Liberty Mutual Health Plan
Summary Plan Description
(For U.S. Employees Only)

Effective January 1, 2017
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(For Active Employees)

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HEALTH PLAN

Overview

The Liberty Mutual Health Plan ("Plan") offers eligible employees participation in a national health plan. For purposes of this Summary Plan Description, “Company” means Liberty Mutual Group Inc., and “Participating Employers” means the Company and its subsidiaries that participate in the Plan. A list of Participating Employers is available in the Benefits section of the Employee Center on the Liberty Mutual Intranet.

A Self-Insured Plan

The Plan is a "self-insured" plan. This means that health care claims are paid from the Company’s general assets. The money used to pay the claims comes from your contributions for coverage and the Company’s contributions. Please note: The only exception is for employees who reside in Hawaii. As a result of state mandates, the benefit design differs, and the plan option offered to Hawaii residents is a fully insured plan through UnitedHealthcare.

Plan Design

The Plan offers employees and eligible dependents two options: a national network Preferred Provider Organization (PPO) plan and a Consumer Directed Health plan (CDHP). Both options provide in-network and out-of-network coverage, depending on whether or not a network provider is used. Covered employees may choose to receive services from either in-network or out-of-network providers. The claims administrators for the provider networks do not provide health care insurance; they process the claims and manage the health care provider networks. The claims administrator is UnitedHealthcare. Prescription drug benefits are a component of the Plan and are administered by CVS/caremark.

Note: If you live in Hawaii, as noted above, your health and prescription drug benefits differ from those offered in all other states and are covered and administered by UnitedHealthcare.

If you live in Massachusetts, Maine or New Hampshire, preferred providers are part of the “UnitedHealthcare Choice Plus with Harvard Pilgrim” network where Harvard Pilgrim is the Claims Administrator. If you live outside of these states, preferred providers are part of the “UnitedHealthcare Choice Plus” network.

Under the Plan, there is in-network coverage and out-of-network coverage, depending on whether you choose to use a preferred provider who is in the network, or an out-of-network provider. This refers to the “network” of health care providers (including Physicians, Specialists, and hospitals) that have contracted to provide quality services in a cost-effective manner. When you receive in-network care from a preferred provider, your out-of-pocket expenses are generally lower (for example, 90% or 80% coinsurance vs. 70% or 60% coinsurance for out-of-network).

The Plan also has annual deductibles and out-of-pocket maximums. All services have coinsurance, with the amount depending on whether you receive care from a preferred or a non-preferred provider and potentially whether you see a Primary Care Physician or a Specialist for an office visit. The only exception is in-network Preventive Care coverage, which is covered at 100% (see the “Preventive Care” section for more information).

A directory of providers who participate in each of the claims administrators’ networks is available through the Your Total Rewards website and the claims administrator’s website, www.myuhc.com and www.caremark.com, or by calling the claims administrator directly. Plan coverage and provisions are explained in further detail in this Summary Plan Description. The toll-free Member Services telephone number for your claims
administrator can be found on your identification card, or on the Your Total Rewards website. Contact information can also be found at the end of this document.

**General Provisions**
This Summary Plan Description contains general information that applies to the self-insured plan. Pages B-5 through B-13 apply to the fully-insured plan offered in Hawaii; however, please contact UnitedHealthcare for an informational packet containing coverage provisions specific to the fully-insured plan.

**Eligibility**
You become eligible for coverage on your date of employment if you are on the U.S. payroll and are an employee regularly scheduled to work at least 20 hours or more per week. Individuals classified as independent contractors or leased employees are not eligible for coverage, even if they are later reclassified as common law employees for tax purposes. Coverage must be elected within thirty (30) days of your date of eligibility or during the Annual Benefits Enrollment period.

**Eligible Dependents**
As an eligible employee, you may also choose to enroll your eligible dependents for coverage. Eligible dependents include:

- your legally married spouse (the Plan does not allow dependent coverage for an ex-spouse even if a court mandates that you provide coverage) or eligible domestic partner; and
- your child (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) younger than age 26. This does not include a child for whom your parental rights have been legally terminated.

Coverage for an adult child who attains age 26 will continue until the last day of the month in which his or her birthday occurs.

Coverage for an adult child age 26 and older may be continued under the Plan if the adult child is unable to earn his own living because of a physical disability, mental illness, or developmental disability. Coverage will be continued in accordance with "Dependents: Coverage Continuation under Special Circumstances."

If you and your spouse or domestic partner are both employees of Participating Employers, you may each be covered as an employee or as a dependent, but not both. In addition, only one of you is eligible to choose coverage for your dependent children.

**Important Note:** When you elect coverage for a dependent, you are certifying the eligibility of that individual as meeting the definition of a dependent as outlined in this Summary Plan Description. Knowingly enrolling or continuing coverage for an individual who does not meet the dependent eligibility requirements may result in disciplinary action up to, and including, termination of employment for cause. Please note that the Company may require from time to time that you provide proof that your dependents meet the eligibility criteria under the Plan.

**Domestic Partners**
An unmarried eligible employee may enroll an unmarried same-sex or opposite-sex domestic partner as a dependent under the Plan. If you and your domestic partner meet the eligibility criteria set forth below and enroll in the Plan, benefit coverage generally is provided under the Plan as though your domestic partner were your spouse, except where federal and/or state tax and other applicable laws and regulations prohibit doing so. To be eligible to enroll your domestic partner in the Plan, when you enroll for coverage, you and your domestic partner must meet the following criteria:
(a) have entered into a state-registered domestic partnership and provide proof that you (1) are registered as
domestic partners in a state that formally recognizes domestic partners, (2) have entered into a civil union
in a state that formally recognizes civil unions, or (3) are registered as reciprocal beneficiaries in a state that
formally recognizes reciprocal beneficiaries to the extent that you are in a spouse-like relationship with and
are not related to your reciprocal beneficiary; or

(b) if you do not meet the requirements of section (a), you and your domestic partner must:
   (1) share an exclusive, committed relationship together and intend to do so indefinitely;
   (2) have shared a common residence together for the past twelve (12) months;
   (3) be at least 18 years of age or older
   (4) be jointly responsible for each other’s common welfare and financially interdependent;
   (5) not be related to a degree of closeness that would prohibit legal marriage in the state where you
      legally reside;
   (6) not be legally married to, or the domestic partner of, anyone else; and
   (7) satisfy such other criteria as the Company may require from time to time, including providing
      proof, at the Company’s request, that your domestic partnership meets the eligibility criteria set
      forth above.

If you and your eligible domestic partner are both employees of Participating Employers, you may each be
covered as an employee or as a domestic partner, but not both. In addition, only one of you is eligible to choose
coverage for your dependent children.

You may also cover your domestic partner’s unmarried children (including any stepchild, foster child, legally
adopted child or a child for whom a court order of custody or guardianship has been obtained) younger than
age 26.

Coverage for your domestic partner’s child who attains age 26 will continue until the last day of the month in
which his or her birthday occurs.

Coverage for your domestic partner’s child who is age 26 or older may be continued under this Plan if the
adult child is unable to earn his own living because of a physical disability, mental illness or developmental
disability. Coverage will be continued in accordance with the provisions of "Dependents: Coverage
Continuation under Special Circumstances."

Termination of Domestic Partnership
If your state-registered domestic partnership terminates, or if you no longer meet all of the criteria in this
Summary Plan Description, you must complete a status change on the Your Total Rewards website within thirty
(30) days of the termination. If you have any questions, call Benefits Express at 1-800-758-4460. Upon
termination of domestic partner coverage, coverage of the domestic partner’s children also terminates. Your
former domestic partner may be eligible to continue coverage in accordance with the provisions of “COBRA-
like Coverage for Domestic Partners.”

Applying for Coverage

You must apply for health care coverage via the Your Total Rewards website. Coverage will be effective on the
date you are first eligible if you apply on or before that date.

If you are eligible for health coverage and do not make an election, you will be assigned to “No Coverage” in
the Plan.
If you have previously declined coverage under the Plan, either when you were first eligible or during the Annual Benefits Enrollment period, you may reapply for coverage during any Annual Benefits Enrollment period, or during the year provided you have an eligible “Status Change.” You will not be able to change your coverage again until the next Annual Benefits Enrollment period, with the new coverage becoming effective January 1 of the following calendar year, unless you have a “Status Change.” Refer to the “Making Changes Outside of the Annual Benefits Enrollment Period” and “Definitions” sections of this document for more detailed information.

You must notify Benefits Express at 1-800-758-4460 within 30 days if your coverage under another plan is discontinued in order to enroll in the Liberty Mutual Health Plan.

Reinstated Employees
If your employment ends and you are reinstated within thirty (30) days of the date your employment ended, your coverage in the Plan will automatically be reinstated to the same coverage option (No Coverage or Plan coverage) and the same coverage category (employee only, employee plus spouse/domestic partner, employee plus child(ren) or employee plus family) that you had in effect before your employment ended. Contributions for the retroactive coverage will be taken from your first available paycheck.

Network Provider Lists
Provider network information is available through the claims administrators’ website or you may also call the claims administrators directly for information on network providers.

Cost
The Company provides eligible employees with flex credits to apply toward their benefit costs. With the Plan, if you choose coverage, you will also select whether to cover yourself alone or to include members of your family. Each coverage option has a price tag.

If you are an eligible employee regularly scheduled to work 30 hours or more per week and elect coverage under the Plan, the Company currently subsidizes the majority of the price tag, based on the coverage category you select. If you are an eligible employee regularly scheduled to work at least 20 hours but less than 30 hours per week and elect health coverage, the Company subsidizes less of the price tag, based on the coverage category you select. The price tag is the premium cost of coverage in the Plan for a year and is based on actual claims incurred by participants as well as administrative expenses related to the Plan. For specific premium cost information, please contact Benefits Express.

Your cost is shown on the Your Total Rewards website. Your cost will vary with the coverage category you select and the amount of flex credits you receive. Premiums are deducted on a before-tax basis through payroll deduction.

Please note that, unless a domestic partner and the children of a domestic partner are legal dependents of an employee under Internal Revenue Code Section 152, the employee is taxed on the fair market value of the health coverage extended to the domestic partner and to any child of the domestic partner, reduced by any after-tax employee contributions. This is called imputed income and is included in your gross taxable income and is subject to Social Security, federal, state and other payroll withholding taxes.
Annual Benefits Enrollment Period

The Annual Benefits Enrollment period is held in the Fall of each year and is announced in advance to all employees. The coverage option selected (No Coverage or coverage) and the eligible dependents enrolled for coverage are effective the following January 1. The elections will remain in effect for one year until the January 1 following the next Annual Benefits Enrollment period.

Making Changes outside the Annual Benefits Enrollment Period

The only time you can make changes outside the Annual Benefits Enrollment period is if you have a “Status Change.” In that case, you can change your coverage, consistent with the Status Change. See “Status Change” under “Definitions.”

Generally, you have thirty (30) days from the date of the Status Change to request a change in coverage via the Your Total Rewards website. The coverage change will be retroactive to the date of your Status Change. Any adjustment to your paycheck deductions will be retroactive to the effective date of your Status Change.

Reinstated Employees

If your employment ends and you are reinstated within thirty (30) days of the date your employment ended, your coverage in the Plan will automatically be reinstated to the same coverage option (no coverage or Eyewear and Exam coverage) and the same coverage category (employee only, employee and spouse/domestic partner, employee and child(ren), or family) that you had in effect before your employment ended. Contributions for the retroactive coverage will be taken on a before-tax basis from your first available paycheck.

Identification Cards

Health Plan

If you elect coverage, you will receive health plan identification cards from the claims administrator within approximately two to three weeks after the coverage becomes effective.

Replacement cards necessary because of a name change will be processed by the claims administrator once notification of the change is received. Additional cards for other family members or replacement cards necessary because the originally issued card has been lost or damaged should be requested by contacting UnitedHealthcare.

Prescription Drug Plan

If you enroll for coverage in the Plan, you will also receive prescription drug identification cards for the CVS/caremark prescription drug program described later in this Summary Plan Description. If you need replacement or additional prescription drug identification cards, contact CVS/caremark.

Dependents: Coverage Continuation under Special Circumstances

Disabled Dependent Children

A covered employee may continue coverage for certain dependent children who reach the age at which coverage would otherwise cease if the following conditions are met. The employee must provide proof that the child is unable to earn his or her own living for reasons of physical disability or mental illness. The covered employee must be covered for dependent coverage for the child under the Plan on the date he or she reaches age 26.
Medical proof of the dependent child's disability must be received by the appropriate claims administrator within thirty (30) days after the last day of the month he/she reaches age 26. After reviewing the medical proof submitted, the appropriate claims administrator must approve a child’s status as mentally or physically disabled in order for coverage to continue.

A newly eligible employee who has a disabled adult child age 26 or older must provide medical proof of the disability to the appropriate claims administrator within thirty (30) days of initial enrollment in the Plan. In such a case, after reviewing the medical proof submitted, the appropriate claims administrator must approve a child’s status as mentally or physically disabled in order for such a child’s coverage to begin.

The covered employee's or domestic partner's child will be considered a covered dependent as long as the covered employee submits due proof upon request by the claims administrator that the child remains physically or mentally unable to earn his or her own living.

The Company, at its own expense, may have a physician of its choice examine the child during the time his or her coverage is continued. An exam will not be required more than once a year.

A covered employee's coverage for that child will end according to the provisions under Termination of Coverage, or on the earliest of:

- the date the child is able to earn his or her own living;
- failure to provide due proof that the child is unable to earn his or her own living; or
- failure of the child to submit to an exam by a physician.

Dependents of Deceased Employees

Effective January 1, 2017, if an employee is covering dependents under the plan at the time of his or her death, those dependents may continue their coverage for 24 months, payable at the applicable cost.

The spouse or domestic partner must remain unmarried and cannot enter into a new domestic partner relationship within the 24 month period to remain covered under the Plan. If the surviving spouse or domestic partner remarries or enters into a new domestic partnership within the 24 month period, their coverage will terminate on the date of remarriage or upon entering a new domestic partnership. Coverage for dependent children will terminate when the spouse or domestic partner is no longer eligible for coverage or if the dependent children no longer meet the definition of “Dependent” under the Plan. See “Dependents of Deceased Employees” in the “Right to Continue Coverage” section.

Prior to January 1, 2017, coverage for the survivor(s) may continue until the spouse or domestic partner remarries or enters into a new domestic partnership. Coverage for dependent children will terminate when the spouse or domestic partner is no longer eligible for coverage or if the dependent children no longer meet the definition of “Dependent” under the Plan. See “Dependents of Deceased Employees” in the “Right to Continue Coverage” section.

Medicare Benefits for Covered Individuals

Under current law, when you reach age 65 you are eligible to apply for Medicare. You may also be eligible to apply for Medicare before age 65 if you become disabled. Whether or not you apply for Medicare, the Plan will continue as primary payer for you with respect to Medicare until the earliest of:

- the date you cease employment;
- the date you cease contributing to the Plan;
• the date you notify Benefits Express that you do not want Liberty's coverage to continue or update 
your elections on Your Total Rewards (subject to rules for Status Changes); or
• the date you become Medicare-eligible and disabled from work

When your spouse or domestic partner reaches age 65, or your covered dependent becomes eligible for 
Medicare, the Plan will continue as primary payer for your spouse, domestic partner, or covered dependent 
with respect to Medicare until the earliest of:

• the date you cease employment;
• the date you cease contributing to the Plan for your coverage or your spouse's or domestic partner's 
or dependent's coverage; or
• the date your spouse or domestic partner or dependent notifies the Company that he or she does not 
want Liberty's coverage to continue (subject to rules for Status Changes).

The law does not allow the Plan to be secondary to Medicare for charges covered by Medicare while you are 
still working. However, if you are on a leave of absence due to an approved long-term disability and become 
eligible for Medicare, Medicare will become the primary payer for your health coverage. Your pharmacy 
coverage will remain primary through CVS/caremark.

Note: If you discontinue your coverage under the Plan, you must also discontinue coverage for your spouse, 
domestic partner, and/or dependents.

How the Health Plan Works

The Plan is a national network plan with “in-network” coverage and “out-of-network” coverage. You always 
have a choice of whether to use an in-network, or a preferred provider for lower out-of-pocket expenses, or go 
“out-of-network” to see any licensed provider you choose and share in a larger portion of the cost. You do not 
need to choose and coordinate your care through a Primary Care Physician (PCP); however, you will pay a 
lower coinsurance when you visit an in-network PCP than if you visit an in-network Specialist.

While you can visit any network physician, Specialist, or facility without prior authorization from a PCP and 
receive the preferred level of benefits, you need to ensure that you are treated by preferred providers to 
receive in-network coverage. This is not your physician’s responsibility. Do not assume that your physician 
referred you to a preferred provider.

Emergency Coverage While Traveling

Coverage is always available for emergencies. If you are traveling and experience an emergency medical 
situation, seek care immediately. Your emergency use of an ambulance will be covered at the in-network level 
of coinsurance after the in-network deductible has been met, whether or not you use an in-network provider. 
Please see the sections under “Plan Options” for information on how these costs will be applied under the 
PPO and CDHP options.

Annual Health Plan Deductible

Each year, the annual deductible (individual or family) must be met before the Plan begins to pay benefits for 
eligible expenses. The deductible works differently under the PPO and CDHP options – see sections 
“CDHP” and “PPO” for more information.
Expenses for Which There Is No Deductible
You do not have to meet the annual deductible before the Plan provides coverage for the following services:

- In-network routine annual exams, non-diagnostic and associated tests and lab fees for adults;
- In-network well-child care for children through the age of 18;
- In-network healthy newborn inpatient hospital services (excluding separate charges for physician services, lab work, or surgical procedures for the newborn) while the mother is also in the hospital;
- In-network well women’s preventive services (see “Women’s Preventive Services” for more information);
- In-network immunizations administered as preventive services during a routine annual exam; and
- In-network flu prevention injections.

Note: Not all lab work completed during your annual physical may be considered preventive. For more information visit www.myuhc.com.

Expenses That Do Not Count toward the Deductible
These expenses do not count toward meeting your annual deductible (or the out-of-pocket maximum):

- Expenses that exceed the lower of the billed amount or the reasonable and customary charge, as determined by the claims administrator;
- Charges for prescription drugs through CVS/caremark (this applies under the PPO only);
- Charges that exceed the benefit maximums for services such as chiropractic and private duty nursing care;
- Ineligible expenses, such as cosmetic surgery or experimental procedures; and
- $200 Emergency Room charge (this applies under the PPO only). In no event, however, will the $200 charge for use of emergency room services cause you to exceed the out of pocket maximum prescribed under the Affordable Care Act.

Benefits for Specific Services in the Health Plan

Treatment of Mental and Behavioral Disorders While Not Confined in a Hospital
Treatment for Substance Abuse (Chemical Dependency) While Not Confined in a Hospital
Preferred (or in-network) treatment is paid at the in-network level of Covered Health Care Expenses, after the annual deductible is satisfied. Non-preferred (or out-of-network) treatment is covered at the out-of-network level of the lower of the reasonable and customary amount or billed amount after the annual deductible for out-of-network benefits.

Covered Health Care Expenses for professional charges for Treatment of Mental and Behavioral Disorders and Substance Abuse While Not Confined in a Hospital are limited to charges made by a licensed psychiatrist, licensed psychologist or licensed clinical social worker. Charges made by certified addiction counselors are also Covered Health Care Expenses, but only if the treatment is rendered in connection with an accredited outpatient substance abuse treatment program. Charges made by marriage and family therapists are not Covered Health Care Expenses, unless there is a valid behavioral health diagnosis associated with the visit.

Treatment of Mental and Behavioral Disorders While Confined in a Hospital
Treatment for Substance Abuse (Chemical Dependency) While Confined in a Hospital
Preferred (or in-network) treatment is covered at the in-network level, after the annual deductible. Non-preferred (or out-of-network) treatment is covered at the out-of-network level of the lower of the reasonable and
customary amount or billed amount after the annual deductible for out-of-network benefits, for the treatment of mental and behavioral disorders and substance abuse (including inpatient detoxification treatment) while hospital-confined. You must pre-authorize with your claims administrator before your admittance to inpatient care. The telephone number to pre-authorize inpatient care is on your Plan ID card.

Other Hospital Charges
Preferred or (in-network) inpatient hospital charges are covered at the in-network rate after the annual deductible (if not already met). Non-preferred (or out-of-network) charges are paid at the out-of-network rate of the lower of the reasonable and customary amount or billed amount after the annual deductible for out-of-network benefits, for hospital charges listed under subparagraph (1) under Covered Health Care Expenses definition.

Inpatient care must obtain prior authorization by calling your claims administrator’s Member Services area at the telephone number on your health plan ID card. For scheduled inpatient care, you must call at least seven (7) calendar days prior to your admission.

Second Opinion
The Plan will pay the in-network rate for Covered Health Care Expenses after the annual deductible for a second opinion if an in-network PCP/Specialist is used. The Plan will pay the out-of-network rate of the lower of the reasonable and customary amount or billed amount after the annual out-of-network deductible for a second opinion if an out-of-network provider is used. The Plan will also cover a third opinion if the second opinion varies from the first opinion. You can also use Best Doctors’ second opinion review services for oncology diagnoses, which is available at no cost to you. Elective surgery candidates opinion review through Best Doctors for bariatric, knee, hip or spine surgery prior to proceeding with surgery will receive a $500 cash incentive. Check with the claims administrator for additional details.

Treatment of Gender Dysphoria (Gender Identity Disorder)
The Plan will pay for the treatment of gender dysphoria (Gender Identity Disorder) as described under non-surgical and surgical treatment for gender dysphoria:

Non-Surgical Treatment of Gender Dysphoria:
The Plan covers non-surgical treatment for gender dysphoria; the following non-surgical treatments are covered:

- Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses
- Continuous hormone replacement therapy - hormones of the desired gender injected by a medical provider. Note. Coverage is available for certain oral and self-injected hormones under the Prescription Drug Program portion of the Plan
- Laboratory testing to monitor the safety of continuous hormone therapy.

