td>
</tr>
<tr>
<td>35. Navajo</td>
<td>Táá jíik'eh doo báazh 'alingóó bee baa hane'ígít táá ni nizaáá bée-niká'el'eyeego bee ná'ahoot'í. 'Ata'halné'i 4a yínkeédgo, ninaatsoo-nitiz7 'ats775 'bee baa'ahy1 'bee n4hózin7g77 bik11' b44sh bee-bane'7 t'11j77k'eh bée hane'7 bik1'7g77 bích'8 hodilih:dóó'0 bi-</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepali</td>
<td>तपाईले आफ्नो भाषामा नि: डुल्क सहको र आनकारी प्राप्त गर्नुहोस्। अधिकार तपाईले संग्रह गर्नुको अनुमति दिन। तपाईले र आपको प्रवास योजना परिवार करिएको स्थायी टोल-की सदस्यको नम्बर सामर्थ्य सम्पर्क गर्नुहोस्। TTY: 711</td>
</tr>
<tr>
<td>Nilotic-Dinka</td>
<td>Yin naŋ lôn bê yi-kwo nyê nê wëtsëyic de thôŋ du âbac ke cim wëw tâwë-ke pûny. Æcan bâ ran ye koc ger thôk thïeëc, ke yin col nàmba yene yup abac de ran tôg ye koc wâr thôk to nê ID kat duon de pânakim yic, thany 0 yic. TTY: 711</td>
</tr>
<tr>
<td>Norwegian</td>
<td>Du har rett til å få gratis hjelp og informasjon på ditte etterspråk. For å be om eventykt, ring gratisnummret for medlemmersom er oppført på helsesektet ditt og trykk 0. TTY: 711</td>
</tr>
<tr>
<td>Pennsylvania Dutch</td>
<td>Du hoscht die Recht fer Hilfnn Information in deine Schprooch-gügie, fer nix. Wenn du en Ivaneszer hawwe willsch, kannsch du die fiei Telefon Nummer uff dei Gesundheit Blan ID Kaarde yuuse, drickie 0. TTY: 711</td>
</tr>
<tr>
<td>Persian-Farsi</td>
<td>تا را حق دارید که کمک و اطلاعات بخیمیان، خود را طوری می‌گیرید که برای این افراد و شرایط، خود مشاوره یافته‌ای، برنامه، نهادی که در کده فرایند، کمک نیازمند، خاطر، نیازمند و غیره دارید. TTY: 711</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਤੁਸੀਂ ਜੋ ਅਪਨੀ ਆਪਨੀ ਜੀਵਨ ਵਿਚ ਉੱਪਰ ਆਪਨੀ ਭੂਮਿਕਾ ਕਰ ਕੇ ਅਨੁਭਵ ਕਰਵਾਇਆ ਹੈ ਉੱਪਰ ਸੀ ਤੁਸੀਂ ਦੀ ਸੀਰੀਅਸ ਭੂਮਿਕਾ ਖਿੰਚ ਨਾਲ ਨਾਲ ਖਿੰਚ ਨੀ ਮੈਤਰਾ ਤੇਲ ਲਗਤ ਟੀਲੀਅਕਰ। 711 ਦੇ ਹੋਰ ਨੰਬਰ, 0 ਵੇਂਤੇ।</td>
</tr>
<tr>
<td>Polish</td>
<td>Masz prawo do uzyskania bezpłatnej informacji i pomocy w Twoim języku. Po usługi tłumacza zadzwoni pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY: 711</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY: 711</td>
</tr>
<tr>
<td>Romanian</td>
<td>Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cete un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tastă 0. TTY: 711</td>
</tr>
<tr>
<td>Russian</td>
<td>Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика, вы можете набрать бесплатный номер, указанный на карточке вашего медицинского плана, нажав 0. TTY: 711</td>
</tr>
<tr>
<td>№</td>
<td>Язык</td>
</tr>
<tr>
<td>-----</td>
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</tr>
<tr>
<td>37</td>
<td>Serbian-Croatian</td>
</tr>
<tr>
<td>38</td>
<td>Spanish</td>
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<tr>
<td>39</td>
<td>Swahili</td>
</tr>
<tr>
<td>40</td>
<td>Assyrian-Syriac</td>
</tr>
<tr>
<td>41</td>
<td>Tagalog</td>
</tr>
<tr>
<td>42</td>
<td>Telugu</td>
</tr>
<tr>
<td>43</td>
<td>Thai</td>
</tr>
</tbody>
</table>
| 44  | Tongan   | 'Oku ke ma'ua e tokonimo e 'u fakamatala i:ho o lea fakafonua ta'etotongi. Ke kote ha tokotaha fakatonea, ta ki-
ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD).

See Section 14, Glossary in the SPD.
UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, Plan Highlights) when a benefit is available.

What is UnitedHealth Allies?
UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, Glossary.

Selecting a Discounted Product or Service
A list of available discounted products or services can be viewed online at www.Unitedhealthallies.com or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important: You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional
After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information
Additional information on the UnitedHealth Allies program can be obtained online at www.Unitedhealthallies.com or by calling the phone number on the back of your ID card.