Surgical Treatment of Gender Dysphoria:
- The Plan covers surgical treatment for gender dysphoria; the following are covered when the eligibility qualifications for surgery are met below:
  - Genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) and related services.
  - The treatment plan must conform to identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance; and
  - For irreversible surgical interventions, the Covered Person must be age 18 years or older; and
  - Prior to surgery, the Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender.
Important:
• Certain Covered Persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the Covered Person's Physician, this will be determined on a case-by-case basis.
• Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.
• The Claims Administrator has specific guidelines regarding Benefits for treatment of gender dysphoria (Gender Identity Disorder). Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.
• Any combination of Network and Non-Network Benefits for transgender surgery is limited to $75,000 during the entire period of time you are enrolled under the Plan.

Exclusions - Treatment of Gender Dysphoria (Gender Identity Disorder)
• Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
• Sperm preservation in advance of hormone treatment or gender surgery.
• Cryopreservation of fertilized embryos.
• Voice modification surgery.
• Facial feminization surgery, including but not limited to: facial bone reduction, face “lift,” facial hair removal, and certain facial plastic procedures.
• Treatment received outside of the United States.

Glossary
**Gender Identity Disorder:** A disorder characterized by the following diagnostic criteria:
• A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
• Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
• The disturbance is not concurrent with a physical intersex condition.
• The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
• The transsexual identity has been present persistently for at least two years.
• The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Member Cost Share Details:

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<th>CDHP Option</th>
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<td><strong>Annual deductible</strong></td>
<td>Includes medical and prescription drug costs In-network: Individual $1,500 / Family $3,000; Out-of-network: Individual $3,000 / Family $6,000</td>
<td>Includes medical costs only In-network: Individual $600 / Family $1,800*; Out-of-network: Individual $1,500 / Family $4,500</td>
</tr>
<tr>
<td></td>
<td>*For a family of 2 or more, the in-network family deductible of $3,000 must be met before the plan pays coinsurance. Individual deductibles do not apply.</td>
<td>*For a two-person family, the in-network deductible is $1,200.</td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximum</strong></td>
<td>Includes medical and prescription drug costs In-network: Individual $3,425 / Family $6,850; Out-of-network: Individual</td>
<td>Includes medical and prescription drug costs In-network: Individual $3,000 / Family $9,000*; Out-of-network:</td>
</tr>
<tr>
<td></td>
<td>CDHP Option</td>
<td>PPO Option</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Primary care visits</td>
<td>You pay In-network: 20%; Out-of-network: 40%</td>
<td>You pay In-network: 10%; Out-of-network: 30%</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>You pay In-network: 20%; Out-of-network: 40%</td>
<td>You pay In-network: 20%; Out-of-network: 30%</td>
</tr>
<tr>
<td>Diagnostic labs, radiology, and imaging</td>
<td>You pay In-network: 20%; Out-of-network: 40%</td>
<td>You pay In-network: 20%; Out-of-network: 30%</td>
</tr>
</tbody>
</table>

**Coinsurance: The amount you pay after meeting your deductible.**

**Prescription Drug Program Cost Share**

<table>
<thead>
<tr>
<th></th>
<th>CDHP</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CDHP participants must meet the annual deductible before coinsurance applies.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>That means you pay the full cost of most prescriptions until you reach your deductible, then you pay coinsurance (the plan begins to share the cost).</td>
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</tr>
<tr>
<td><strong>Retail 30-Day Supply</strong></td>
<td>Generic drugs: 30% per script; $60 maximum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs: 30% per script; $70 maximum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs: 50% per script; $100 maximum</td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order Maintenance 90-Day Supply</strong></td>
<td>Generic drugs: 30% per script; $120 maximum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs: 30% per script; $140 maximum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs: 50% per script/$200 maximum</td>
<td></td>
</tr>
<tr>
<td><strong>Retail Maintenance 90-Day Supply</strong></td>
<td>Same price as mail order 90-day supply if filled at CVS retail pharmacy</td>
<td></td>
</tr>
<tr>
<td><strong>Certain Preventive Maintenance Medications</strong></td>
<td>Not subject to annual deductible; coinsurance applies</td>
<td>Subject to coinsurance</td>
</tr>
</tbody>
</table>

**Pre-Admission Testing**  
The Plan will pay the in-network rate for Covered Health Care Expenses after the annual deductible is met for
preferred providers, or the out-of-network rate of the lower of the reasonable and customary amount or billed amount after the annual deductible is met for non-preferred providers for charges for pre-admission testing.

**Other Health Care Treatment**
After the annual deductible is met, the Plan will pay the in-network rate for Covered Health Care Expenses not included above for preferred (or in-network) providers, or the out-of-network rate of the lower of the reasonable and customary amount or billed amount for Covered Health Care Expenses after the annual deductible for non-preferred (or out-of-network) providers.

**Pharmacy Benefit**
See the “**Prescription Drug Program**” section for an explanation of the CVS/caremark prescription drug program for participants in the Plan.

**Liberty Health Center (Onsite Clinic)**
The Liberty Health Center is a preferred provider and provides primary care and coordination of a broad spectrum of health care services, including acute episodic care, preventive health services, diagnostic and curative care, as well as appropriate referral to specialty physicians. Premise Health will provide the following services and clinical activities (within the scope of professional practice standards), and in accordance with state and federal regulations to the eligible population:

- Overall Patient Health Management
- Preventive Services
- Acute/Urgent Care
- Clinical Laboratory Services
- Pharmacy Services
- Health Promotion and Patient Education
- Referral Management

**Increases and Decreases in Amounts of Coverage**
Any increase in, or addition of, benefits will take effect on the effective date of the increase or addition. Any such change applies only to Covered Health Care Expenses incurred on or after the effective date of the change.

Any decrease in, or deletion of, benefits will take effect on the date of the decrease or deletion. Any such change applies only to Covered Health Care Expenses incurred on or after the effective date of the change.

**Utilization Review**
Utilization Review is a pre-admission screening program designed to explore treatment alternatives and help you become a better consumer of health care. Its main components are prior authorization and continued stay review. All employees and dependents must participate in Utilization Review for inpatient hospitalizations, skilled nursing facilities, home health care and hospice.

**Prior Authorization Requirements**
In-network providers are generally responsible for obtaining prior authorization from the claims administrator or contacting Personal Health Support before they provide certain services to you. However, there are some Covered Health Care Expenses for which you are responsible for obtaining prior authorization from the claims administrator.

When you choose to receive certain Covered Health Care Services from out-of-network providers, you are
responsible for obtaining prior authorization from the claims administrator before you receive these services.

The services that require prior authorization are:

- Ambulance - non-emergency air
- Clinical trials
- Congenital heart disease surgery
- Diagnostic - stress echo and transthoracic echo, nuclear cardiology
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes
- Genetic testing - BRCA
- Home health care
- Hospice care - inpatient
- Hospital inpatient stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery
- Intensive Behavior Therapy (including ABA) for Neurobiological disorders
- Lab, x-ray and diagnostics as a result of outpatient sleep studies
- Mental Health Services - inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management
- Neurobiological disorders - autism spectrum disorder services and inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management
- Obesity surgery
- Prosthetic devices for items that will cost more than $1,000 to purchase or rent
- Reconstructive procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery
- Skilled nursing facility/inpatient rehabilitation facility services
- Substance-Related and Addictive Disorders Services - inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs
- Surgery - sleep apnea surgeries
- Therapeutics - all outpatient therapeutics, such as dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound
- Transcranial magnetic stimulation
- Transplant

Notification is required within one business day of admission or on the same day of admission if reasonably possible after you are admitted to an out-of-network hospital as a result of an emergency.

The time periods for contacting your claims administrator are as follows:
• **For maternity admissions**, mothers and newborns will be eligible for up to forty-eight (48) hours of hospitalization following normal deliveries and up to ninety-six (96) hours of hospitalization following a cesarean section, without pre-admission certification. The hospital stay begins at the time of delivery (or, in the case of multiple births, at the time of the last delivery). When a delivery occurs outside of the hospital, the stay begins at the time the mother or newborn is admitted to the hospital. The mother’s or newborn’s attending provider may, after consulting with the mother, discharge the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). If the hospital stay is required to extend beyond the time mentioned above, the provider or member must call to get additional days authorized.

• **For all non-emergency hospitalizations**, your claims administrator must be contacted at least five (5) calendar days prior to admission. Your claims administrator may require earlier notification; you should check with your claims administrator as soon as your hospitalization is scheduled.

• **For emergency hospitalizations**, your claims administrator must be contacted within forty-eight (48) hours of the emergency admission.

**Well-Baby Programs**

For additional information, contact your claims administrator as soon as your pregnancy is confirmed. The Plan provides screening for risk factors in pregnancy, patient information, and case management.

Your claims administrator then sends you educational information, sometimes accompanied by a questionnaire designed to help identify potentially high-risk circumstances. Your doctor may also be contacted to help screen for any factors that might put you at risk for complications. If further assistance is appropriate, a nurse works with you on a regular basis to help you and your doctor with any special medical needs. The program’s goal is to assist women in getting the care they need, especially in the important area of prenatal care. All information is kept strictly confidential.

**Emergency Situations**

In life-threatening emergency situations (e.g., severe chest pains, prolonged bleeding, broken bones, etc.) seek medical care immediately.

**Definitions**

A masculine personal pronoun includes the feminine where the context requires.

"Accidental injury" or "injury" means bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

“Active employee” means any full-time or part-time employee of a Participating Employer.

"Ambulatory surgical center" (or freestanding emergency center) means a facility that:

(a) is established, equipped and operated mainly to perform surgical procedures;
(b) is operated under the supervision of a staff of physicians and provides the full-time services of at least one RN;
(c) is licensed by the jurisdiction in which it is located;
(d) has at least two operating rooms and at least one post-anesthesia recovery room;
(e) has a written transfer agreement with one or more hospitals and does not provide its own place for patients to stay overnight;
(f) is not an establishment that is operated by one or more physicians solely for their own patients; and
(g) maintains medical records for each patient.

"Annual Benefits Enrollment period" means the period each year during which eligible employees may enroll for or change coverage under this Plan for the next calendar year.

"Base Pay" means your pay for purposes of determining the plan design for which you are eligible. Your Base Pay is measured annually and is established for the next calendar year as follows:

(a) Salaried Employees:
   o For non-sales employees, this is your annual base rate of pay on or around the September 1st preceding the next calendar year.
   o For sales employees, this is your annual base rate of pay plus your sales bonus and/or commissions paid to you in the most recent 12-month period on or around the September 1st preceding the next calendar year.

(b) Hourly Employees:
   o For non-sales employees:
     • If you are regularly scheduled to work 30 hours or more per week, this is 30 hours times your hourly rate of pay on or around the September 1st preceding the next calendar year.
     • If you are regularly scheduled to work at least 20 hours but not more than 30 hours per week, this is 20 hours times your hourly rate of pay on or around the September 1st preceding the next calendar year.
   o For sales employees:
     • If you are regularly scheduled to work 30 hours or more per week, this is 30 hours times your hourly rate of pay plus your sales bonus and/or commissions paid to you in the most recent 12-month period on or around the September 1st preceding the next calendar year.
     • If you are regularly scheduled to work at least 20 hours but not more than 30 hours per week, this is 20 hours times your hourly rate of pay plus your sales bonus and/or commissions paid to you in the most recent 12-month period on or around the September 1st preceding the next calendar year.

"Birthing center" means a facility licensed as such according to the statute in the state where the facility is located.

"Brand name drug" means a prescription drug that is protected by a patent and is marketed under a specific name.

"Calendar year" means the period starting January 1 of any year and continuing through December 31 of that same year.

“Center of excellence” or designated facility means a facility or clinic within a Plan Administrator’s network that is recognized for its high-quality, high-value health care providers for certain surgical procedures.

"Claims administrator" means the party designated by the Company to administer claims. The claims administrator also is responsible for managing the network of health care providers. The health care claims administrator is UnitedHealthcare. The claims administrator for the prescription drug program is CVS/caremark.

"Coinsurance" means the share you have to pay of your Covered Health Care Expenses.
"Cosmetic Surgery" means surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

"Covered dental injury" means an injury caused by a sudden and violent external force. The injury must be unexpected and unavoidable. A chewing injury is not a covered dental injury.

"Covered dependent" means a dependent whose coverage under the Plan is in effect. It does not include a dependent whose coverage under the Plan has ended.

"Covered employee" means an active employee regularly scheduled for a minimum of 20 hours per week, or a retired employee whose coverage is in effect. It does not include an employee whose coverage has ended.

"Covered person" means a covered employee or a covered dependent.

"Custodial care" means a level of routine maintenance or supportive care, whether provided in the home or in an institution or other facility, which need not be provided by skilled professional medical personnel and will include, but not be limited to, care designed to assist the covered person in the activities of daily living.

"Day treatment program" means nonresidential programs for alcohol and drug dependent covered persons, which are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities, and nonresidential programs for treatment of behavioral or mental disorders, which are operated by facilities certified to provide treatment for behavioral or mental disorders, that provide case management, counseling, healthcare and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

"Deductible" means the amount of money you pay each calendar year before the Plan begins to pay benefits for eligible expenses.

"Dependent" means: (a) an employee's spouse or domestic partner; and (b) an employee's child (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) younger than age 26. This does not include a child for whom your parental rights have been legally terminated.

"Dependent" does not include a person who is: (a) covered under this Plan as an employee; (b) a legally divorced spouse, or (c) a child for whom your parental rights have been terminated.

Coverage for an adult child age 26 or older may be continued under this Plan if the adult child is unable to earn his own living because of a physical disability, mental illness or developmental disability. Coverage will be continued in accordance with "Dependents: Coverage Continuation under Special Circumstances." An unmarried employee may cover as a dependent under the Plan a domestic partner provided the employee and the domestic partner meet all the eligibility criteria and requirements.

"Dependent coverage" means coverage of a covered employee with respect to his dependents.

"Durable medical equipment" means equipment that:

(a) can withstand repeated use;
(b) is primarily and customarily used to serve a medical purpose;
(c) is generally not useful to a person in the absence of injury or sickness;
(d) is appropriate for use in the home; and
(e) is not primarily and customarily for the convenience of the covered person.
"Eligible dependent" means a dependent of an employee who is eligible for coverage.

"Emergency medical condition" means the sudden onset of an injury or acute illness that has the capability to cause severe pain, loss of consciousness, excessive bleeding, or which becomes a threat to life or limb if medical treatment is not rendered promptly. Examples include severe chest pains, prolonged bleeding, seizures, severe allergic reaction, poisoning, loss of consciousness, and broken bones.

“Experimental” or investigational services means 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 are determined to be any of the following:

(a) 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.

(b) 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.)

(c) 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.

"Generic drug" means a drug that has the same active ingredients as the brand name drug that no longer is protected by a patent. FDA-approved generic drugs are therapeutically equivalent to the original and usually are less expensive.

"Home health aide" means a certified or trained professional who provides services through a home health care agency that:

(a) are not required to be performed by an RN, LPN or LVN;

(b) primarily aid the covered person in performing the normal activities of daily living while recovering from an injury or sickness; and

(c) are described under the home health care plan.

"Home health care agency" means an agency or organization that:

(a) is licensed, if required, by the appropriate licensing body to provide home health services and medical supplies;

(b) is primarily engaged in nursing and other therapeutic services; and,

(c) has its policies set up by professionals associated with the agency.

"Home health care plan" means a program for continued health care and treatment in the covered person's home. It must either (a) follow within 24 hours of and be for the same or related cause(s) as a period of hospital or skilled nursing facility confinement; (b) be in lieu of a hospital or skilled nursing facility confinement; or (c) in lieu of treatment at a hospital or skilled nursing facility. It must be pre-certified by a physician and renewed with the claims administrator every 60 days. Such physician must certify that the proper treatment would require confinement as an inpatient in a hospital or skilled nursing facility if the services and medical supplies were not provided under a home health care plan. He must also examine the covered person at least once a month.

"Hospice" means a facility or program providing a coordinated program of home and inpatient care that treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent hospice administration, helping the patient to cope with
physical, psychological and social stresses. The hospice administration must meet the standards of the national Hospice Organization and any licensing requirements.

"Hospice benefit period" means a period that begins on the date the attending physician certifies that the covered person is a terminally ill patient who is expected to live less than six months. The attending physician must recertify any hospice benefits in excess of six months.

"Hospice care expenses" are the reasonable and customary charges made by a hospice for the following services or medical supplies:
(a) charges for inpatient care;
(b) charges for drugs and medicines;
(c) charges for part-time nursing by an RN, LPN or LVN;
(d) charges for physical and respiratory therapy in the home;
(e) charges for the use of medical equipment;
(f) charges for visits by licensed or trained social workers, psychologists, counselors, or home health aides;
(g) charges for respite care for up to 5 days in any 30-day period.

"Hospital" means a lawfully operating institution engaged mainly in providing treatment of sick or injured persons. The treatment must be by or under the supervision of a physician. The institution must have 24-hour nursing services by or under the supervision of RNs. It must have organized facilities on the premises for: (a) diagnosis, and (b) major surgery, unless it is a hospital dealing mainly in the treatment of mental disease, alcoholism, drug addiction or TB. "Hospital" does not include: nursing or convalescent homes; half-way houses for recovering alcoholics or drug addicts; extended care facilities; homes for the aged or places for custodial care; and sanitariums maintained or accredited by the Christian Science Church.

"Immediate family" means a covered person's spouse, domestic partner, child, domestic partner's child, brother, sister, parent or in-laws.

"In-Network benefits" means the level of benefits you receive when you and/or your covered dependents are treated by network, or preferred providers. Typically, the Plan pays more when you receive treatment from an in-network, or preferred provider.

"In-Network care" means care provided by a network, or preferred provider. Typically, the Plan pays more when you receive treatment from an in-network, or preferred provider.

"In-Network provider" means a health care provider (such as a physician, hospital, pharmacy, or laboratory) that enters into a contract with the claims administrator to provide care at a specified, discounted rate. Typically, the Plan pays more when you receive treatment from an in-network, or preferred provider.

"Medically necessary" means a service or supply that the Plan determines is: (a) required for the treatment or management of an injury or sickness; (b) commonly and customarily recognized by physicians as appropriate in the active therapeutic treatment or management of the injury or sickness (as determined by the AMA or other nationally recognized medical boards); (c) other than educational or experimental; (d) not primarily for the comfort or convenience of the physician or covered person; (e) given in the most cost-efficient setting consistent with maintaining high quality care; and (f) for other than custodial care. With respect to confinement
in a hospital, "medically necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.

"Medical supplies" means items that are, as determined by the Plan, (a) used primarily to treat an illness or injury; (b) generally not useful to a person in the absence of an illness or injury; (c) the most appropriate item which can be safely provided to you and accomplish the desired end result in the most economical manner; and (d) prescribed by a physician. The item’s primary function must not be for the patient's comfort or convenience.

"Network negotiated rate" means the specified, discounted rate agreed to by in-network, or preferred providers.

"Non-preferred prescription" means a prescribed drug that is not on CVS/caremark “formulary” (preferred list) of brand name drugs.

"Out-of-Network benefits" means the level of benefits you receive when you and/or your covered dependents are treated by out-of-network providers. Typically, the Plan pays less when you receive treatment from an out-of-network provider than when you receive treatment from an in-network, or preferred provider.

"Out-of-Network care" means care provided by an out-of-network provider. Typically, the Plan pays less when you receive treatment from an out-of-network provider than when you receive treatment from an in-network, or preferred provider.

"Out-of-Network provider" means a health care provider (such as a physician, hospital, pharmacy, or laboratory) that has not entered into a contract with the claims administrator to provide care at a specified, discounted rate.

"Out-of-Pocket maximum" means the limit on your total deductibles and/or coinsurance under the Plan in a calendar year.

"Personal coverage" means coverage of a covered employee with respect to himself.

"Physician" means only (a) a medical practitioner who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures; or (b) a licensed dentist practicing within the terms of his license; or (c) a psychologist practicing in conformity with applicable state law; or (d) any other licensed practitioner of the healing arts in a category specifically favored under the health insurance laws of the state where the service for which claim is made is performed, practicing within the terms of his license.

"Pre-admission testing" means necessary diagnostic x-rays or laboratory tests as an outpatient under a pre-admission testing program administered by a hospital. Under such a program, the tests must be: (a) ordered by the physician who directs confinement; (b) made within seven days immediately before treatment and at the same hospital where treatment will be rendered and (c) accepted by the hospital in place of the same tests that would normally be made after confinement. Benefits are payable for pre-admission tests only if benefits would have been payable for the same tests had they have been performed while confined as an in-patient.

"Preferred benefits" means the level of benefits you receive when you and/or your covered dependents are treated by preferred, or in-network, providers. Typically, the Plan pays more when you receive treatment from a preferred, or in-network provider.

"Preferred brand name prescription" means a prescribed drug that is included in the CVS/caremark “preferred” or formulary list of brand name drugs. CVS/caremark selects drugs based on their safety, clinical efficacy, and cost-effectiveness to the Plan.
"Preferred care" means care provided by a preferred, or in-network, provider. Typically, the Plan pays more when you receive treatment from a preferred, or in-network provider.

"Preferred provider" means a health care provider (such as a physician, hospital, or laboratory) that enters into a contract with the claims administrator to provide care at a specified, discounted rate. Typically, the Plan pays more when you receive treatment from a preferred, or in-network provider.

"Pregnancy" includes miscarriage, abortion, childbirth or any complications thereof.

"Primary Care Physician" under this Plan includes physicians whose primary practice is one of the following: Family Practice, Internal Medicine, General Practice, OB/Gyn, Pediatrics, and Mental Health/Substance Abuse.

"Reasonable and customary (R&C) charge" means the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the customary charge for the service or procedure. Such customary charge will be determined from within the range of charges made for the service or procedure by most providers in the general geographic area where the provider maintains his usual place of business. The reasonable and customary charge will not exceed the 80th percentile of the HIAA (Health Insurance Association of America) prevailing fee schedules (or the schedule used by the claims administrator that most closely approximates the HIAA fee schedules).

"Rehabilitation facility" means an institution whose primary purpose is to provide restorative therapy to disabled persons. Such facility must be licensed as such in the state in which it operates or be certified by CARF (Commission on Accreditation of Rehabilitation Facilities). "Rehabilitation Facility" does not include places for custodial care or places for confinement of drug addicts or alcoholics.

"Respite care" means care provided to give temporary relief to the family or other caregivers in emergencies and from the daily demands of caring for a terminally ill covered person.

"Retired employee" means one who is so classified by the Participating Employer.

"Second opinion" means an opinion of a physician based on his examination of a person to evaluate the need for an elective procedure. The person must be examined in person by the physician giving the second opinion. "Second Opinion" does not include an opinion given: (a) by the physician who gives the treatment; (b) while the person is hospital-confined as an inpatient; (c) for dental surgery; (d) for childbirth or elective abortion; or (e) for any procedure not covered under the Plan. A second opinion will include a third opinion if the second opinion does not confirm the need for treatment.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the sickness. Sickness also includes pregnancy.

"Skilled nursing facility" means a lawfully operating institution engaged mainly in providing treatment for people convalescing from injury or sickness. It must have:
(a) organized facilities for medical services;
(b) 24-hour nursing service by Registered Nurses;
(c) daily medical records for each patient; and
(d) a physician available at all times.

"Skilled nursing facility" does not include: rest homes, homes for the aged, places for custodial care, or places for confinement of drug addicts or alcoholics.
"Sound teeth" are teeth that: (1) are fully restored to function; (2) do not have any decay; (3) are not more susceptible to injury than virgin teeth; (4) do not have significant periodontal disease or (5) must be in good repair and firmly attached to the jaw at the time of injury.

"Specialist" under the Plan includes physicians whose primary practice is other than one of the following: Family Practice, Internal Medicine, General Practice, OB/Gyn, Pediatrics, and Mental Health/Substance Abuse.

"Status Change" means an event described in Internal Revenue Code Section 125 that permits you to change your coverage during a calendar year. Your Status Change must affect eligibility under the Plan and must be consistent with your coverage change. Status Change events include:

- marriage (change in coverage category only or coverage to no coverage allowed);
- divorce or legal separation (change in coverage category only or no coverage to coverage allowed) gaining a dependent through birth or adoption (including any stepchild, foster child, legally adopted child, or a child for whom a court order of custody or guardianship has been obtained) (change in coverage category only or no coverage to coverage allowed);
- loss of dependent status due to attainment of age or loss of eligibility (change in coverage category only allowed);
- death of a spouse or dependent (change in coverage category only allowed except may change coverage option if going from no coverage to coverage if death results in loss of coverage);
- change in your employment status, such as a switch from benefits ineligible to benefits eligible (change in coverage category only or no coverage to coverage allowed);
- change in an adult child (under age 26) or spouse's employment status or the gain or loss of health coverage, even if voluntary (change in coverage category only allowed, except may change coverage option if going from no coverage to coverage or coverage to no coverage if you become covered under your spouse's plan).

Employees who initially declined health coverage under the Plan can enroll themselves and their dependents within thirty (30) days of their date of marriage. In the case of gaining a dependent through birth, adoption, or placement of a child for adoption, you have sixty (60) days from the date of the birth or adoption to request a Status Change. The Status Changes listed above are intended to comply with the HIPAA special enrollment rights provisions regarding loss of eligibility from other group health plan or health insurance coverage, or if the employer contributions toward other coverage ceases. Loss of coverage under this special enrollment rights provision also includes reaching the end of COBRA coverage. In addition, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created special enrollment rights for employees and dependents (see "Children's Health Insurance Program Reauthorization Act of 2009" for more information).

With respect to coverage of a domestic partner, you may make the following changes outside of the Annual Benefits Enrollment period upon the occurrence of the following events and the change must be consistent with the event:

- new domestic partnership and you and your domestic partner (a) meet the eligibility criteria when you complete a status change via the Your Total Rewards website (change in coverage category only);
- termination of domestic partnership after completing a status change via the Your Total Rewards website within 30 days (change in coverage category only);
- gaining a dependent child of a covered domestic partner through birth or adoption (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) (change in coverage category only);
- loss of dependent child of a covered domestic partner due to attainment of age (change in coverage category only).
only allowed);

- death of a covered domestic partner or a covered domestic partner’s child (change in coverage category only);
- change in domestic partner's adult child (younger than age 26) or domestic partner’s employment status or the gain or loss of health coverage, even if voluntary (change in coverage category only allowed except may change coverage option if going from no coverage to coverage due to loss of coverage under your domestic partner’s health plan).

“Virtual health care visits” allow you to see and talk to a provider, for non-emergencies, from your mobile device or computer.

**Covered Health Care Expenses**

Covered Health Care Expenses incurred for services and medical supplies:

- must be medically necessary;
- must be prescribed or ordered by the attending physician; and
- will not include amounts in excess of the reasonable and customary charge.

1. The date the service is performed or the supply is purchased is the date the covered medical expense is incurred. The Covered Health Care Expenses are:

   - Hospital charges for:
     - room and board, but not in excess of the hospital's average rate for semi-private accommodations;
     - an intensive care unit;
     - services and medical supplies during hospital confinement as an inpatient (including medications at discharge);
     - outpatient services for surgery;
     - outpatient services for treatment of an emergency medical condition;
     - outpatient services for pre-admission testing;
     - outpatient services for chemotherapy, radiation therapy and dialysis; and
     - outpatient diagnostics services, e.g. MRI, CAT Scans.

2. Charges made by an ambulatory surgical center for services in connection with outpatient surgery.

3. Charges made by a birthing center for treatment in connection with pregnancy.

4. Charges made by a skilled nursing facility for treatment rendered while confined:

   - in lieu of a hospital confinement; or
   - within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.

   Room and board charges in excess of the skilled nursing facility's average rate for semi-private accommodations and any charges for days of confinement in excess of 100 in a calendar year are not Covered Health Care Expenses. The 100-day limit is a combined in- and out-of-network limit.

5. Charges made by a rehabilitation facility when confinement in the facility follows within twenty-four (24) hours of, and is for, the same or related cause(s) as a period of hospital or skilled nursing facility confinement.
(6) Charges made by a home health care agency for treatment rendered in a covered person’s home pursuant to a home health care plan. Covered Health Care Expenses for home health care are limited to the following:

(a) part-time or intermittent nursing care by or under the supervision of an RN, LPN or LVN;
(b) part-time home health aide services that consist primarily of caring for the patient;
(c) medical social services by licensed or trained social workers, psychologists or counselors;
(d) nutrition services provided by a licensed dietitian;
(e) medical supplies attendant to the above services.

Provided further, that in determining the limit of benefits for services in (a) through (e) above:

1. each visit by a member of a home health care team (other than a home health aide) will be counted as one home health care visit; and
2. four hours or less of home health aide service will be counted as one home health care visit. (Note: The 120-visit limit is a combined in- and out-of-network limit.)

(7) Charges made by a hospice for hospice care expense incurred by a terminally ill covered person during a hospice benefit period.

(8) Charges for physician’s professional services.

(9) Charges for professional ambulance service in connection with an emergency medical condition and for medical transportation. Covered Health Care Expenses for the service are limited to charges for land transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.

(10) Charges for covered drugs requiring a written prescription and not covered under any of the preceding paragraphs. Injectable insulin and syringes for its administration are considered drugs under this paragraph. Participants should refer to the “Prescription Drug Program” section for additional details.

(11) Charges for services of licensed physical, physical/occupational (including respiratory) rehabilitation and speech therapists. Such services must be rendered on an outpatient basis. However, they may be rendered in the covered person’s home if done as part of a home health care plan. Covered Health Care Expenses for such services are limited to 60 visits for speech therapists, 60 visits for occupational and/or physical therapists and 60 visits for respiratory therapists in a calendar year. (Note: limit is a combined in- and out-of-network limit. Additional visits beyond these limits may be approved upon medical review demonstrating progression in goal-directed rehabilitation services, regardless of diagnosis).

(12) Charges for the transfusion or dialysis of blood, the cost of whole blood, blood components and the administration thereof.

(13) Charges for the purchase, repair and replacement of oxygen and equipment for its administration and other durable medical equipment and accessories required for operation or maintenance on durable medical equipment, limited to once every three years. The option to rent or purchase any such equipment must be reviewed by the Plan claims administrators for necessity and appropriateness before charges will be considered a covered medical expense. The rental charges for equipment shall not exceed the purchase price for such equipment.

(14) Charges for the use of radium and radioactive isotopes.
(15) Charges for non-dental prosthetic devices to replace natural body parts. Replacement of such a device is covered only if required by the covered person's physical change, or because the prosthesis is no longer functional due to wear or damage.

(16) Charges for anesthesia and its administration, x-rays and laboratory work, casts, splints, trusses and braces.

(17) Charges for an on-site nursing assessment by an RN, if ordered by the Plan's claims administrator.

(18) Charges for private duty nursing on an outpatient basis. Covered Health Care Expenses are limited to 70 shifts in a calendar year, where eight hours of services count as one shift. (Note: the limit is a combined in-and out-of-network limit; no coverage for “maintenance visits.”)

(19) Charges for chiropractic care services performed by chiropractors, subject to a 12-visit maximum in a calendar year. (Note: the 12-visit limit is a combined in- and out-of-network limit.)

(20) Charges for a covered dental injury to sound natural teeth; includes all dental work, surgery, and orthodontic treatment to repair teeth damaged due to a covered dental injury. If crowns, dentures, bridgework, or appliances are installed due to injury, only charges for the first crown, denture, bridgework, or appliance are covered.

(21) Charges for surgical treatment of temporomandibular joint dysfunction (i.e., arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations); charges for non-surgical temporomandibular joint dysfunction (i.e., clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections) not to exceed a $1,000 lifetime maximum benefit. (Note: the limit includes surgical and non-surgical treatment, including appliances.)

(22) Charges for allergy treatment, including exams, serums, and injections.

(23) Charges for surgical services for morbid obesity, including gastroplasty and gastric bypass surgery only if:
   1. prior authorization is received from the claims administrator;
   2. presence of severe obesity defined as either:
      a) body mass index (BMI) exceeding 40; or
      b) BMI greater than 35 in conjunction with any of the following co-morbidities:
         i. coronary heart disease;
         ii. type 2 diabetes mellitus;
         iii. clinically significant obstructive sleep apnea; or
         iv. medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);
   3. patient has completed growth (18 years of age, or documentation of completion of bone growth);
   4. patient has attempted weight loss in the past without successful long-term weight reductions;
   5. patient has participated in a consistent program that is physician-supervised with integrated components of a dietary regimen, appropriate exercise and behavioral modification and support;
   6. an evaluation has been performed by a multi-disciplinary team with medical, surgical, psychiatric and nutritional expertise; and
   7. for patients who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary in order to exclude patients who are unable to provide informed consent or who are unable to comply with the pre- and postoperative
regimen. Please note that the presence of depression due to obesity is not normally considered a contraindication to obesity surgery. There is a maximum of one procedure per lifetime.

(24) Charges for FDA approved multi-channel cochlear implants in patients who meet both the following criteria: (1) At least 12 months of age; and (2) profound bilateral sensorineural deafness (a hearing threshold of 70 decibels or greater) that cannot benefit from hearing aids. Deafness cannot be due to: lesions of the acoustic nerve or central auditory pathway, otitis media or other active unresolved ear problems, or if there is radiographic evidence of absent cochlear development.

(25) Charges for the implantation of a bone conductor for patients whose bilateral conduction hearing loss cannot effectively be restored by usual hearing aids. Indications for coverage include:
- congenital or surgically caused malformations of the external ear canal or middle ear;
- chronic otitis media or otitis externa;
- tumors of the external canal or tympanic cavity; and
- dermatitis of the external canal.

Audiologic criteria include:
- pure tone average bone conduction threshold of up to 70 dB; and
- a speech discrimination score better than 60%.

(26) Charges for outpatient cardiac rehabilitation.

(27) Charges for vasectomies and tubal sterilizations.

(28) Charges for an annual flu shot when administered by an in-network provider.

(29) Charges for contraceptive devices, including diaphragms, IUDs, and Norplant.

(30) Charges by a marriage and family therapist, only where there is a valid behavioral health diagnosis.

(31) Charges for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder 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, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- 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. When the covered person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the plan to substantiate that initial or continued medical treatment is needed and that the covered person's condition is clinically improving as a result of the habilitative service. When the treating provider 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.
For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

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 in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, 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.

(32) Charges for orthognathic surgery – please contact the claims administrator for additional information.

(33) Charges for hearing aids required for the correction of a hearing impairment, including fitting, testing, replacement, limited to one hearing aid per impaired ear every three years, up to $2,000 per ear. (Note: the limit is a combined in- and out-of-network limit).

(34) Charges for wigs and other scalp hair prosthesis, up to $350 – please contact the claims administrator for additional information.

(35) Charges for the Maternity Support Program that provide education information, advice and comprehensive case management. The program offers:

- Enrollment by an OB nurse;
- Pre-conception health coaching;
- Written and online educational resources covering a wide range of topics;
- First and second trimester risk screenings;
- Identification and management of at- or high-risk conditions that may impact pregnancy;
- Pre-delivery consultation;
- Coordination with and referrals to other benefits and programs available under the health plan;
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more and;
- Post-partum depression screening

(36) Charges for Congenital Heart Disease (CHD) surgeries including 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.

- 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.
### Prescription Drug Program

The program described here applies to all participants enrolled in the Plan. CVS/caremark, the program’s claims administrator, has a toll-free member services telephone number for your questions on the prescription drug program, including the list of drugs: 1-888-562-3784. You may obtain information on the CVS/caremark website: www.caremark.com. If you’re a first-time visitor to the site, please take a moment to register and have your member ID and a prescription number available.

The program has three components: a retail program, a mail service program and a specialty pharmacy program.

If you take a long-term maintenance medication (i.e., to lower high blood pressure or reduce cholesterol), your medication may be part of the Maintenance Choice program (see the following table for further details).

It is important to note that, under the terms of the Plan, your prescription will be filled automatically with a generic drug, if one is available, unless your doctor has written “dispense as written” on the prescription. If you or your doctor requests a brand name medication and there is a therapeutically equivalent generic alternative available, you will be required to pay the difference in cost between the brand name medication and its generic alternative, as well as the brand name coinsurance amount, not to exceed the maximum amount per prescription and corresponding drug tier (see the section “Prescription Costs” under “Plan Options”).

These expenses will apply toward the coinsurance maximum but not toward the prescription out-of-pocket maximum. If you are enrolled in the CDHP, these costs also will not apply toward the annual deductible. Please see the sections under “Plan Options” for information on how these costs will be applied under the PPO and CDHP. If you have tried the generic alternative and have had an adverse reaction to it, such as an allergic reaction to a dye or other ingredient that may be used in the generic, you may appeal.

### Maintenance Choice Program

Under Maintenance Choice, you will continue to have the choice of whether to purchase your long-term maintenance medication in 30-day supplies through your local retail pharmacy or switch to the convenience of the CVS/caremark mail-order service for a 90-day supply or a 90-day supply at a local CVS pharmacy.

If your prescription is part of the Maintenance Choice program, after three retail purchases of a maintenance drug, you will pay 100% of the cost of the drug if you continue to use a retail pharmacy (with the exception of refills through a CVS retail pharmacy). Please see the section “CVS/caremark Mail Order Service” for more information.

Visit www.caremark.com for information on whether your medication is part of the Maintenance Choice program and how to easily move your prescription from retail to mail.

Here’s an example of your estimated costs for a 90-day supply of cholesterol lowering drugs (this example is for illustration only):

<table>
<thead>
<tr>
<th></th>
<th>Member Coinsurance</th>
<th>Pharmacy Mail-Order Service Coinsurance Amount (90-day supply)</th>
<th>Retail Pharmacy Coinsurance Amount (Estimated cost for 90-day supply after 3 purchases of drug at retail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug: Simvastatin (40 mg)</td>
<td>30%</td>
<td>$16.15</td>
<td>$51.97</td>
</tr>
<tr>
<td>Preferred Brand Drug: Crestor (40 mg)</td>
<td>30%</td>
<td>$140.00</td>
<td>$572.27</td>
</tr>
</tbody>
</table>
Non-Preferred Brand Drug: Lipitor (40mg)  
50%  $200.00  $731.71

CVS/caremark Mail-Order Service
If you need a medication on a long-term basis, you will save money using the CVS/caremark mail-order service, where a 90-day supply of your medication is delivered right to you. You may also secure a 90-day supply of your maintenance medication at a CVS/caremark retail location, at the same lower, mail order pricing.

Participating Pharmacies
For a current listing of pharmacies that participate in the CVS/caremark network, or for information on participating pharmacies in your area, call CVS/caremark at 1-888-562-3784 or visit www.caremark.com.

Please note that if you use a participating pharmacy, but do not provide your CVS/caremark identification card or participant information, you may be responsible for paying for the prescription and then submitting a claim to CVS/caremark. Your reimbursement will be for the CVS/caremark contracted amount, less the coinsurance, not the full price. If you have the pharmacy reprocess your purchase within seven (7) days of the original date of the purchase, then your reimbursement would be for your purchase price, less your coinsurance.

Non-Participating Pharmacies
If you choose to have your prescription filled at a non-participating pharmacy, you must pay for your prescription in full at the time of purchase and submit a claim to CVS/caremark. You will be reimbursed the amount you would have been charged by a participating pharmacy, less the required coinsurance. Claim forms can be obtained by calling CVS/caremark at 1-888-562-3784.

Please note that the Plan will not reimburse costs for any prescriptions filled at Walgreens (or any Walgreens owned or affiliated pharmacies).

CVS/caremark Formulary Management
The Plan’s drug program with CVS/caremark includes a “formulary” drug list management feature. A formulary is a list of commonly prescribed medications that are preferred based on their safety, clinical efficacy, and cost-effectiveness to the Plan. Under CVS/caremark Formulary Management, if your doctor prescribes medication that can be interchanged with one on the formulary list, the CVS/caremark pharmacist may ask your doctor if a substitution may be made. No substitution will be made without your doctor’s approval.

CVS Specialty Pharmacy
CVS Specialty Pharmacy is designed to help you meet the particular needs and challenges of using certain medications, many of which require injection, infusion or special handling, called “specialty medications.” These medications are used to treat conditions such as MS, Hepatitis C, Rheumatoid Arthritis, among others.

If your physician prescribes a drug that falls into the specialty pharmacy definition, that drug must be purchased through CVS Specialty Pharmacy; otherwise, you will be responsible for the full cost.

Benefits of using CVS Specialty Pharmacy include:

- 24/7 access to pharmacists who are trained in specialty medications, their side effects, and the conditions they treat.
- Expedited delivery to your home or your doctor’s office for all your specialty prescription medications.
- Some supplemental supplies, such as needles and syringes, required to administer the medication will be included at no additional charge.
- Scheduling of refills and coordination of services with home care providers, case managers, and doctors or other healthcare professionals.
The list of medications subject to the specialty pharmacy program may change, and you should check with CVS Specialty Pharmacy before you fill a prescription for a specialty medication. You may also be eligible to receive specialty pharmacy services through CVS Specialty Pharmacy if you are taking a covered specialty medication.

To find out if you are eligible, call CVS Specialty Pharmacy at 1-800-237-2767, Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time.

**Special Provisions**

**Specialty Guideline Management:** Under the prescription drug program there are certain high-cost medications that fall under the “Prior Authorization for Certain Drugs” provision. Under this provision, those medications will be subject to accepted therapeutic norms and authorized at the point-of-sale. If the utilization is outside of the accepted therapeutic norms, you will be required to receive prior authorization before the prescription is dispensed.

**Step Therapy:** This program uses clinical logic to perform an automated check of your medical profile and drug history to determine whether or not you have tried a clinically appropriate and available generic or lower cost drug before providing coverage of the brand or met other clinical criteria for coverage. The classes of medications subject to step therapy are:

- Stomach and Ulcer
- Depression
- Osteoporosis
- Sleep Agents
- Cardiovascular/hypertension

**Member Pay the Difference:** If you or your doctor request a brand name medication when a generic alternative is available, you will be responsible for the brand name drug coinsurance and also for the difference in cost between the brand name and generic drug. This difference will apply toward the coinsurance maximum ($60/$70/$100 retail or $120/$140/$200 through the CVS/caremark mail-order service), but not toward the prescription out-of-pocket maximum. If you are enrolled in the CDHP, these costs also will not apply toward the annual deductible.

**Prior Authorization for Certain Drugs**

Certain medications that are covered by the Plan have multiple uses or a very high cost, thus restrictions on the use or quantity may apply. In those cases, the covered person must receive prior authorization from CVS/caremark before the prescription can be filled.

If you fill a prescription at the retail level for a drug that requires prior authorization, you or your pharmacist can ask your physician to call CVS/caremark at 1-888-562-3784 to initiate the review process for you. It typically takes two business days. You and your physician will be notified when the review process is completed. If your medication is not approved for coverage under the Plan, you will have to pay the full cost of the drug, or you may appeal.

If you choose instead to fill your prescription through the mail service program, the CVS/caremark pharmacist will contact your doctor to set up the prior authorization, if appropriate, and your prescription will be filled and mailed to you.

Drugs that currently require prior authorization include (Note: this is not an all-inclusive list and may change at any time):

- Antinarcotic Agents
- Cancer Therapies
• Erythroid Stimulants
• Fertility Agents
• Growth Hormones
• Immunomodulatory Therapy
• Interferon
• Lupron
• Multiple Sclerosis Therapy
• Myeloid Stimulants
• Respiratory Agents

**Dose Management Programs**
Dose Management uses clinical guidelines to provide coverage for an amount sufficient to treat the specific disease and provides coverage for additional drug quantities through a prior authorization process.

Under the Dose Management Programs, the following may apply:
- **Quantity Limits** restrict the number of tablets covered per month.
- **Duration Limits** restrict the length of time a prescription will be covered without going through the prior authorization process.

Drugs used for the following conditions that currently have quantity or dose duration limits include those listed below (Note: this is not an all-inclusive list and may change at any time):
- Anti-emetics
- Anti-secretory PPIs
- Arthritis
- Cholesterol
- Erectile Dysfunction Agents
- Sleep Agents
- Migraine Therapy
- Pain

**Fraud, Waste and Abuse Program**
CVS/caremark monitors physician and patient drug utilization patterns to help the Plan reduce wasteful spending and health risk associated with fraud, waste and abuse of prescription drugs. This program identifies potential problem prescribers and members with unusual or excessive utilization patterns. When a member is identified as showing an unusual pattern of prescription use that may indicate drug-seeking behavior, the member may be required to use one designated pharmacy to obtain controlled substances and/or one single physician for prescriptions of substances. CVS/caremark will send a letter to the member prior to initiating any such restriction.

A substantiated case of fraud or abuse may result in disciplinary action up to, and including, termination of employment for cause.

**Preventive Care**

**Benefits for Children through Age 18**
A baby is covered as a dependent from the date of birth, provided that dependent coverage is in force at that time, or is added, as a Status Change, within sixty (60) days of the birth. This includes coverage for hospital
charges for routine nursery care during the mother's hospital confinement, physician's charges for circumcision, and the initial in-hospital physician's visit.

Benefits are provided for in-network outpatient preventive care services from the date of birth through 18 years of age, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment according to the age-based schedule.

These services shall also include hereditary and metabolic screening at birth, appropriate immunizations (only when an in-network provider is used) and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician. The services are covered at 100% without an annual deductible if a preferred provider is used. If an out-of-network provider is used, the out-of-network benefits level applies. All other applicable provisions, limitations, exclusions and exceptions of the Plan also apply.

**Coverage for Health Examinations (Age 19 and Older)**
Under the in-network level of benefits, members may receive an annual health assessment from an in-network (or preferred) provider, limited to one visit per calendar year, with services covered at 100% without an annual deductible. Routine immunizations, tests, and lab fees administered as preventive services during the health assessment are included.

**Annual Flu Prevention**
Under the in-network preventive services benefits, members may receive an annual flu shot from an in-network (or preferred) provider, limited to one shot per calendar year, with services covered at 100% without an annual deductible. Office visits associated with the flu shot, other than for an annual physical, will be subject to deductibles and coinsurance.

**Cancer Screenings**
Under the in-network level of benefits, women may receive an annual examination by a preferred gynecologist. The office visit and all lab tests administered during the visit, including routine PAP lab charges, are covered at 100%. Please note that mammogram screenings are usually performed separately from the annual examination and are separately covered at 100% in-network. The Plan follows the American Cancer Society's recommendations for mammography screening, as follows:
- for women age 35 through 39, one baseline mammogram;
- for women age 40 or older, one mammogram every year. More frequent mammograms conducted upon the recommendation of a physician will be subject to the annual deductible and coinsurance.

Colon and Rectal Cancer screenings are considered covered preventive care services for members age 50 and older as follows:
- fecal occult blood test (FOBT), one per member every year;
- sigmoidoscopy, one per member every five years;
- colonoscopy, one per member every ten years;
- double-contrast barium enema, one per member every five years.

The following are also covered preventive care services under the Affordable Care Act:
- Lung cancer screenings for members age 55 – 80 with a 30 year smoking history;
- BRCA risk assessments and genetic counseling/testing for women with a family history of breast cancer;
- Preventive breast cancer drugs (tamoxifen and raloxifene) for women over the age of 35:
  a. Who do not have a prior history of diagnosed breast cancer, DCIS or LCIS
  b. If prescribed for the purpose of primary prevention of invasive breast cancer because the
patient is deemed high risk
c. Are post-menopausal if prescribed raloxifene.

Other Preventive Services

- Routine PSA screenings for males age 40 and older - up to one screening per calendar year is covered under the Plan.
- Tobacco use interventions for adults and adolescents;
- Certain FDA approved tobacco cessation medications (subject to Utilization Management under the Prescription Drug Program);
- Alcohol misuse screening and counseling for adults;
- Hepatitis infection screening for adults at high risk (with dates of birth between 1946 and 1965); and
- HIV screening for members age 15 – 65 (and others) if at increased risk, including pregnant women.

The benefits provided under the health examination provision are subject to all other applicable provisions, limitations and exceptions of the Plan.

Coverage for Women’s Preventive Services

The Patient Protection and Affordable Care Act (PPACA) provides certain women’s preventive care health and prescription drug benefits at no cost to the member. Under the in-network level of benefits, members may receive the following services not subject to coinsurance or an annual deductible:

Coverage for Preventive Prenatal Care

- **Prenatal visits** limited to pregnancy-related physician office visits including the initial and subsequent physical exams (maternal weight, blood pressure and fetal heart rate check). Does not include coverage for inpatient admissions, high risk specialist visits, ultrasounds, amniocentesis, fetal stress tests, certain pregnancy diagnostic lab tests, and delivery including anesthesia.
- **Gestational diabetes screening.**

Breast Feeding Supplies and Counseling

- Rental of a hospital-grade electric pump when the baby is detained in the hospital.

- Purchase of a standard electric breast pump (non-hospital grade) if requested within sixty (60) days from the date of birth provided a standard electric breast pump or a manual breast pump has not been covered within the previous three years.
- Purchase of a manual breast pump, if requested within twelve (12) months from the date of birth provided a standard electric breast pump or a manual breast pump has not been covered within the previous three years.
- Purchase of a new set of breast pump supplies in any year when a member would not qualify for the purchase of a new pump.
- Six visits per year to a qualified lactation consultant for either individual or group classes.

Contraceptive Methods and Counseling

- Office visits for the administration of contraceptive devices (e.g., insertion of IUD; injectable) including the cost of the device or injectable.
- Oral and Emergency prescription contraceptives (generics only).
  - Important Note: The mail incentive benefit (Maintenance Choice Program) still applies to contraceptives. Your first three fills at a participating retail pharmacy will have $0 coinsurance; however, if you continue to use retail for the fourth refill and thereafter, you will pay 100% of
the cost of the drug (with the exception of refills through a CVS retail pharmacy). Please see the section “CVS/Caremark Mail Order Service” for more information. Generic contraceptives filled at Mail Order will have a $0 coinsurance.

- Sterilization procedures - surgical or implant (Ensure).
- Contraceptive counseling limited to two visits per year.

Other Counseling
- Intimate partner violence screening for women of childbearing age.

Coverage for Organ Transplants

Except as provided below, benefits for organ transplants are payable on the same basis as any other sickness or injury.

Covered Health Care Expenses for charges incurred by a covered person in connection with an organ transplant will include charges incurred by the donor, including charges for transportation of the organ(s), to the extent that the charges are not covered by the donor's plan of coverage or insurance. Covered Health Care Expenses will not include charges incurred by the covered person as an organ donor.

Coverage for Infertility Benefits

As used in this provision, "infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year and has been under the care of a physician. To be eligible for the benefit, the individual will need to be enrolled in the Reproductive Resource Services (RRS) Program described below.

Benefits will be paid for reasonable charges incurred by a covered person for the diagnosis and treatment of infertility, to the same extent as those provided for any other pregnancy-related expense. Benefits provided under the Plan, however, are determined per covered person. For instance, if an employee and his spouse or domestic partner were each covered persons under the Plan, the maximum benefits available under the Plan, as described below, for each of them as a covered person may not be combined or shared to increase a covered person’s limits to an amount greater than an individual limit. Prior authorization is required in advance of receiving infertility treatment. For additional information, please contact your claims administrator at the number on your ID card.

The lifetime maximum for non-drug treatments is $20,000 with a $10,000 lifetime maximum for drug treatments (each limit is a combined in- and out-of-network limit). The following procedures will be covered:

- artificial Insemination and Intruterine Insemination;
- In Vitro Fertilization and Embryo Placement;
- Assisted Reproductive Technologies (ART), Gamete Intra-Fallopian Transfer (GIFT) and Intra Cytoplasmic Sperm Injection (ICSI);
- sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any; and
- cryopreservation of embryos, limited to 12 months

Benefits will not be paid for:

- surrogacy;
- reversal of voluntary sterilization;
• any other experimental infertility procedure unless the procedure becomes recognized by the American Fertility Society or the American College of Obstetrics and Gynecology and the procedure is performed after that date;
• any charge if the covered person previously underwent a voluntary sterilization;
• charges for recruitment of or reimbursement to egg donors, any costs attributed as “enrollment fees” in any donor egg program or charges for the physical or psychological screening of a potential egg donor.
• charges for any treatment that could not be performed on a covered person of that gender.

Participants pay the applicable prescription coinsurance for outpatient fertility drugs purchased at a CVS/caremark participating retail pharmacy or mail-order program, subject to the $10,000 lifetime maximum for drug treatments.

The benefits provided under this provision are subject to all other applicable provisions, limitations and exceptions of the Plan.

Reproductive Resource Services (RRS) Program
The Plan pays Benefits for the infertility services described above when the member participates in the Reproductive Resource Services (RRS) program. The RRS program provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.

For infertility services and supplies to be considered covered under the plan, contact RRS and enroll with a nurse case manager prior to receiving services.

To enroll in the program:
• Be referred to RRS by the Claims Administrator.
• Call the telephone number on your ID card.
• Call RRS directly at 1-866-774-4626.

Exclusions
The following are not Covered Health Care Expenses:

(1) charges for services and medical supplies that are not medically necessary;

(2) charges for services or medical supplies to the extent that benefits are available for the services or medical supplies elsewhere under the Plan or under any other plan or group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group offered by the Company whether or not a covered person is covered for such benefits;

(3) charges for services or medical supplies for which benefits are not payable because of deductible or coinsurance provisions under this Plan, including the prescription drug program, or under any other plan or group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group offered by the Company;

(4) charges for routine eye examinations; eye refractions; vision therapy; radial keratotomy; eyeglasses; contact lenses, except the first pair following cataract surgery and only if vision can be corrected to 20/40 or better with contact lenses but not with conventional lenses (eyeglasses); or other vision aids;
(5) charges for cosmetic surgery other than:
   a. surgery performed to correct a congenital disease or anomaly of a dependent child;
   b. reconstructive surgery to restore tissue damaged by an injury or sickness; or
   c. for covered persons receiving benefits for a medically necessary mastectomy who elect breast reconstruction after the mastectomy; coverage will be provided for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas;

(6) charges for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home;

(7) charges for treatment to the teeth or gums except expense incurred for treatment of covered dental injury, other than a chewing injury, to sound natural teeth;

(8) charges for non-surgical treatment of temporomandibular joint dysfunction that exceed the lifetime maximum benefit of $1,000, including appliances;

(9) charges for vitamins or food supplements (the only exception is prenatal vitamins, which are covered when prescribed by a physician), Retin A (age 25 and older), Renova, topical fluoride, non-prescription over-the-counter drugs, medicines and medical supplies, experimental drugs or drugs limited by law to investigational use and any charges for the administration of such substances;

(10) charges for private duty nursing services in a hospital or any other facility;

(11) charges incurred by a covered person as an organ donor;

(12) charges incurred or treatment rendered unless the covered person is under a legal obligation to pay for such treatment;

(13) charges for expenses incurred due to accidental injury or sickness that arises out of or in the course of employment or for which benefits are payable under a Workers' Compensation Law; or where benefits are payable under no-fault automobile coverage laws or similar laws if you could elect it, or could have it elected for you;

(14) charges for custodial care;

(15) charges for reversal of a voluntary surgical sterilization;

(16) charges for items used for personal comfort and/or that are useful or that improve the covered person's household, whether or not recommended by a physician, including but not limited to:
   a. air conditioners, humidifiers and air cleaners or filtration systems,
   b. all types of exercise equipment such as exercise bicycles and treadmills,
   c. whirlpools and saunas,
   d. lift chairs and all types of beds, except hospital beds covered as durable medical equipment,
   e. vans, van lifts and alterations to motor vehicles; or
   f. stair lifts, ramps and alterations and/or remodeling of any household;

(17) charges for care, treatment, services and medical supplies that are primarily for dietary control, including but not limited to any exercise and/or weight reduction programs, whether or not recommended by a
physician; with the exception of surgical services for morbid obesity including gastroplasty and gastric bypass surgery covered under certain conditions as detailed in the “Covered Health Care Expenses” section;

(18) charges for any testing, training or rehabilitation for educational, developmental or vocational purposes, including but not limited to charges for the diagnosis or treatment of an Academic Skills Disorder, including a Developmental Arithmetic Disorder, a Developmental Expressive Writing Disorder, a Developmental Articulation Disorder, a Developmental Expressive Language Disorder, or a Developmental Receptive Language Disorder, whether or not recommended by a physician;

(19) charges for marriage counseling and/or sexual therapy, unless there is a valid behavioral health diagnosis;

(20) charges for exercise programs that are primarily used to maintain a level of health, whether or not recommended by a physician;

(21) charges for services rendered by a chiropractor that exceed the maximum benefit of 12 visits per calendar year including charges for “maintenance” services;

(22) charges for travel or transportation to obtain medical services, treatment or medical supplies except for:
   a. professional ambulance service as set forth in subparagraph (9) under Covered Health Care Expenses; or
   b. bariatric surgery if the closest center of excellence is 50 miles or more from your home;

(23) charges for dentures except as required to replace sound natural teeth lost because of injury not caused by biting or chewing on food or other objects;

(24) charges for any care, treatment, services or medical supplies that are:
   a. not approved or accepted as essential to the treatment of an Injury or Sickness by any of the following: The American Medical Association, the U.S. Surgeon General, the U.S. Department of Public Health, or the National Institute of Health; or
   b. not recognized by the medical community as potentially safe and efficacious for the care and treatment of the injury or sickness;

(25) charges incurred outside the United States if:
   a. the covered person traveled to such location to obtain medical services, drugs or medical supplies; or
   b. such services, drugs or medical supplies are unavailable or illegal in the United States;

(26) charges for speech therapy; charges are covered only when such therapy is administered by a provider licensed to administer speech therapy to a covered person whose previously unimpaired speech is affected by an injury or sickness, or to a dependent child as part of that child's treatment to correct a congenital disorder;

(27) charges for multiple surgical procedures, whether or not related, in excess of 100% of the covered charge for the greater procedure and 50% of the covered charge for each lesser procedure during the same operative session;

(28) charges of an assistant surgeon or surgical assistant in excess of the lesser of:
   a. the actual billed charge;
   b. the negotiated rate; or
   c. 30% of the reasonable and customary charge for surgery for non-preferred benefits;
(29) charges for thermography or its interpretation;
(30) charges for birth preparation classes, such as Lamaze;
(31) full charges for a preferred or non-preferred brand name drug for which there is a generic substitution;
(32) charges for the difference in cost between a preferred or non-preferred brand name drug and the generic
drug if a therapeutically equivalent generic drug is available but the physician has written “dispense as
written” on the prescription;
(33) charges for 100% of the cost of a drug after three purchases of a maintenance medication at a retail
pharmacy;
(34) charges for certain compound drugs;
(35) charges for routine hearing tests except for newborns;
(36) charges for autologous (own) or directed blood donation (selected donor) and blood storage prior to
surgery when surgery requires transfusion;
(37) charges for acupuncture;
(38) charges for orthopedic shoes, foot orthotics, or other devices to support the feet;
(39) charges for routine foot care;
(40) charges for certain specialty medications that are not purchased through the CVS Specialty Pharmacy;
(41) charges for prescription drugs where an equivalent over-the-counter drug is available;
(42) charges for prescription drugs purchased at Walgreens (or any Walgreens owned or affiliated pharmacies);
(43) $200 per visit emergency room charge (as applicable dependent on the Plan option you choose);
(44) charges for services related to autism spectrum disorders, no benefits are provided for services: furnished
by school personnel under an individualized education program; furnished or required by law to be
furnished by a school or in a school-based setting;
(45) charges for services incurred in excess of any annual limits under the Plan; and
(46) charges for services performed by an unlicensed provider or a provider who is operating outside of the
scope of his or her license;

**Personal Health Support**

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized,
efficient care for you and your covered dependents. Personal Health Support Nurses center their efforts on
prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the
most appropriate and cost-effective services available.

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 healthcare. Program components are subject to change without notice.

**Condition Management Programs**

Condition Management Programs are offered to members who are living with a serious illness or chronic disease. Condition management is a coordinated system of health care communications and information (brochures, mail, e-mail, phone contact with clinicians) combined with doctor support designed to assist people with their chronic conditions. Condition management uses evidence-based guidelines and standardized outcomes and data assessment. Program staffers from UnitedHealthcare or CVS/caremark may contact your doctor to make sure your plan of care reflects science-based standards of care applicable to your condition. Incentives may be offered for participation in the program for eligible employees.

**Castlight Health**

This tool is available to employees enrolled in the Plan and their enrolled spouses/domestic partners and dependents age 18 and older. Castlight is a web-based tool that gives you personalized out-of-pocket costs and coverage information so you’re in control of your health care. The Castlight portal is customized to you and your plan and your health information is always confidential and completely secure. You can use Castlight to search for a doctor and estimate your costs before your visit. You can access health care records for your family all in one place, and can check which benefits are covered by your plan, how much you’ve spent towards your deductible and coinsurance and CDHP participants can check their HSA balance. Plan participants can register for Castlight through Your Total Rewards website or directly at www.mycastlight.com/libertymutual. Your spouse/domestic partner or other eligible dependent age 18 and older can also register at www.mycastlight.com/libertymutual.

**Coordination of Benefits**

If a member of your family is covered by another employer’s benefit plan, there may be some duplication of benefit coverage between the Plan and the other plan. This coordination of benefits (COB) provision describes how benefits are paid in such cases. Its purpose is to ensure that, when benefits are payable under both the Plan and another group plan or plans, or Medicare, the total benefits paid do not exceed the total that would be payable under the Plan in the absence of other coverage. Note that the prescription drug benefit program does not coordinate benefits with other plans.

To determine how plans coordinate benefits, one plan is considered primary and the other is considered secondary. The primary plan pays benefits first, up to that plan’s limits. The secondary plan will not pay benefits until the primary plan pays a portion of or denies a claim. How a plan is determined to be primary is explained in the “Non-Duplication of Benefits” section below.

The word "plan" as used in this provision applies to any of the following that provides benefits or services for health care:

- group insurance or group prepayment coverage; or
- coverage for persons in a group (whether or not on an insured basis); or
- governmental programs and coverage required or provided by statute including, but not limited to,
automobile no-fault insurance and Medicare.

The word "plan" applies separately to:

- each policy or other arrangement for benefits or services; or
- the portion of such policy or other arrangement that reserves the right to consider other plans in determining its benefits.

"Allowable Expense" means any necessary, reasonable, and customary item of expense at least a part of which is covered by one of the plans that covers the person for whom claim is made (claimant). When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

In applying this provision, it will be presumed that all affected employees and dependents have chosen to assert their rights under other plans of benefits, including automobile no-fault laws based on the actual coverage that has been selected.

Non-Duplication of Benefits

A plan without a COB provision is always the primary plan. The primary plan is the plan that pays its benefits first. If all plans have COB provisions, the following rules apply:

- **The Plan is primary for covered employees of Participating Employers.**
- **Any other plan covering a dependent as an employee is the primary plan for that person.** For example, if your spouse or domestic partner is covered by a plan offered by his or her employer, then that plan will be primary for your spouse or domestic partner.
- **If your child is covered by this plan and your spouse's plan or domestic partner's plan as a dependent, then the birthday rule determines which plan is primary.** Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is your child’s primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If your spouse’s or domestic partner’s plan does not have the birthday rule, then the spouse’s or domestic partner’s plan is primary.
- **If parents are divorced or separated and a court decree establishes financial responsibility for health care of a child,** then the plan of the parent assigned that responsibility will be that child’s primary plan. In the absence of a court decree and when not remarried, the plan of the parent with custody will pay benefits before the plan of the other parent. If the parent with custody has remarried or entered into a domestic partnership and the stepparent’s or domestic partner’s plan also covers the child, the plan of the parent with custody will pay first, then the plan of the stepparent or domestic partner will pay next, and the plan of the parent without custody will pay last.

There are two other rules to keep in mind regarding non-duplication of benefits. First, when an individual has coverage from two employers – one a current employer, and the other a previous employer – the current employer’s plan is primary. Second, when the preceding rules do not resolve which plan is primary, the plan covering the individual the longest is primary.

When the Plan is primary, the Plan pays benefits as if it were the only plan. After the Plan pays its benefits, or denies a claim, you may file a claim for any unpaid amounts with the secondary plan.

The following describes how the Plan coordinates benefits when it is the secondary plan:

- **The Plan determines the benefit that would be paid if it were the only plan.** This includes applying the appropriate deductible and coinsurance, and all other benefit limitations.
- **The amount of benefit paid by the primary plan is subtracted, or “carved out,” from any benefit that**
would be paid by the Plan. This means that when the Plan is secondary, it will only pay the difference, if any, between its usual benefit and the benefit paid by the primary plan (including Medicare, if applicable).

- Therefore, coverage under the Plan and another plan will not likely result in your receiving reimbursement greater than the total that would be payable under the Plan in the absence of other coverage for your health care expenses.

Right to Receive and Release Necessary Information
The Plan has the right, without obtaining consent or serving notice, to release or obtain benefit information needed in order to implement this provision.

Optional Payment of Benefits
If payments should have been made under this Plan but were made under any other plan(s), the Plan may make payments to such other plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Plan will no longer be liable for the payments.

Right of Recovery
If payments were made under this Plan that should have been made under any other plan, the Plan has the right to recover such payments. This right may be exercised against any persons to, for, or with respect to, whom the payments were made and any insurance companies or other organizations.

Reimbursement and Subrogation
Subrogation applies when the Plan has paid benefits on your behalf for a sickness or injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and 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 a third party is alleged to be responsible.

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

As a covered person or dependent under the Plan, you must:
• Notify 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.
• Provide any relevant information/documents requested by the Plan in order to secure the subrogation and reimbursement claim.
• Respond to requests for information about any accident or injuries.
• Make court appearances.
• Obtain the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
The Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or offset from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, 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 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 shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

The Plan's rights to recovery will not be reduced due to your own negligence.

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, 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 a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (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.

Termination of Coverage

The personal coverage of a covered employee will end on the date that any of the following events first occur, subject to any applicable Continuation of Coverage Provisions:

(a) the date employment or eligibility ends for any reason, except that coverage may be continued if employment ends due to becoming a retired employee (refer to the "Benefits for Retired Employees" section later in this summary plan description);
(b) the Plan terminates;
(c) the end of the last period for which a covered employee makes a required contribution, or otherwise failed to pay any required portion of the cost of personal coverage.

Employees who were on an approved long term disability leave as of December 31, 2014, and whose employment terminates as of December 31, 2016 after 24 months of continuous absence are eligible to continue to participate in the Plan at the applicable cost determined by the Plan Administrator for them and their eligible dependents until they attain age 65, or earlier if they retire prior to age 65, provided:

- they were covered by the Plan immediately prior to their employment termination,
- they pay their applicable premium for coverage under the Plan, and
- they remain disabled under the terms of the Liberty Mutual Long Term Disability Plan

For employees who were on an approved long-term disability leave after December 31, 2014, and whose employment ends on or after January 1, 2017 after 24 months of continuous absence, benefits under the Plan will terminate on the date that their employment terminates with the Company. Coverage may be continued subject to the provisions of the “Right to Continue Coverage (COBRA)” section.

The employee's coverage of a covered dependent will end on the date that any of the following events first occur, subject to any applicable Continuation of Coverage Provisions:

(a) status as a dependent ends;
(b) the covered employee's personal coverage ends;
(c) dependent coverage is deleted from the Plan;
(d) the end of the last period for which a covered employee makes a required contribution, if he has canceled his payroll deduction authorization, or otherwise failed to pay any required portion of the cost of dependent coverage; or
(e) the dependent becomes covered as an employee.

Please refer to the section entitled “Right to Continue Coverage (COBRA)”

How to Claim Your Benefits

Note: If you receive in-network care, you usually will not have to file a claim form. Your preferred providers will file claims for you and bill you for any deductible and/or coinsurance for which you may be responsible.

Health Care Claim Forms
If you receive out-of-network care, you may need to pay the provider and file a claim with the claims administrator for reimbursement by contacting the claims administrator directly for a claim form. In addition, the claims administrators’ Member Services group can help you with questions you may have on completing your claim form.

Once you have completed your claim form and attached your itemized bill or original receipt, mail the form directly to the claims administrator at the address shown on the form. Health care bills must be on the doctor's bill form or letterhead, fully itemized with patient's name, dates of treatment, kinds of treatment, e.g., office visit, surgery, injection, etc. "Balance due" bills are not acceptable because they do not include the specifics outlined in this paragraph.

Claims must be submitted within twelve months from the date that charges are incurred unless they are delayed by the claimant’s legal incapacity, or they will not be paid.

Direct Payment of Benefits
The Plan allows for direct payment of benefits to any provider (doctor, hospital, etc.) regardless of whether such payment is made at the employee's request or with his or her consent.

If you assign payment to a provider, your bill must be paid directly to the provider. If an assigned bill is marked paid, the provider must be able to confirm that there is no balance before a benefit will be sent to the employee. If you seek care from an out-of-network provider, it is your responsibility to pay for those charges, including any difference between what you were billed and what the Plan paid. When you assign your Benefits under the Plan to an out-of-network provider with UnitedHealthcare's consent, and the out-of-network provider submits a claim for payment, you and the out-of-network provider represent and warrant that the Covered Health Care Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of benefits under the Plan, the assignment must reflect the agreement of the covered dependent in that the out-of-network provider will be entitled to all the covered dependent's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning those benefits, and that the covered dependent will no longer be entitled to those rights.

If an assignment form does not comply with this requirement, but directs that the benefit payment should be made directly to the out-of-network provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat the covered dependent, rather than the provider, as the beneficiary of the claim. If benefits are assigned or payment to an out-of-network provider is made, the Company reserves the right to offset the benefits to be paid to the provider by any amounts that the provider owes the Company pursuant to “Coordination of Benefits”.

CVS/caremark Prescription Drug Claim Forms
In most cases you will not need to file claims for prescriptions. Instead you will pay the applicable coinsurance either at a CVS/caremark participating pharmacy or through the CVS/caremark mail-order service.
You will need to file a claim if you have your prescription filled at a non-participating pharmacy. For more information, contact CVS/caremark at 1-888-562-3784. You can also request claim forms by logging on to www.caremark.com.

**Explanation of Benefits (Health Statement)**

An explanation of benefits (EOB) or Health Statement is issued when there is a participant liability or a claim is denied. It lists the dates of services, medical providers, amounts considered, coinsurance level and remaining lifetime maximum benefit. In order to receive your EOB, you must register on www.myuhc.com. Once registered, you will receive an email when an EOB is posted to your account on www.myuhc.com. You may request to receive your EOBs by mail by contacting UnitedHealthcare.

If you have any questions regarding payments, you may write or call UnitedHealthcare at the address and telephone number listed on your EOB. Your questions can be answered more quickly by stating the claim ID number that is located on the EOB.

**Women's Health and Cancer Rights Act Notification (WHCRA)**

For covered persons receiving benefits for a medically necessary mastectomy who elect breast reconstruction after the mastectomy, coverage will be provided for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas. *This language is intended to satisfy the Women’s Health and Cancer Rights Act annual notice requirement regarding mastectomy-related services available under the Plan.*

**Qualified Medical Child Support Order (QMCSO)**

A "Qualified Medical Child Support Order" may require benefits for a dependent child under the Plan. Generally, this is a judgment, decree, or order that pertains to divorce. You can obtain a copy of the Plan's QMCSO procedures, without charge, by calling Benefits Express at 1-800-758-4460.

**Right to Continue Coverage (COBRA)**

It is important that both you and your spouse or domestic partner read this summary. These provisions generally explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The federal law known as COBRA requires most employers sponsoring group health plans to offer employees and their families who would otherwise lose group health plan coverage a temporary extension of coverage under the employer's group health plan. COBRA continuation coverage is continuation of plan coverage when coverage would otherwise end because of a qualifying event, specified below. COBRA continuation coverage must be offered to each person who is a qualified beneficiary, defined as a person who will lose plan coverage because of a qualifying event.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.
COBRA continuation coverage for the Plan is administered by Benefits Express, telephone number: 1-800-758-4460.

Employee

Employees covered by this Plan will become qualified beneficiaries and can elect COBRA continuation coverage if Plan coverage is lost because a reduction in hours of employment or termination of employment, including retirement (for other than gross misconduct). Benefits Express, as COBRA administrator, will notify the employee whose coverage would otherwise end because of such a qualifying event that the employee has sixty (60) days to inform Benefits Express of his or her intent to elect COBRA continuation coverage. An employee must elect COBRA continuation coverage following such a qualifying event within sixty (60) days of receiving notice of his or her COBRA election rights from Benefits Express via the COBRA Enrollment Notice. To elect continuation of coverage, employees may call Benefits Express at 1-800-758-4460 or enroll on the Your Total Rewards website. If the employee does not elect COBRA continuation coverage within sixty (60) days of receiving the COBRA Enrollment Notice from Benefits Express, group health plan coverage will end on the date of the qualifying event.

Spouse and Dependent Children

Dependent spouses and children covered by this Plan will become qualified beneficiaries and can elect COBRA continuation coverage if Plan coverage is lost because of any of the following qualifying events:

- death of an employee (see "Dependents of Deceased Employees" below);
- termination of an employee's employment, including retirement (for other than gross misconduct), or reduction in hours of employment, or movement to benefits ineligibility status;
- divorce or legal separation of the spouse from an employee; or
- child loses "dependent" status as defined under the Plan.

Newborns and children placed for adoption with a covered employee during a period of COBRA continuation coverage will be eligible for coverage immediately under a parent's COBRA coverage as qualified beneficiaries.

Notification

If the qualifying event that will cause a loss of Plan coverage is divorce, legal separation or a child's loss of dependent status under the Plan, the employee or a family member must inform Benefits Express at 1-800-758-4460 within sixty (60) days of such a qualifying event. Supporting documentation may be required. For such qualifying events, and the other qualifying events listed under “Spouse and Dependent Children,” Benefits Express, as COBRA administrator, will then notify the person whose coverage would otherwise end because of such qualifying events that he or she has sixty (60) days to inform Benefits Express of his or her intent to elect COBRA continuation coverage. The qualified beneficiary must elect COBRA continuation coverage following such qualifying events within sixty (60) days of receiving notice of his or her COBRA election rights from Benefits Express. If a qualified beneficiary does not elect COBRA continuation coverage within sixty days of receiving the COBRA Enrollment Notice from Benefits Express, group health plan coverage will end on the date of the qualifying event. Pay in lieu of Flexible Time Off accrued will not extend your employment or coverage. To elect continuation of coverage, employees may call Benefits Express at 1-800-758-4460 or enroll on the Your Total Rewards website. A qualified beneficiary does not have to give evidence of insurability to continue coverage.

Period of COBRA Continuation Coverage
COBRA continuation coverage, if chosen, is identical to Plan coverage provided to similarly situated employees or family members. COBRA continuation coverage, if chosen, will begin as of the date of the qualifying event.

If the qualifying event is the employee’s death, entitlement to Medicare, divorce or legal separation, or a child losing dependent status, COBRA continuation coverage may last for up to thirty-six (36) months. If the qualifying event is termination of employment (for other than gross misconduct) or reduction in hours, the COBRA continuation coverage may last for up to eighteen (18) months. There are two ways in which this 18-month COBRA continuation coverage can be extended.

First, if a second qualifying event occurs during this 18-month period that would entitle the qualified beneficiary to continue coverage for a longer period (e.g., termination of employment followed by employee’s death, divorce or legal separation, or a child losing dependent status), coverage may be extended up to thirty-six (36) months from termination or reduction in hours. The qualified beneficiary must inform Benefits Express at 1-800-758-4460, within sixty (60) days of the second qualifying event. In no event will COBRA continuation coverage last beyond thirty-six (36) months from the event that originally made the qualified beneficiary eligible to elect COBRA continuation coverage.

Second, the 18-month continuation period may be extended to twenty-nine (29) months for individuals who qualified for COBRA continuation coverage because of termination of employment or reduction in hours and either the individual or one of his/her covered dependents is later determined to be disabled by the Social Security Administration (“SSA”) during the first sixty (60) days of COBRA continuation coverage. Non-disabled family members of disabled qualified beneficiaries are also entitled to this extension. This 11-month extension is available within sixty (60) days of the later of:

- the date of the SSA determination of disability;
- the date on which the qualifying event occurs under the plan; or
- the date on which you or your covered dependent are informed of your responsibility to provide notice of your disability to the Benefits Express COBRA Department; and
- in all cases, before the end of the original 18-month period of COBRA coverage.

Notice must be provided, including a copy of the SSA determination, to the Benefits Express COBRA Department at PO BOX 14904, Lincolnshire, IL, 60069-1490; telephone number: 1-800-758-4460.

If the SSA determines that you or the applicable covered dependent is no longer disabled, you must notify the Benefits Express COBRA Department at the address listed above within thirty (30) days of the final SSA determination. You should also include a copy of the SSA determination.

**Termination of COBRA Continuation Coverage**

COBRA continuation coverage may be terminated before the end of the maximum period of COBRA continuation coverage if:

- provision of group health coverage to employees ceases;
- the charge for COBRA coverage continuation is not paid when due;
- the qualified beneficiary becomes entitled to Medicare upon the effective date of enrollment in Medicare after electing COBRA continuation coverage;
- the qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan;
- the qualified beneficiary extends coverage for up to twenty-nine (29) months based on an SSA determination of disability and there has been a final SSA determination that the individual is no longer disabled; or
• otherwise becomes ineligible under the terms of the Plan.

Cost

In most cases, the charge for continuation of coverage will be 102% of the full cost under the Plan. In cases where the eleven (11)-month extension is available based on an SSA determination of disability as described above, the charge for the additional 11 months of COBRA continuation coverage will be increased from 102% to 150% of the full cost under the Plan. There is a grace period of at least thirty (30) days for payment of the regularly scheduled charges.

Trade Act of 2002

Special COBRA rights apply to employees who have been terminated or experienced a reduction in hours and who qualify for trade adjustment assistance under the Federal Trade Act of 1974 (“Eligible Individuals”). Eligible Individuals may be entitled to a second 60-day COBRA election period. The Trade Act of 2002 created a new tax credit under which Eligible Individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you qualify or may qualify for assistance under the Trade Act of 1974, please contact Benefits Express COBRA Department for additional information at 1-800-758-4460. You must contact Benefits Express promptly or you may lose your special COBRA rights.

Address Changes, Correspondence and Questions

To protect your family’s rights when you change your address, you should notify, Benefits Express at 1-800-758-4460 about any changes in the addresses of you and your family members. You should keep a copy for your records of any such notices. If you have questions about COBRA continuation coverage, you should contact Benefits Express or you may contact the nearest Regional or District Office of the US Department of Labor’s Employee Benefits Security Administration (“EBSA”). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

COBRA-Like Continuation Coverage for Domestic Partners

Although there is no legal obligation to offer COBRA continuation rights to covered domestic partners and their children, the Company has elected to provide the opportunity for such persons to continue their health care coverage if coverage otherwise ends, upon the occurrence of certain events. Specifically, covered domestic partners and their dependent children generally will be allowed to continue coverage similar to coverage provided to COBRA qualified beneficiaries under the same terms as described above upon the:

• death of an employee (see "Dependents of Deceased Employee");
• termination of an employee's employment, including retirement (for other than gross misconduct), or reduction in hours of employment, or movement to benefits ineligibility status;
• termination of Domestic Partnership within thirty (30) days of the termination of domestic partnership of the domestic partner from an employee;
• domestic partner’s child loses "dependent" status as defined under the Plan; or
• employee entitlement to Medicare.

Dependents of Deceased Employees

Effective January 1, 2017, if an employee is covering dependents under the Plan at the time of his or her death, those dependents may continue their coverage under the Plan for 24 months, payable at the applicable cost.
The spouse or domestic partner must remain unmarried and cannot enter into a new domestic partner relationship within the 24 month period to remain covered under the Plan. If the surviving spouse or domestic partner remarries or enters into a new domestic partnership within the 24 month period, their coverage will terminate on the date of remarriage or upon entering a new domestic partnership. Coverage for dependent children will terminate when the spouse or domestic partner is no longer eligible for coverage or if the dependent children no longer meet the definition of “Dependent” under the Plan. See “Dependents of Deceased Employees” in the “Right to Continue Coverage” section.

Prior to January 1, 2017, coverage for the survivor(s) may continue until the spouse or domestic partner remarries or enters into a new domestic partnership. Coverage for dependent children will terminate when the spouse or domestic partner is no longer eligible for coverage or if the dependent children no longer meet the definition of “Dependent” under the Plan. See “Dependents of Deceased Employees” in the “Right to Continue Coverage” section.

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

Employees and dependents who are eligible but not enrolled for coverage in the Plan may enroll in that coverage under two scenarios:

- The employee’s or dependent’s Medicaid or CHIP (Children’s Health Insurance Program) coverage is terminated as a result of loss of eligibility for such coverage; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

If you are eligible under either of the above two scenarios, you must request this special enrollment within sixty (60) days of the loss of coverage in the first scenario, or within sixty (60) days of when eligibility for a premium assistance subsidy is determined in the second scenario. To request the CHIPRA special enrollment, call Benefits Express.

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. For information on eligibility for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

USERRA: Continuation of Coverage during Military Leave

If you are away from work due to military leave, different rules pertain to the continuation of your benefits, depending on the length of your leave.

If your aggregate military leave during your employment with the Company is two (2) years or less, Plan coverage will remain effective and you will be responsible for the employee share of the benefit cost unless you Benefits Express to suspend your benefits before your leave begins. All Plan provisions will apply, including any exclusion for “acts of war.”
If, and when your aggregate military leave exceeds two years, you may elect to continue your Plan coverage for up to twenty-four (24) additional months, or such time period required under USERRA as amended from time to time; however, you will be required to pay 102% of the full cost to continue coverage. If your military leave ends prior to the expiration of this 24-month period and you are reinstated with the Company, your benefits under the Plan will be reinstated without exclusions or waiting periods.

For enrollment and billing information, contact the Benefits Express.

**Special Provisions for Employees on an approved LOA as of December 31, 2014 and whose employment terminated on December 31, 2016**

- This group of participants has been grandfathered into the coverage outlined in this Summary Plan Description with the following exceptions:
- Participants may remain on coverage until their Long-Term Disability or Worker’s Compensation benefits have been exhausted.
- Participants may not increase coverage level or add a dependent if that dependent was not previously covered under this Plan as of December 31, 2016.
- Participants may drop coverage at any time without requiring a qualifying event.

**Benefits for Retired Employees**

If you are covered by the Plan immediately prior to your retirement and you have at least 10 years of continuous Eligible Credited Service and are at least age 55, you may continue this coverage after retirement by electing either retiree coverage or COBRA coverage.

If you are eligible to elect retiree health care coverage and do not enroll at the time of your retirement, you will forfeit your eligibility for this coverage. It is important that you give this decision careful consideration because this is the only time that you may enroll in coverage. It is important to note that you may not increase your coverage option after you retire. Also, you may not change your health coverage at a later date unless you are dropping coverage or decreasing your coverage category (i.e. going from family to retiree only coverage).

Employees who were on an approved long term disability leave as of December 31, 2014, and:

- whose employment terminates on or after January 1, 2017 after 24 months of continuous absence;
- remain disabled and eligible for coverage under the terms of the Liberty Mutual Long-Term Disability Plan; and
- have attained age 55 and have at least 10 years of continuous Eligible Services with Liberty and/or an Affiliate at the time of their termination of employment with Liberty or an Affiliate

will be allowed to postpone participation in the Plan until the first day of the month following the date on which they reach age 65, or earlier if they retire prior to age 65, provided that such member has been a participant in the Liberty Mutual Health Plan immediately prior to enrolling in the Plan.

Current options available to retirees under age 65 include:

- No coverage – once this election is made, coverage cannot be elected in the future; or
- Plan coverage in the PPO.

If you are age 65 or older at the time you retire, you will need to elect a coverage option and category at the
time of retirement. You may not defer your election to a later date. It is important that you give this decision careful consideration because this is the only time that you may enroll. Current options available to age 65 and older retirees include:

- No coverage - once this election is made, coverage cannot be elected in the future;
- Medical with Prescription Drug option; or
- Medical Only* option; this option does not have prescription drug coverage.

*The Medical Only option is the same design as the existing Medical with Prescription Drug option, but excludes prescription drug coverage. If you or your spouse/domestic partner enroll in a Medicare Part D prescription drug program at any time, you and your eligible dependents will automatically be moved to this Medical Only option and will not be allowed to move back to the Medical with Prescription Drug Program Option at any time in the future. If you select the Medical Only option, you may purchase your own individual Medicare Part D prescription drug program through a provider in your local area. It's important to understand that if you select the Medical Only option:

- you may not change your coverage to the Medical with Prescription Drug option at any time in the future;
- if your eligible dependent is not Medicare eligible at the time you make your election, but becomes eligible at a later time, your dependent may only enroll in the Medical Only option; or
- if your eligible dependent is older than you and selects the Medical Only option before you reach age 65, your only Plan option when you reach age 65 will be the Medical Only option.

For additional information on the options available to you in retirement, access the Your Total Rewards website.

Please note: As a retiree, there are restrictions on changes that can be made at the time you retire and once you are enrolled. At the time you retire, you may only enroll yourself and your eligible dependents for coverage if you and your dependents were enrolled in the Plan at the time of your retirement. For example, if you have employee only coverage as an active employee, you may not change your coverage category to employee plus spouse or domestic partner at the time of your retirement. After you retire, coverage can only be changed in the following situations:

- You may change your coverage category if your spouse or domestic partner involuntarily loses coverage under his or her employer's plan and has no other group coverage available. To cover a domestic partner, you must meet the eligibility requirements and provide any proof the Company may require from time to time.
- You may change your coverage category if a covered dependent dies and there are no other covered dependents, or if you acquire an eligible dependent after your retirement.

Note: Retirees and their covered dependents who are under age 65 at the time of the employee's retirement and who elect health coverage must elect a different option at the time they turn age 65. In addition, if you are younger than age 65, but your spouse or domestic partner is age 65 or older, you each enroll in the option available depending on whether you or your spouse are younger than age 65 or not. If a retiree or covered dependent elects the Medical Only option, this election applies to all participants upon reaching Medicare eligibility with no opportunity to elect the Medical with Prescription Drug option in the future.

All employees who are enrolled in the Plan and who retire, including those with more than ten (10) years of employment, will be eligible for COBRA coverage at retirement for up to eighteen (18) months, at a cost of 102% of the full price of coverage under the Plan. If you retire with ten (10) or more years of employment, although you are eligible for COBRA, if you elect COBRA instead of retiree coverage, you will not be eligible for retiree coverage at the end of the COBRA period. For more information, refer to the section entitled
"Right To Continue Coverage".

Benefits for Disabled Dependents of a Retiree
If your covered dependent becomes eligible for Medicare for any reason other than reaching age 65 (for example, if a permanent disability results in Medicare eligibility), you must contact Benefits Express to inform them of your dependent’s Medicare eligibility and elect coverage for them under the Medical with Prescription Drug option or the Medical Only option. If you do not report the change in Medicare status to Benefits Express and incur claims that are paid primarily by the Plan, you may be responsible for repaying any amounts that should have been paid by Medicare, rather than the Plan. Note: Retirees age 65 and older and Medicare eligible dependents can enroll in either the Medical with Prescription Drug option or the Medical Only option. If a retiree or covered dependent elects the Medical Only option, this election applies to all participants upon reaching Medicare eligibility with no opportunity to elect the Medical with Prescription Drug option in the future.

Cost For Retiree Coverage

Retirement on or after January 1, 2014
An active employee’s age and service as of December 31, 2013, is used to determine the age and service category to establish the contribution amount annual multiplier. Employees hired after December 31, 2013 will be in the less than 60 category. Eligible credited service for the purposes of determining your age and service category is based on the greater of your continuous years of service from your most recent hire date or years of vested service in the pension plan as of December 31, 2013. The annual contribution amount will be multiplied by your total number of years of eligible service at your retirement date (up to a maximum of 35 years). In the event you have a break in service, different rules apply as outlined in the “Break in Service” section. For retirements prior to January 1, 2014, different plan provisions applied.

Please contact Benefits Express for detailed information on the cost of coverage. Please note that rates and contribution levels for all retirees are subject to change at any time in the Company’s sole discretion.

The following chart shows the 2017 contribution schedule for employees who qualify for retiree coverage, and who are enrolled in the Plan immediately prior to their retirement date:

<table>
<thead>
<tr>
<th>Age + eligible credited service as of December 31, 2013</th>
<th>Health Coverage² (Full-Time Employees)</th>
<th>Health Coverage² (Part-Time Employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Younger Than Age 65 (Non-Medicare Eligible)</td>
<td>Age 65 or Older (Medicare Eligible)</td>
</tr>
<tr>
<td>85 or more</td>
<td>$210.00</td>
<td>$334.46</td>
</tr>
<tr>
<td>80 – 84</td>
<td>$188.46</td>
<td>$32.31</td>
</tr>
<tr>
<td>75 – 79</td>
<td>$166.92</td>
<td>$30.16</td>
</tr>
<tr>
<td>70 – 74</td>
<td>$145.39</td>
<td>$28.00</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$123.85</td>
<td>$25.85</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$102.31</td>
<td>$23.69</td>
</tr>
<tr>
<td>Less than 60</td>
<td>$80.77</td>
<td>$21.54</td>
</tr>
</tbody>
</table>

¹Pension credited service through December 31, 2013, will be based on the applicable vesting schedule in place as of your initial termination date (i.e., 5 or 10 years).
²The Company contribution amount will increase by 2.5% on an annual basis to help retirees manage health care cost inflation.

Note: When you reach age 65 and become Medicare eligible, your health care and prescription drug coverage become secondary to Medicare, and the premium cost and Company contribution amount you receive decreases.
Example: Pre-65 Health Care Costs: As of December 31, 2013, an employee was age 60 with 26 years of eligible credited service. If the employee retires in December 2017 at age 63, cost-sharing would be determined as follows:

**Step 1: Determine Age + Eligible Credited Service**

*Cost-Share Tier as of 12/31/2013*

60 (Age) + 26 (eligible credited service) = **86 [85 or more tier]**

**Step 2: Determine Eligible Credited Service as of Date of Termination**

11/30/2017 (date of termination) - 11/30/1988 (date of hire) = **29 years**

**Step 3: Calculate Annual Company Contribution Amount**

$210.00 (85 or more tier) X 29 (eligible credited service from Step 2) = **$6,090.00**

**Step 4: Calculate Annual Retiree Contribution Amount**

<table>
<thead>
<tr>
<th>2017 Annual Health Care Cost (Retiree Only)</th>
<th>$12,251.59</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Annual Company Contribution Amount</td>
<td>$6,090.00</td>
</tr>
<tr>
<td><strong>Annual Retiree Cost</strong></td>
<td><strong>$6,161.59</strong></td>
</tr>
<tr>
<td><strong>Monthly Retiree Cost</strong></td>
<td><strong>$513.97</strong></td>
</tr>
</tbody>
</table>
Example: Post-65 Medical Costs: As of December 31, 2013, an employee was age 63 with 26 years of eligible credited service. If the employee retires in December 2017 at age 66, cost-sharing would be determined as follows for the Medical with Prescription Drug option:

**Step 1: Determine Age + Eligible Credited Service**

Cost-Share Tier as of 12/31/2013

63 (Age) + 26 (eligible credited service) = 89 [85 or more tier]

**Step 2: Determine Eligible Credited Service as of Date of Termination**

11/30/2017 (date of termination) - 11/30/1987 (date of hire) = 30 years

**Step 3: Calculate Annual Company Contribution Amount**

$34.46 (85 or more tier) \times 30 \text{ (eligible credited service from Step 2)} = $1,033.80

**Step 4: Calculate Annual Retiree Contribution Amount**

| 2017 Annual Health Care Cost (Retiree Only)* | $3,378.69 |
| - Annual Company Contribution Amount | $1,033.80 |
| **Annual Retiree Cost** | **$2,344.89** |
| **Monthly Retiree Cost** | **$195.41** |

*Note: Generally only continuous service with your employer during the period your employer is a Participating Employer counts for determining eligibility and/or cost-sharing for post-retirement Plan coverage. In some cases, however, service with your employer prior to it becoming a Participating Employer or service with a previous employer, may count towards eligibility and/or cost-sharing, as listed below:

- Former CIGNA Bond Services employees who were employed as of January 24, 1994, receive credit for prior employment service with ICNA for purposes of eligibility and cost-sharing.

- Former CUMIS General Insurance Co. and CUNA Mutual General Agency of Texas employees who transferred to a Participating Employer in conjunction with the acquisition of CUMIS General on July 1, 1998, receive credit for prior employment service with CUNA Mutual Insurance Co. for purposes of eligibility and cost-sharing.

Golden Eagle Insurance Corporation employees who were employed as of October 1, 1997, receive credit for prior employment service with Golden Eagle Insurance Co. for purposes of eligibility only.
• Liberty Real Estate Management, Inc. employees who were employed on January 1, 1997, receive credit for prior employment service with Liberty Real Estate Group, Inc. and Liberty Sanibel II Limited Partnership for purposes of eligibility and cost-sharing.

• Wausau Service Corporation and former Nationwide Trial Division employees who were employed as of the acquisition date of December 31, 1998, receive credit for prior employment service with Wausau Service Corporation or Nationwide Trial Division for purposes of eligibility and cost-sharing.

• Atlantic Health Group employees who were employed as of March 31, 1997, receive credit for prior employment service with New England Health Group from the later of January 2, 1996, or the employee’s date of hire for purposes of eligibility and cost sharing.

• ACE employees who were employed as of January 1, 2000, received credit for prior continuous service from their last full-time hire date with CIGNA (if they transferred from CIGNA to ACE on July 2, 1999) or from their last full-time hire date with ACE (if hired by ACE after July 2, 1999) for purposes of eligibility and cost-sharing.

• RAM employees who were former employees of The Netherlands Insurance Company (“TNIC”) who lost or retained post-retirement coverage under the TNIC welfare benefit plans as of December 31, 1998, and who were employed by TNIC on December 31, 2000 will receive prior service credit for purposes of eligibility and cost-sharing.

• RAM employees who were not former employees of TNIC referenced above are granted past service credit towards eligibility, but not cost-sharing, provided, however, that such employees who have less than 10 years of service for cost-sharing but at least 10 years of service for eligibility will be eligible for the minimum Company contribution to the cost of the post-retirement Plan.

• RAM and Liberty Mutual employees who were former employees of OneBeacon Insurance Company on December 31, 2001, and who are employed by Participating Employers on January 1, 2002, receive credit for prior employment service with OneBeacon companies for purposes of eligibility and cost-sharing.

• Former employees of Merchants Holding Corporation who transferred and became employees of The Netherlands Insurance Company on April 1, 2002, receive credit for prior employment service with Merchants Holding Corporation, for eligibility purposes only.

• Cascade Disability Management, Inc. (“Cascade”) employees employed with Cascade as of January 1, 2003, receive credit for prior employment service with Cascade, for eligibility purposes only.

• Former employees of Liberty Financial Companies, Inc. (“LFC”) who are employed by Participating Employers on or after January 1, 2003, receive credit for prior employment service with LFC, for eligibility purposes only.

• Former employees of Prudential Commercial Insurance Company, Inc., Prudential General Insurance Company, and Prudential Property and Casualty Insurance Company (collectively referred to as “Prudential”) who transferred to Participating Employers on November 1, 2003, receive credit for prior employment service with Prudential, for eligibility purposes only.

• Liberty Northwest employees employed with Liberty Northwest as of January 1, 2006, receive credit for prior employment service with Liberty Northwest for purposes of determining years of service for eligibility and cost-sharing.

• Former Ohio Casualty Corporation (OCAS) employees who were employed by a Participating Employer as of January 1, 2008 and retire after December 31, 2013, will receive credit for purposes of eligibility and cost-sharing based on the following:
Employees with 25 years of continuous eligible service as of July 1, 2004:

- Younger than Age 65
  - Cost sharing based on actual years of eligible credited service with Ohio Casualty and Liberty Mutual (up to a maximum of 35 years).

- Age 65 or Older
  - Company contribution category: 75 to 79
  - Years of eligible credited service: 25

Employees with less than 25 years of continuous eligible service as of July 1, 2004 and more than 10 years of total service:

- Younger than Age 65
  - Eligibility based on total years of eligible credited service. Cost sharing based on eligible credited service from July 1, 2004 forward.

- Age 65 or Older
  - Company Contribution Category: < 60
  - Years of eligible credited service: Service from July 1, 2004 forward.

- Former Ohio Casualty Corporation (OCAS) employees who were employed by a Participating Employer as of January 1, 2008 and retired before December 31, 2013 will receive credit for purposes of eligibility and cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Grandfathered Age and Service Points as of 12/31/2004</th>
<th>Younger than Age 65</th>
<th>Age 65 or Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>87 or more</td>
<td>Company contribution category: 85 Credit service for multiplier: 35</td>
<td>Company contribution category: &lt; 60 Credit service for multiplier: 10</td>
</tr>
<tr>
<td>82 through 86</td>
<td>Company contribution category: 85 Credit service for multiplier: 32</td>
<td>Company contribution category: &lt; 60 Credit service for multiplier: 10</td>
</tr>
</tbody>
</table>

- Safeco employees employed with Safeco as of January 1, 2009, receive credit for prior employment service with Safeco for eligibility purposes only.

- Former grandfathered employees of Safeco Corporation and subsidiaries who transitioned to Participating Employers on January 1, 2009 who retire after December 31, 2013, will receive credit for purposes of eligibility and cost-sharing based on the following:
Former grandfathered employees of Safeco Corporation and subsidiaries who transitioned to Participating Employers on January 1, 2009 who retired before December 31, 2013, will receive credit for purposes of eligibility and cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Grandfathered Age and Service Points as of 12/31/2004</th>
<th>Younger than Age 65</th>
<th>Age 65 or Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>87 or more</td>
<td>Cost sharing based on 35+ years of service category.</td>
<td>Cost sharing based on 10-19 years of service category.</td>
</tr>
<tr>
<td>82 through 86</td>
<td>Cost sharing based on 30-34 years of service category.</td>
<td>Cost sharing based on 10-19 years of service category.</td>
</tr>
<tr>
<td>78 through 81</td>
<td>Cost sharing based on 20-24 years if service category.</td>
<td>Cost sharing based on 10-19 years of service category.</td>
</tr>
<tr>
<td>75 through 77</td>
<td>Cost sharing based on 10-14 years of service category.</td>
<td>Cost sharing based on 10-19 years of service category.</td>
</tr>
</tbody>
</table>

Note: Eligible participants who were retired at the time of the acquisition and transitioned to the Company’s plans may have a different cost sharing arrangement based on the agreement in place at the time of acquisition. Price tags and contribution levels are subject to change at the Company’s discretion.

**Break in Service**

For purposes of determining eligible credited service for post-retirement health care coverage, a termination of employment prior to retirement eligibility impacts whether or not you receive any service credit under the plan as outlined below.

Eligible Credited Service with a Participating Employer will be maintained if there is a break in service of less than 12 months.

1. **Employees rehired with a one-year or less break in service from date of termination:**

<table>
<thead>
<tr>
<th>Health &amp; Welfare Age &amp; Service Tier at Retirement</th>
<th>Service for Determining Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who were employed in 2013</td>
<td>Age + Service as of December 31, 2013.</td>
</tr>
<tr>
<td>Who were not employed in 2013</td>
<td>Less than 60</td>
</tr>
</tbody>
</table>
Retiree Rehire
(whether or not enrolled in retiree Health & Welfare at initial retirement)

<table>
<thead>
<tr>
<th>Age + Svc as of December 31, 2013 -or- Determined based on Age + Eligible credited service prior to break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible credited service prior to termination + Continuous service</td>
</tr>
</tbody>
</table>

Note: Employees with multiple consecutive service breaks of 12 months or less will have an adjusted continuous service date calculated.

Eligible credited service with a participating employer will change if the break in service exceeds one year, based on service at the time of the termination.

2. Employees rehired with a one-year or greater break in service from date of termination:

<table>
<thead>
<tr>
<th>Health &amp; Welfare Age &amp; Service Tier at Retirement</th>
<th>Additional Service Required</th>
<th>Service for Determining Subsidy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee with at least 5 years of eligible credited service prior to break (including Acquisition Groups)</td>
<td>Less than 60 Points</td>
<td>At least 5 years of Continuous service</td>
</tr>
<tr>
<td>Employee without at least 5 years of eligible credited service prior to break (including Acquisition Groups)</td>
<td>Less than 60 Points</td>
<td>At least 5 years of Continuous service</td>
</tr>
<tr>
<td>Retiree Rehire enrolled in retiree Health &amp; Welfare</td>
<td>Age + Service as of December 31, 2013 -or- Determined based on Age + eligible credited service prior to break in service</td>
<td>None</td>
</tr>
<tr>
<td>Retiree Rehire not enrolled in retiree Health &amp; Welfare</td>
<td>Less than 60 Points</td>
<td>At least 5 years of continuous service</td>
</tr>
</tbody>
</table>

Note: If you are a regular full-time employee, a one-year break in service results with respect to each 12 consecutive month period after your "service termination date" (as defined in the Plan; generally, the date your employment ends) in which you are not credited with an hour of service. If you are a part-time employee or temporary full-time employee, a one-year break in service occurs for any calendar year in which you are credited with 500 or fewer hours of service.

3. Employees on a leave of absence due to a Long-Term Disability received age and service credit while on long-term disability through December 31, 2013. No future service credit will apply to employees while on a leave of absence due to a long-term disability after December 31, 2013.
Medicare

It is important that each covered person enroll for the full benefits of Medicare as soon as the person becomes eligible for Medicare. The Plan does not cover charges payable by Medicare. In addition, the Plan will pay no more after Medicare than it would pay as primary payer. For example, if Medicare has already paid 80% of a covered charge, the Plan will pay nothing further. If you are eligible for Medicare, the Plan will apply the coordination of benefits rule whether or not you have actually applied for Medicare coverage. Covered expenses that you pay will be applied toward your Plan out-of-pocket maximum.

If you continue working after attaining age 65, the above exclusion will not apply to you, your spouse or domestic partner or dependents while the Plan continues as primary payer, as explained under the headings entitled “Benefits for Disabled Dependents of an Active Employee” and "Benefits for Covered Individuals Age 65 and Over.” However, when the Plan ceases as primary payer for you upon retirement, Medicare entitlement due to disability or termination of employment, or ceases as primary payer for your spouse or dependents, the above Medicare exclusion will apply to the affected person. Therefore, you should consult with your local Social Security office as to the best time to enroll in Medicare so that comprehensive health coverage continues without interruption.

Please note that for active employees who are Medicare-eligible, the Plan continues as primary payer as explained under the heading entitled “Benefits for Covered Individuals Age 65 and Over.”

Rights of Plan Participants (ERISA)

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other locations all documents governing the Plan including the Plan documents 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 copies upon written request to the Plan Administrator of Plan documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue COBRA health care coverage for yourself, spouse/domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights, if any. Please note domestic partners and their dependents are not entitled to COBRA continuation coverage under federal law.

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

Under ERISA there are steps you can take to enforce your rights. For example, you may file suit in a federal court if:
- you have a claim for benefits that is denied or ignored, in whole or in part;

- you request materials from the Plan Administrator and do not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator; or

- The Plan fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay the 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, if, for example, it finds your claim to be frivolous.

If you have any questions, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.

**HIPAA Privacy**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information and to periodically inform you about:

- the Plan’s uses and disclosures of Protected Health Information (PHI);
- your privacy rights and the Plan’s duties with respect to your PHI;
- your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS); and
- the person to contact for further information about the Plan’s privacy practices.

A description of HIPAA Privacy rights can be found in the HIPAA Notice provided to participants covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by law.

If you have a complaint, question or concern, or require a copy of the Privacy Notice, please contact the Manager, Benefits Administration, Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, MA 02116, Attention: Benefits Department - Mailstop M03E.

*This language is intended to satisfy the notice requirements regarding HIPAA Privacy rights with regards to the Liberty Mutual Health Plan.*

**HIPAA Portability**

A notice of the special enrollment rights under HIPAA must be provided to all employees at the time the employee is initially offered a chance to enroll in the Plan. This notice is provided to all newly eligible employees within their new hire materials. Members may also request this notice by contacting their claims administrator.
Administration of the Plan

Interpretation of Plan
The benefit plan Summary Plan Description summarizes the important features of the Plan document. While the summary plan description attempts to accurately describe benefits available as of the date of publication, it does not cover every provision of each policy or plan. In the event of a question of interpretation or conflict, the Plan document or group insurance policy will govern.

Authority of Plan Administrator
The Plan Administrator, or its designee, has the authority, in its sole discretion, to construe the terms of this Plan and decide all questions of eligibility to participate in the Plan and decide any other matters relating to the administration or operation of the Plan.

Authority of Claims Administrators
The Plan claim administrators, UnitedHealthcare and CVS/caremark, have the authority, in their sole discretion, to provide a full and fair review of and to make determinations on first-level and second-level appeals of denied claims under the Plan. In making determinations on first and second-level claim appeals, such claim administrators shall act as the appropriate named fiduciary with the discretionary authority to construe the terms of the Plan and to determine eligibility for benefits, including the amount, time, and manner of payment of benefits.

Claim and Appeal Procedures
All claims by participants, beneficiaries, and others based on a purported failure to follow the Plan's terms, including but not limited to, an alleged failure to follow any direction from a participant pursuant to Plan terms, an alleged administrative error or omission, or other alleged misconduct, are subject to the Plan's claims procedures.

Claim Procedures
The Plan Administrator shall designate a claims administrator for purposes of responding to claims filed in accordance with the claim and appeal procedures below.

Filing Claims:
- You may file claims for health benefits with the Plan claims administrator, UnitedHealthcare.
- Claims for pharmacy or prescription drug benefits may be filed with CVS/caremark.
- You may request a first-level review, second-level review, and external review of an adverse health or prescription claim decision by the Plan claims administrators.
- You must exhaust each level of review prior to proceeding to the next level of review. For example, a first-level appeal request must be denied by the claims administrator before you can request a second-level review.
- Claims may be filed either by you or through an authorized representative, who may be a spouse, domestic partner, parent, or designated health care agent. In the case of a claim involving emergency or urgent care, a health care professional with knowledge of your condition may act as your authorized representative.
- An urgent care claim is any claim as to which application of the pre-service claim time periods described below could seriously jeopardize your life or health or ability to regain maximum function or would in the opinion of a physician with knowledge of your condition subject you to severe pain that cannot be adequately managed without care or treatment.
Urgent Care Claims
If the claims administrator or your physician determines that you have an emergency or urgent care claim, you will be notified of the decision not later than seventy-two (72) hours after the claim is received. If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but no later than twenty-four (24) hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than forty-eight (48) hours, to provide the information. You will be notified of the decision not later than 48 hours after the end of that additional time period or after receipt of the information, if earlier. The time frames described above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

Pre-Service and Post-Service Claims
If a service, supply, or procedure requires advance approval before a benefit will be payable, which is considered a pre-service claim. You will be notified of the decision not later than fifteen (15) days after receipt of the pre-service claim. A post-service claim is a request for coverage or reimbursement when you have already received the service, supply, or procedure. For post-service claims, you will be notified of the decision not later than thirty (30) days after receipt of the claim. The time frames described above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

For either a pre-service or a post-service claim, the time periods referenced above may be extended up to an additional fifteen (15) days due to circumstances outside the Plan’s control. In that case, you will be notified of the extension before the end of the initial 15-day or 30-day period. If the extension is necessary because of a failure to submit sufficient information, you will be notified of the specific information necessary and given an additional period of at least forty-five (45) days to furnish the additional information. In such a case, the decision-making period is tolled or suspended from the date the extension notice is sent until the earlier of the date the additional information is received or the end of the 45-day period. You will be notified of the claim decision no later than fifteen (15) days after the end of that additional 45-day period or after receipt of the information, if earlier.

If you do not follow the pre-service claim procedures, you will be notified of the failure and the proper procedures no later than five (5) days following the failure, or within twenty-four (24) hours for emergency or urgent care claims. The notice may be oral unless you request written notice.

Concurrent Care: Ongoing Course of Treatment
If you are receiving an ongoing course of treatment, you will be notified in advance if the claims administrator intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves emergency or urgent care and you request an extension of the course of treatment at least twenty-four (24) hours before its expiration, you will be notified of the decision within twenty-four (24) hours after receipt of the request. The time frames described above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

Claim Denial Letters
If your claim is denied in whole or in part, you will receive a written notice of the denial. The denial letter will contain:

1. the specific reason for the denial;
2. reference to specific provisions on which the decision is based;
3. a description of any additional information necessary to perfect the claim and the reason why such information is necessary;
4. a description of the appeal procedures and time frames, including a statement of the right to bring a civil action under ERISA following an adverse decision on review;
5. if applicable, the specific rule, guideline, protocol, or other similar criterion relied upon in making the
decision, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request;
(6) if the decision was based on a “medical necessity” or “experimental treatment” or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free upon request;
(7) date of service, health care provider, claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment code and their corresponding meanings; and
(8) instructions for requesting denial notices in a culturally and linguistically appropriate manner.

Appeal Procedures with respect to claim denials by UnitedHealthcare or CVS/caremark

Internal Review Process
First-Level Review Appeal Time Periods
If you wish to appeal an adverse benefit decision made by UnitedHealthcare or CVS/caremark, you must do so in writing to the appropriate Plan claims administrator, at the address listed below, within one hundred eighty (180) days of the adverse benefit decision. You will be notified of the decision not later than fifteen (15) days (for pre-service claims) or thirty (30) days (for post-service claims) after the appeal is received.

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

CVS/caremark
Appeals Department
P.O. Box 52084, MC109
Phoenix, AZ, 85072-2084
Fax: 1-866-689-3092

If the claim involves emergency or urgent care, you or your authorized representative may appeal the denial either orally or in writing to the appropriate Plan claims administrator. All necessary information, including the appeal decision, will be communicated between you or your authorized representative by telephone, facsimile, or other similar method. You will be notified of the decision not later than seventy-two (72) hours after the appeal is received.

The appeal time periods described above begin at the time an appeal is received, without regard to whether all the information necessary to make a decision on the appeal accompanies the filing.

Second-Level Review Appeal Time Periods
If you choose to appeal an adverse first-level decision by UnitedHealthcare or CVS/caremark, you must submit a written second-level appeal request to the appropriate Plan claims administrator (at the address listed in the “First-Level Review Appeal Time Periods” section) within sixty (60) days following receipt of such a decision.

You will be notified of the decision by the appropriate Plan claims administrator not later than 15 days (for pre-service claims) and thirty (30) days (for post-service claims) after the second level appeal is received.

The appeal time periods described above begin at the time an appeal is received, without regard to whether all the information necessary to make a decision on the appeal accompanies the filing.
**Appeal Rights**
You may submit, and have a right to an appeal review that takes into account, written comments, documents, records, and other information relating to the claim, whether or not such information was submitted or considered in the initial decision. You may request, free of charge, copies of all documents, records, and other information relevant to your claim. You have a right to an appeal review that does not afford deference to the initial denial and that is conducted by a person who is neither the individual who made the initial denial, nor that person’s subordinate. The claim administrator, in deciding an appeal based on a medical judgment, must consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the denial, nor is the subordinate of any health care professional consulted during the initial claim review. You have a right to the identification of medical or vocational experts consulted in connection with a claim denial, without regard to whether the advice was relied upon in making the decision.

**Appeal Denial Letter**
First-Level and Second-Level Appeals denial letters will contain:

1. the specific reasons for the adverse decision on appeal;
2. reference to specific provisions on which the decision is based;
3. a statement that the claimant is entitled to receive free copies of all documents, records, and other information relevant to the claimant's claim;
4. a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under ERISA section 502(a);
5. if applicable, the specific rule, guideline, protocol, or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request;
6. if the decision was based on a “medical necessity” or “experimental treatment” or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free upon request;
7. date of service, health care provider, claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment code and their corresponding meanings; and
8. instructions for requesting denial notices in a culturally and linguistically appropriate manner.

**External Review**
The Patient Protection and Affordable Care Act (PPACA) provides you with the right to request an external review with an independent review organization not affiliated with the claims administrators. To request an external review, you must complete the external review request form that is provided with the second-level appeal denial notice provided by the claims administrator. If you request an external review, you must do so within four months after receipt of the notice of a second level claim denial (if the date falls on a Saturday, Sunday or holiday, the deadline is the next business day). Within five (5) business days after receipt of an external review request, the applicable claims administrator must complete a preliminary review of the request to determine whether:

- the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the denial does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan;
• the claimant has exhausted the Plan’s internal appeals process unless the claimant is not required to do so; and
• the claimant has provided all the information and forms required to process an external review.

Claims eligible for external review include decisions that involve medical judgment, as determined by the external reviewer, including, but not limited to, determinations based on:
• medical necessity; base pay
• appropriateness;
• health care setting;
• level of care;
• medical effectiveness;
• the Plan’s determination that treatments are experimental or investigational; and
• a rescission of coverage.

The claims administrator must issue a written notification to the claimant within one business day after completing the preliminary review. If the request was complete but not eligible for external review, the notification will include the reasons for ineligibility and contact information for the Employee Benefits Security Administration. If the request was not complete, the notification will describe the information or materials needed to complete the request, and the applicable claims administrator must allow the claimant to perfect the request within the four-month filing period, or within the 48-hour period following receipt of the notification, whichever is later.

If the request is deemed eligible for external review, your request will be randomly assigned to an Independent Review Organization (IRO). The IRO will notify the claimant in writing of the acceptance for external review and the opportunity for the claimant to submit in writing to the IRO within ten (10) business days of receipt of notice any additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days. Within five (5) business days after the date of assignment of the IRO, the Plan or applicable claims administrator must provide to the IRO the documents and any information considered in making its denial decision. If the Plan or applicable claims administrator fails to provide the documents and information timely, the IRO may terminate the external review and make a decision to reverse the Plan’s denial. Within one business day of making its decision, the IRO must notify the claimant and the Plan.

The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. The IRO must provide written notice of its decision within 45 days after the IRO receives the request for external review. The IRO must deliver notice of its decision to the claimant and the Plan.

The IRO’s decision notice must contain:

• a general description of the reason for the request for external review, including information sufficient to identify the claim;
• the date the IRO received the assignment to conduct the external review and the date of the IRO’s decision;
• references to the evidence of documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
• a discussion of the principal reason(s) for the IRO’s decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
• a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant;
a statement that judicial review may be available to the claimant; and

• current contact information, including a phone number, for any applicable office of health insurance consumer assistance.

Upon receipt of a notice of an IRO decision reversing the applicable claim administrator or Plan’s denial, the Plan immediately must provide coverage or payment for the claim.

** Expedited External Review **
You (or your authorized representative) have the right to request an expedited external review when your situation is immediate or requires urgently-needed services as follows:

• When your appeal concerns health care or treatment for which waiting for a response under the standard (non-expedited) external review time frames would seriously jeopardize your life or health or your ability to regain maximum function; or

• When your request for external review concerns an adverse final decision regarding a benefit determination for an admission, availability of care, continued stay, or health care services for which you received emergency services, while you are an inpatient.

The IRO must provide notice of an expedited external review decision no later than seventy-two (72) hours after request has been received.

Upon receipt of a notice of an IRO decision reversing the second-level denial, the Plan will provide coverage or payment for the claim. The decision rendered by the IRO will be final and binding.

** Legal Proceedings **
You will not be entitled to challenge a claim decision made by the Claims Administrator in federal or state court or in any other administrative proceeding until all of the Claim and Appeal procedures outlined above have been complied with and exhausted: No lawsuit shall be brought against the Plan, the Plan Sponsor, the Company, the Plan Administrator or the Claims Administrator by you or your authorized representative until:

• 60 days after Proof of claim has been given; and

• no more than three years after the time Proof of claim is required.

** Amendment or Termination of the Plan **
The Company can adopt any amendment to the Plan or terminate the Plan at any time. Any action that may be taken by the Company to amend or terminate the Plan may also be taken by the Company’s Chief Executive Officer except as otherwise restricted under the Company’s Compensation Committee charter.

** General Provisions **
The Liberty Mutual Health Plan is a group health plan. Plan records are maintained on a calendar-year basis: January 1 through December 31.

The Plan Sponsor is Liberty Mutual Group Inc. The employer identification number assigned by the Internal Revenue Service to Liberty Mutual Group Inc. is 04-3583679. The plan number assigned in accordance with instructions of the Internal Revenue Service is 503.
The Plan offers participation to employees of the Company and its subsidiaries that participate in the Plan, including, Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116 Attention: Benefits Department – Mailstop M03E. A list of participating subsidiaries is available on request.

Benefits are paid out of the Company's general assets (except for benefits in Hawaii, which are provided on a fully insured basis). The Plan is unfunded. Costs of coverage are shared by the Company and employees. Price tags and contribution levels are subject to change at the Company’s discretion.

Active employee contributions are made on a before-tax basis through the Liberty Mutual Section 125 Plan. Retiree contributions are made on an after-tax basis. The Company has contracted with UnitedHealthcare and CVS/caremark to provide administrative services only with respect to the Plan's self-funded preferred provider organization coverage and prescription drug program. The Company has also contracted with UnitedHealthcare to provide fully insured coverage in Hawaii. Claims administrator addresses are listed below.

For purposes of ERISA and the Plan, Liberty Mutual Insurance Company is the Plan Administrator. Your rights under ERISA are described above. Melanie M. Foley, Executive Vice President and Manager, Chief Talent and Enterprise Services Officer is designated as agent for service of legal process for the Plan Administrator. Process may be served on her at Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116, Attention: Benefits Department - Mailstop M03E; phone number: 1-617-357-9500.

**Claims Administrators**

The following is a list of claims administrators under the Plan:

- UnitedHealthcare, 185 Asylum Street, Hartford, CT 06103; 1-844-LIB-MUT4 (1-844-542-6884)
- CVS/caremark, P.O. Box 52084, MC 109, Phoenix, AZ 85072-2084; 1-888-562-3784
Plan Options

The Plan offers two options (except those who reside in Hawaii): the Consumer Directed Health Plan (CDHP) and the Preferred Provider Organization (PPO). Both options are administered by UnitedHealthcare and use the same provider network and offer comprehensive coverage (including 100% coverage of preventive care). The following sections describe how each option works.

CDHP

The following pages briefly highlight the covered major benefits and the in-network and out-of-network coverage levels under the CDHP. Please refer to the “Covered Medical Expenses,” “Definitions,” and “Exclusions” sections for detailed information, including the definition of “Primary Care Physician” and “Specialist.”

<table>
<thead>
<tr>
<th>CDHP PLAN FEATURES</th>
<th>IN-NETWORK BENEFITS¹</th>
<th>OUT-OF-NETWORK BENEFITS¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>Plan pays:</td>
<td>Plan pays (see footer):</td>
</tr>
<tr>
<td>Well Child care visits, including related tests and immunizations (according to age-based schedule).</td>
<td>100% (no deductible).</td>
<td>60% after deductible (visits up to age 6 only).</td>
</tr>
<tr>
<td>Adult (age 19 and older) routine annual physical examination including related tests and immunizations (according to Plan schedule).</td>
<td>100% (no deductible).</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Routine Annual Gynecological Exam</td>
<td>100% (no deductible).</td>
<td>No coverage for routine exams.</td>
</tr>
<tr>
<td>Annual Pap Test</td>
<td>100% (no deductible).</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Allergy Treatment/ Testing</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Primary Care Physician Office Visits</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Immunizations (other than routine)</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Surgery</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>CDHP PLAN FEATURES</td>
<td>IN-NETWORK BENEFITS(^1)</td>
<td>OUT-OF-NETWORK BENEFITS(^1)</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physician Services (cont’d)</td>
<td>Plan pays:</td>
<td>Plan pays (see footer):</td>
</tr>
<tr>
<td>Physician Hospital Services</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Diagnostic Labs, Radiology and</td>
<td>80% after deductible.</td>
<td>60% after deductible; no coverage for labs ordered by an out-of-network provider through Quest Diagnostics</td>
</tr>
<tr>
<td>other tests(^3)</td>
<td>Note: labs ordered through Quest Diagnostics may not be</td>
<td></td>
</tr>
<tr>
<td></td>
<td>covered at the in-network rate at all times – please check</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for coverage with your provider prior to having labs done.</td>
<td></td>
</tr>
<tr>
<td>Specialists Office Visits</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Virtual Health Care Visits</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
</tbody>
</table>

**Hospital**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>80% after deductible; contact claims administrator for prior authorization before inpatient admission.</th>
<th>60% after deductible. Contact claims administrator prior authorization before inpatient admission.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Coverage</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Outpatient Coverage</td>
<td>80% after deductible</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Use of Emergency Room</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Urgent Care Coverage</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

**Other Covered Services\(^2\)**

<p>| Skilled Nursing Facility           | 80% after deductible, up to 100 days per calendar year; care must be pre-authorized with the claims administrator. | 60% after deductible up to 100 days per calendar year; care must be pre-authorized with the claims administrator. |
| Home Health Care                   | 80% after deductible, up to 120 visits per calendar year; care must be pre-authorized with the claims administrator. | 60% after deductible up to 120 visits per calendar year; care must be pre-authorized with the claims administrator. |
| Hospice                            | 80% after deductible; care must be pre-authorized with the claims administrator.                  | 60% after deductible; care must be pre-authorized with the claims administrator.               |
| Durable Medical Equipment          | 80% after deductible.                                                                             | 60% after deductible.                                                                           |</p>
<table>
<thead>
<tr>
<th>CDHP PLAN FEATURES</th>
<th>IN-NETWORK BENEFITS</th>
<th>OUT-OF-NETWORK BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Covered Services (cont'd)</td>
<td>Plan pays:</td>
<td>Plan pays (see footer):</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>One hearing aid per impaired ear every three years, up to a maximum of $2,000 per ear</td>
<td>One hearing aid per impaired ear every three years, up to a maximum of $2,000 per ear</td>
</tr>
<tr>
<td>Emergency Use of Ambulance</td>
<td>80% after deductible.</td>
<td>80% after in-network deductible.</td>
</tr>
<tr>
<td>Non-Emergency Use of Ambulance</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
</tbody>
</table>

**Centers of Excellence**

| Bariatric Surgery               | 80% after deductible if performed at a center of excellence; 60% after deductible if performed at an in-network facility (but not a center of excellence) | No coverage |
|                                 | Travel benefit provided where the nearest center of excellence is 50 miles or more from your home; benefit payable per IRS guidelines; any amounts you pay will be excluded from the annual medical deductible. |

**Short-Term Rehabilitation**

| (includes speech therapy; physical and/or occupational therapy; and respiratory therapy) | 80% after deductible; up to 60 visits per calendar year for speech; up to 60 visits per calendar year for physical and/or occupational therapy combined; up to 60 visits per calendar year for respiratory therapy. (Note: additional visits beyond these limits may be approved upon medical review demonstrating progression in goal-directed rehabilitation services, regardless of diagnosis) | 60% after deductible; up to 60 visits per calendar year for speech; up to 60 visits per calendar year for physical and/or occupational therapy combined; up to 60 visits per calendar year for respiratory therapy. (Note: additional visits beyond these limits may be approved upon medical review demonstrating progression in goal-directed rehabilitation services, regardless of diagnosis) |

**Mental Health**

| Inpatient Care                  | 80% after deductible; contact claims administrator for prior authorization. | 60% after deductible; contact claims administrator for prior authorization. |
| Outpatient Care                 | 80% after deductible. | 60% after deductible. |
### CDHP PLAN FEATURES

<table>
<thead>
<tr>
<th>Chemical Dependency</th>
<th>IN-NETWORK BENEFITS&lt;sup&gt;1&lt;/sup&gt;</th>
<th>OUT-OF-NETWORK BENEFITS&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Care</td>
<td>Plan pays: 80% after deductible; contact claims administrator for prior authorization.</td>
<td>Plan pays (see footer): 60% after deductible; contact claims administrator for prior authorization.</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>80% after deductible.</td>
<td>60% after deductible.</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Usually coordinated by your in-network provider. Prior authorization required for inpatient hospital confinements, need to contact claims administrator at least 5 calendar days prior to admission. Check with administrator on requirements. For emergency admissions, call within 48 hours of admission.</td>
<td>Prior authorization required for inpatient hospital confinements, need to contact claims administrator at least 5 calendar days prior to admission. Check with administrator on requirements. For emergency admissions, call within 48 hours of admission.</td>
</tr>
</tbody>
</table>

<sup>1</sup>Coincidence applies after the annual deductible is met, up to the annual out-of-pocket maximum. If you use out-of-network benefits, separate deductibles and out-of-pocket maximums apply.

<sup>2</sup>Coverage maximums are a combination of in-network and/or out-of-network benefits. (Example, if in-network benefit is for 60 days and out-of-network benefit is for 60 days, the maximum benefit is 60 days, not 120 days.) Benefits subject to calendar year day/visit maximums also apply towards meeting your annual deductible.

### Annual Deductible - CDHP

Employees and eligible dependents participating in the Plan are required to pay an annual deductible. The deductible is the amount of money you pay before the Plan begins to pay your eligible expenses (i.e., coinsurance). Each calendar year you have a new deductible.

Under the CDHP, both your eligible health care and prescription drug costs will apply toward the annual deductible, shown below.

<table>
<thead>
<tr>
<th></th>
<th>Individual Deductible</th>
<th>Family Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

---

The out-of-network coinsurance is paid based on the lower of the Reasonable and Customary amount or the billed amount.

**Reasonable and Customary (R&C)** is defined as the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the customary charge for the service or procedure. Such customary charge will be determined from within the range of charges made for the service or procedure by most providers in the general geographic area where the provider maintains his usual place of business. The reasonable and customary charge will not exceed the 80th percentile of the HIAA (Health Insurance Association of America) prevailing fee schedules (or the schedule used by the claims administrator that most closely approximates the HIAA fee schedules). This amount may be less than the provider’s actual charge. In this case, you must pay the amount of the actual charge that is in excess of the allowed charge. This is in addition to any applicable coinsurance.

<sup>1</sup>Coincidence applies after the annual deductible is met, up to the annual out-of-pocket maximum. If you use out-of-network benefits, separate deductibles and out-of-pocket maximums apply.

<sup>2</sup>Coverage maximums are a combination of in-network and/or out-of-network benefits. (Example, if in-network benefit is for 60 days and out-of-network benefit is for 60 days, the maximum benefit is 60 days, not 120 days.) Benefits subject to calendar year day/visit maximums also apply towards meeting your annual deductible.
Meeting the Single Deductible - CDHP
With an in-network deductible of $1,500 (i.e., Employee Only coverage), here is how you might meet the deductible.

<table>
<thead>
<tr>
<th>In-Network Eligible Expenses</th>
<th>Amount You Pay</th>
<th>Amount Applied Toward Single Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 office “sick” visit</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>$125 office preventive care visit</td>
<td>$0</td>
<td>$0. The Plan covers 100% of eligible preventive care.</td>
</tr>
<tr>
<td>$800 x-rays</td>
<td>$800</td>
<td>$800</td>
</tr>
<tr>
<td>$100 office “sick” visit</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>$200 medication</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>$1,500 emergency room visit</td>
<td>$300; you then pay 20% of the remaining $1,200 ($1,500 - $300 = $1,200 * .20 = $240). Total amount you pay is $540.</td>
<td>$300. You have met your annual deductible. The Plan then pays 80% of $1,200 ($1,500 - $300 = $1,200).</td>
</tr>
<tr>
<td>$25 flu shot</td>
<td>$0. Charges for an annual flu shot are covered at 100% by the Plan.</td>
<td>$0. The Plan covers 100% of eligible preventive care.</td>
</tr>
</tbody>
</table>

Any in-network expenses you incur for the remainder of the calendar year are paid at the 80% coinsurance level by the Plan since you have met your individual annual deductible, until you meet your out-of-pocket maximum. At that point, the Plan pays 100% for the remainder of the calendar year.

Meeting the Family Deductible – CDHP
Eligible expenses incurred by any two or more enrolled family members can be combined to meet the family deductible. If you have coverage for yourself and one other family member, your annual family deductible maximum is two individual deductibles.

For example, assume:
- a family of four is enrolled in the Plan with an in-network family deductible of $3,000
- the family has in-network expenses that total $3,050 for all family members combined.

Here is an example of how the family might meet the family deductible, assuming that the eligible expenses below are for services covered at 80%:
### Coinsurance – CDHP

The Plan will pay a portion of the Covered Health Care Expenses incurred by each covered individual in each calendar year, subject to:

- an annual deductible, and
- the Plan's limitations, exclusions and exceptions.

After you meet the annual deductible, the Plan pays a percentage of your eligible expenses, and you pay the remaining amount. The amount you pay is called coinsurance. Coinsurance amounts and deductibles apply to your out-of-pocket maximum.

If you receive your care from an in-network provider, your coinsurance amount is 20% of the network negotiated rate or billed amount, whichever is less. The Plan pays the 80% balance. If you receive your care from an out-of-network provider, your coinsurance amount is 40% of the lower of the reasonable and customary amount or billed amount. The Plan pays the 60% balance. Other exceptions are:

- for bariatric surgery performed at an in-network facility (but not a center of excellence); the Plan pays the 60% balance (excluding emergency medical procedures).

### Out-of-Pocket Maximum – CDHP

To protect you against unusually high expenses, the Plan also includes annual out-of-pocket maximums. If your out-of-pocket expenses (that is, the deductible plus the coinsurance) reach the maximum in any given year, the Plan will pay 100% of the lower of the reasonable and customary amount or billed amount for any remaining covered expenses for that year. Remember, since you do not pay anything toward in-network preventive care, there are no out-of-pocket expenses to apply to the out-of-pocket maximum.

The following chart summarizes each option by out-of-pocket maximum for covered expenses:

<table>
<thead>
<tr>
<th></th>
<th>Single Out-of-Pocket Max</th>
<th>Family Out-of-Pocket Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$3,425</td>
<td>$6,850</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$8,000</td>
<td>$16,000</td>
</tr>
</tbody>
</table>
The following chart illustrates how the coinsurance percentage applies. It assumes the employee chooses to use all in-network benefits and is in Employee Only coverage. It also assumes that:

- none of the care was Preventive Care, which would be covered at 100%, before the annual deductible, and therefore, the employee has no out-of-pocket expenses to apply toward the out-of-pocket maximum; and
- eligible expenses are services covered at 80%.

<table>
<thead>
<tr>
<th>Expense</th>
<th>You Pay</th>
<th>The Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$1,500</td>
<td>$0</td>
</tr>
<tr>
<td>Next $9,625 of Covered Medical Expenses</td>
<td>$1,925</td>
<td>$7,700 (80% of $9,625)</td>
</tr>
<tr>
<td>(20% coinsurance on $9,625)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remaining Covered Medical Expenses for the Year</td>
<td>$0</td>
<td>100% (since your covered out-of-pocket expenses = $3,425)</td>
</tr>
</tbody>
</table>
### Prescription Costs – CDHP

Your costs for prescription coverage are outlined in the table below.

<table>
<thead>
<tr>
<th>When To Use It</th>
<th>CVS/caremark Retail Program</th>
<th>CVS/caremark Mail-Order Service</th>
<th>CVS Specialty Pharmacy*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You Pay</strong></td>
<td>For immediate drug needs or short-term medications; up to a 30-day supply</td>
<td>For maintenance or long-term medications; up to a 90-day supply</td>
<td>For self-administered specialty medications (i.e. self-injectable) and other medications to treat rare or specialty conditions including certain infused medications</td>
</tr>
<tr>
<td></td>
<td>• 0% for certain preventive medications (e.g., generic contraceptives)</td>
<td>• 0% for certain preventive medications (e.g., generic contraceptives)</td>
<td>• After you have met the annual deductible:</td>
</tr>
<tr>
<td></td>
<td>• Certain maintenance medications (e.g., to control blood pressure) will not be subject to the annual deductible; however, coinsurance will apply as shown below.</td>
<td>• Certain maintenance medications (e.g., to control blood pressure) will not be subject to the annual deductible; however, coinsurance will apply as shown below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• After you have met the annual deductible:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 30% for each generic prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 30% for each preferred brand name prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 50% for each non-preferred brand name prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The maximum amount you will pay per prescription is $60 for generic drugs; $70 for preferred brand name drugs; $100 for non-preferred brand name drugs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Note: 90-day fills available at participating CVS/caremark retail pharmacies, subject to mail order rates as</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Specialty medications are limited to a 30-day supply.</td>
</tr>
</tbody>
</table>
Refill Limit

<table>
<thead>
<tr>
<th>CVS/caremark Retail Program</th>
<th>CVS/caremark Mail-Order Service</th>
<th>CVS Specialty Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>None, except as limited by your doctor. After three purchases at retail for a maintenance drug, your coinsurance will increase by 100%.*</td>
<td>None, except as limited by your doctor.</td>
<td>None at retail. If you choose to purchase specialty medications at retail, you will pay the entire cost at any pharmacy other than CVS Specialty Pharmacy.</td>
</tr>
</tbody>
</table>

* If your prescription is part of the Maintenance Choice program, after three retail purchases of a maintenance drug, you will pay 100% of the cost of the drug if you continue to use a retail pharmacy (with the exception of refills through a CVS retail pharmacy). Please see the section “CVS/caremark Mail Order Service” for more information.

**PPO**

The following pages briefly highlight the covered major benefits and the in-network and out-of-network coverage levels under the PPO. Please refer to the “Covered Medical Expenses,” “Definitions,” and “Exclusions” sections for detailed information, including the definition of “Primary Care Physician” and “Specialist.”

<table>
<thead>
<tr>
<th>PPO PLAN FEATURES</th>
<th>IN-NETWORK BENEFITS†</th>
<th>OUT-OF-NETWORK BENEFITS‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>Plan pays:</td>
<td>Plan pays (see footer):</td>
</tr>
<tr>
<td>Well Child care visits, including related tests and immunizations (according to age-based schedule).</td>
<td>100% (no deductible).</td>
<td>70% after deductible (visits up to age 6 only).</td>
</tr>
<tr>
<td>Adult (age 19 and older) routine annual physical examination including related tests and immunizations (according to Plan schedule).</td>
<td>100% (no deductible).</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Routine Annual Gynecological Exam</td>
<td>100% (no deductible).</td>
<td>No coverage for routine exams.</td>
</tr>
<tr>
<td>Annual Pap Test</td>
<td>100% (no deductible).</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Allergy Treatment/ Testing</td>
<td>90% after deductible.</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Primary Care Physician Office Visits</td>
<td>90% after deductible.</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Immunizations (other than routine)</td>
<td>90% after deductible.</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Surgery</td>
<td>90% after deductible.</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>PPO PLAN FEATURES</td>
<td>IN-NETWORK BENEFITS(^1)</td>
<td>OUT-OF-NETWORK BENEFITS(^1)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Physician Services (cont’d)</td>
<td>Plan pays: 90% after deductible.</td>
<td>Plan pays (see footer): 70% after deductible.</td>
</tr>
<tr>
<td>Physician Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Labs, Radiology and other tests(^3)</td>
<td>80% after deductible. Note: labs ordered through Quest Diagnostics may not be covered at the in-network rate at all times – please check for coverage with your provider prior to having labs done.</td>
<td>70% after deductible; no coverage for labs ordered by an out-of-network provider through Quest Diagnostics</td>
</tr>
<tr>
<td>Specialists Office Visits</td>
<td>80% after deductible.</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Virtual Health Care Visits</td>
<td>90% after deductible</td>
<td>70% after deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Coverage</td>
<td>90% after deductible; contact claims administrator for prior authorization before inpatient admission.</td>
<td>70% after deductible. Contact claims administrator to prior authorization before inpatient admission.</td>
</tr>
<tr>
<td>Outpatient Coverage</td>
<td>90% after deductible</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Use of Emergency Room(^2)</td>
<td>First you pay $200 charge (waived if admitted); applied to out-of-pocket maximum; then Plan pays 90% after deductible for remaining charges (80% for labs, radiology and other tests)</td>
<td>First you pay $200 charge (waived if admitted); applied to out-of-pocket maximum; then Plan pays 90% after in-network deductible for remaining charges (80% for labs, radiology and other tests)</td>
</tr>
<tr>
<td>Urgent Care Coverage</td>
<td>80% after deductible.</td>
<td>70% after deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services(^3)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>90% after deductible, up to 100 days per calendar year; care must be pre-authorized with the claims administrator.</td>
<td>70% after deductible up to 100 days per calendar year; care must be pre-authorized with the claims administrator.</td>
</tr>
<tr>
<td>PPO PLAN FEATURES</td>
<td>IN-NETWORK BENEFITS¹</td>
<td>OUT-OF-NETWORK BENEFITS¹</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Other Covered Services</td>
<td>Plan pays:</td>
<td>Plan pays (see footer):</td>
</tr>
<tr>
<td>(cont’d)</td>
<td>90% after deductible; care must be pre-authorized with the claims administrator.</td>
<td>70% after deductible; care must be pre-authorized with the claims administrator.</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>90% after deductible.</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>One hearing aid per impaired ear every three years, up to a maximum of $2,000</td>
<td>One hearing aid per impaired ear every three years, up to a maximum of $2,000</td>
</tr>
<tr>
<td>Emergency Use of Ambulance</td>
<td>90% after deductible.</td>
<td>90% after in-network deductible.</td>
</tr>
<tr>
<td>Non-Emergency Use of</td>
<td>90% after deductible.</td>
<td>70% after deductible.</td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Centers of Excellence**

| Bariatric Surgery         | 90% after deductible if performed at a center of excellence; 70% after deductible if performed at an in-network facility (but not a center of excellence) | No coverage |
|                          | Travel benefit provided where the nearest center of excellence is 50 miles or more from your home; benefit payable per IRS guidelines; any amounts you pay will be excluded from the annual medical deductible. |                         |

**Short-Term Rehabilitation³**

<p>| (includes speech therapy; physical and/or occupational therapy; and respiratory therapy) | 90% after deductible; up to 60 visits per calendar year for speech; up to 60 visits per calendar year for physical and/or occupational therapy combined; up to 60 visits per calendar year for respiratory therapy. (Note: additional visits beyond these limits may be approved upon medical review demonstrating progression in goal-directed rehabilitation services, regardless of diagnosis) | 70% after deductible; up to 60 visits per calendar year for speech; up to 60 visits per calendar year for physical and/or occupational therapy combined; up to 60 visits per calendar year for respiratory therapy. (Note: additional visits beyond these limits may be approved upon medical review demonstrating progression in goal-directed rehabilitation services, regardless of diagnosis) |</p>
<table>
<thead>
<tr>
<th>PPO PLAN FEATURES</th>
<th>IN-NETWORK BENEFITS¹</th>
<th>OUT-OF-NETWORK BENEFITS¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td><strong>Plan pays:</strong></td>
<td><strong>Plan pays (see footer):</strong></td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>90% after deductible; contact claims administrator for prior authorization.</td>
<td>70% after deductible; contact claims administrator for prior authorization.</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>90% after deductible.</td>
<td>70% after deductible.</td>
</tr>
</tbody>
</table>

| **Chemical Dependency**         | **Plan pays:**        | **Plan pays (see footnote):** |
| Inpatient Care                  | 90% after deductible (80% for labs, radiology and other tests); contact claims administrator for prior authorization. | 70% after deductible; contact claims administrator for prior authorization. |
| Outpatient Care                 | 90% after deductible (80% for labs, radiology and other tests). | 70% after deductible |
| Inpatient Hospital Prior Authorization | Usually coordinated by your in-network provider. Prior authorization required for inpatient hospital confinements, need to contact claims administrator at least 7 calendar days prior to admission. Check with administrator on requirements. For emergency admissions, call within 48 hours of admission. | Prior authorization required for inpatient hospital confinements, need to contact claims administrator at least 7 calendar days prior to admission. Check with administrator on requirements. For emergency admissions, call within 48 hours of admission. |

The out-of-network coinsurance is paid based on the lower of the Reasonable and Customary amount or the billed amount. **Reasonable and Customary (R&C)** is defined as the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the customary charge for the service or procedure. Such customary charge will be determined from within the range of charges made for the service or procedure by most providers in the general geographic area where the provider maintains his usual place of business. The reasonable and customary charge will not exceed the 80th percentile of the HIAA (Health Insurance Association of America) prevailing fee schedules (or the schedule used by the claims administrator that most closely approximates the HIAA fee schedules). This amount may be less than the provider’s actual charge. In this case, you must pay the amount of the actual charge that is in excess of the allowed charge. This is in addition to any applicable coinsurance.

¹Coinsurance applies after the annual deductible is met, up to the annual out-of-pocket maximum. If you use out-of-network benefits, separate deductibles and out-of-pocket maximums apply.

²In no event will the $200 charge for use of emergency room services because you to exceed the annual medical out-of-pocket maximum prescribed under the Affordable Care Act.

³Coverage maximums are a combination of in-network and/or out-of-network benefits. (Example, if in-network benefit is for 60 days and out-of-network benefit is for 60 days, the maximum benefit is 60 days, not 120 days.) Benefits subject to calendar year day/visit maximums also apply towards meeting your annual deductible.
Annual Deductible – PPO
Employees and eligible dependents participating in the Plan are required to pay an annual deductible. The deductible is the amount of money you pay before the Plan begins to pay your eligible expenses (i.e., coinsurance). Each calendar year you have a new deductible.

Under the PPO, only your eligible health care costs will apply toward the annual deductible (i.e., your prescription drug costs will not apply), shown below.

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Single Deductible</th>
<th>Family Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$600</td>
<td>$1,800</td>
<td></td>
</tr>
<tr>
<td>$1,500</td>
<td>$4,500</td>
<td></td>
</tr>
</tbody>
</table>

Note: The $200 Emergency Room charge is applicable in all instances and is not applied toward the annual deductible.

Meeting the Single Deductible – PPO
With an in-network deductible of $600 (i.e., Employee Only coverage), here is how you might meet the deductible.

<table>
<thead>
<tr>
<th>In-Network Eligible Expenses</th>
<th>Amount You Pay</th>
<th>Amount Applied Toward Single Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 office “sick” visit</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>$125 office preventive care visit</td>
<td>$0</td>
<td>$0. The Plan covers 100% of eligible preventive care.</td>
</tr>
<tr>
<td>$100 x-rays</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>$110 office “sick” visit</td>
<td>$110</td>
<td>$110</td>
</tr>
<tr>
<td>$1,500 emergency room visit</td>
<td>$200 (will not apply to your deductible). You then pay only 10% of the remaining charge ($1,500 - $200 - $290 = $1,010 x 0.10 = $101)</td>
<td>$290 to meet your annual deductible. The Plan then pays 90% of the remaining charge of $1,010 ($909).</td>
</tr>
<tr>
<td>$25 flu shot</td>
<td>$0. Charges for an annual flu shot are covered at 100% by the Plan.</td>
<td>$0. The Plan covers 100% of eligible preventive care.</td>
</tr>
</tbody>
</table>

Any in-network expenses you incur for the remainder of the calendar year are paid at the 90% coinsurance level by the Plan (excluding the $200 charge for each emergency room visit) since you have met your individual annual deductible, until you meet your out-of-pocket maximum. At that point, the Plan pays 100% for the remainder of the calendar year.
Meeting the Family Deductible - PPO

Eligible expenses incurred by any two or more enrolled family members can be combined to meet the family deductible. If you have coverage for yourself and one other family member, your annual family deductible maximum is two individual deductibles.

For example, assume:

- A family of four is enrolled in the Plan with an in-network family deductible of $600 per individual and $1,800 per family (a maximum of three individual deductibles).
- The family has in-network expenses that total $2,260 for all family members combined.

Here is an example of how the family might meet the family deductible, assuming that the eligible expenses below are for services covered at 90%:

<table>
<thead>
<tr>
<th>Family Member</th>
<th>In-Network Eligible Expenses</th>
<th>Amount Applied Toward Family Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mom</td>
<td>$200</td>
<td>$200. The full amount of eligible expenses ($200) applies toward the family deductible.</td>
</tr>
<tr>
<td>Dad</td>
<td>$720</td>
<td>$600. The first $600 of eligible expenses applies toward the family deductible. Why? Because an individual family member’s eligible expenses in excess of the $600 individual annual deductible cannot be applied to the family deductible. The Plan will pay 90% toward the $120 over the individual annual deductible amount.</td>
</tr>
<tr>
<td>Daughter</td>
<td>$650</td>
<td>$600. Like Dad, the first $600 applies toward the family deductible because the individual family member’s eligible expenses in excess of the $600 individual annual deductible cannot be applied to the family deductible. The Plan will pay 90% toward the $50 over the individual annual deductible amount.</td>
</tr>
<tr>
<td>Son</td>
<td>$500</td>
<td>$400. The son has $500 of eligible expenses, $400 of which makes up the balance needed to meet the family deductible of $1,800. The Plan pays 90% of the $100 over the family deductible amount.</td>
</tr>
<tr>
<td>Total</td>
<td>$2,070</td>
<td>$1,800. The Plan pays 90% of the remaining $270 of in-network expenses. After the family deductible is met, any eligible in-network expenses incurred by a family member will be paid at 90% (exclusive of emergency room visits).</td>
</tr>
</tbody>
</table>

Coinsurance – PPO

The Plan will pay a portion of the Covered Health Care Expenses incurred by each covered individual in each calendar year, subject to:

- an annual deductible, and
- the Plan’s limitations, exclusions and exceptions.

After you meet the annual deductible, the Plan pays a percentage of your eligible expenses, and you pay the remaining amount. The amount you pay is called coinsurance. Coinsurance amounts and deductibles apply to your out-of-pocket maximum.
If you receive your care from an in-network provider, your coinsurance amount is 10% of the network negotiated rate or billed amount, whichever is less. The Plan pays the 90% balance. If you receive your care from an out-of-network provider, your coinsurance amount is 30% of the lower of the reasonable and customary amount or billed amount. The Plan pays the 70% balance. Other exceptions are:

- for use of an emergency room, you first pay a $200 charge toward emergency room covered charges that are not included in your deductible;
- for in-network Specialist office visits (see “Definitions”), your coinsurance amount is 20% of the network negotiated rate or billed amount, whichever is less; the Plan pays the 80% balance;
- for diagnostic labs, radiology and other tests, your coinsurance amount is 20% of the network negotiated rate or billed amount, whichever is less; the Plan pays the 80% balance; and
- for bariatric surgery performed at an in-network facility (but not a center of excellence); the Plan pays the 70% balance (excluding emergency medical procedures).

Out-of-Pocket Maximum – PPO

To protect you against unusually high expenses, the Plan also includes annual out-of-pocket maximums. If your out-of-pocket expenses (that is, the deductible plus the coinsurance) reach the maximum in any given year, the Plan will pay 100% of the lower of the reasonable and customary amount or billed amount for any remaining covered expenses for that year. Remember, since you do not pay anything toward in-network preventive care, there are no out-of-pocket expenses to apply to the out-of-pocket maximum.

The following chart summarizes each option by out-of-pocket maximum for covered expenses:

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Individual Out-of-Pocket Max</th>
<th>Family Out-of-Pocket Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000</td>
<td>$9,000*</td>
<td></td>
</tr>
<tr>
<td>$5,000</td>
<td>$15,000</td>
<td></td>
</tr>
</tbody>
</table>

*Not to exceed $3,000 per person, up to the aggregate family limit

Note: The $200 charge for each emergency room visit is applicable in all instances and is applied toward the out-of-pocket maximum, but will not cause a participant to exceed the out-of-pocket maximum prescribed under the Affordable Care Act.

The following chart illustrates how the coinsurance percentage applies. It assumes the employee chooses to use all in-network benefits and is in Employee Only coverage. It also assumes that:

- none of the care was Preventive Care, which would be covered at 100%, before the annual deductible, and therefore, the employee has no out-of-pocket expenses to apply toward the out-of-pocket maximum; and
- eligible expenses are services covered at 80%.

<table>
<thead>
<tr>
<th>Expense</th>
<th>You Pay</th>
<th>The Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$600</td>
<td>$0</td>
</tr>
<tr>
<td>Next $24,000 of Covered Medical Expenses</td>
<td>$2,400</td>
<td>$21,600 (90% of $24,000)</td>
</tr>
<tr>
<td>(10% coinsurance on $24,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remaining Covered Medical Expenses for the Year</td>
<td>$0</td>
<td>100% (since your covered out-of-pocket expenses = $3,000)</td>
</tr>
</tbody>
</table>
## Prescription Costs – PPO

Your costs for prescription coverage are outlined in the table below.

<table>
<thead>
<tr>
<th>When To Use It</th>
<th>CVS/caremark Retail Program</th>
<th>CVS/caremark Mail-Order Service</th>
<th>CVS Specialty Pharmacy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>For immediate drug needs or short-term medications</td>
<td>For maintenance or long-term medications</td>
<td>For self-administered specialty medications (i.e. self-injectable) and other medications to treat rare or specialty conditions including certain infused medications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>You Pay*</th>
<th>CVS/caremark Retail Program</th>
<th>CVS/caremark Mail-Order Service</th>
<th>CVS Specialty Pharmacy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 0% for certain preventive medications (e.g., generic contraceptives)</td>
<td>• 0% for certain preventive medications (e.g., generic contraceptives)</td>
<td>• 30% for each generic prescription</td>
<td></td>
</tr>
<tr>
<td>• 30% for each generic prescription</td>
<td>• 30% for each generic prescription</td>
<td>• 30% for each preferred brand name prescription</td>
<td></td>
</tr>
<tr>
<td>• 30% for each preferred brand name prescription</td>
<td>• 30% for each preferred brand name prescription</td>
<td>• 50% for each non-preferred brand name prescription</td>
<td></td>
</tr>
<tr>
<td>• 50% for each non-preferred brand name prescription</td>
<td>• 50% for each non-preferred brand name prescription</td>
<td>The maximum amount you will pay per prescription is $120 for generic drugs; $140 for preferred brand name drugs; $200 for non-preferred brand name drugs.</td>
<td></td>
</tr>
</tbody>
</table>

The maximum amount you will pay per prescription is $60 for generic drugs; $70 for preferred brand name drugs; $100 for non-preferred brand name drugs.

*Specialty medications are limited to a 30-day supply.

**Note:** you may also fill a 90-day supply at participating CVS/caremark retail pharmacies, subject to mail order rates as shown in this table.
<table>
<thead>
<tr>
<th>Refill Limit</th>
<th>CVS/caremark Retail Program</th>
<th>CVS/caremark Mail-Order Service</th>
<th>CVS Specialty Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None, except as limited by your doctor.</td>
<td>None, except as limited by your doctor.</td>
<td>None at retail. If you choose to purchase specialty medications at retail, you will pay the entire cost at any pharmacy other than CVS Specialty Pharmacy.</td>
</tr>
<tr>
<td></td>
<td>After three purchases at retail for a maintenance drug, your coinsurance will increase by 100%.*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* If your prescription is part of the Maintenance Choice program, after three retail purchases of a maintenance drug, you will pay 100% of the cost of the drug if you continue to use a retail pharmacy (with the exception of refills through a CVS retail pharmacy). Please see the section “CVS/caremark Mail Order Service” for more information.