NTESS UnitedHealthcare Benefit Summary

(Employees, PreMedicare Retirees, Surviving Spouse, & Long-Term Disability (LTD) Terminees)

Revised: January 1, 2023

Benefit Summary

IMPORTANT

This Benefit Summary applies to all Active Employees, PreMedicare Retirees, Surviving Spouses, and Long-Term Disability (LTD) Terminees effective January 1, 2023.

For more information on other benefit programs, refer to the NTESS Health and Welfare Benefits Plan for Active Employees Summary Plan Description or the NTESS Post-Employment Health and Welfare Benefits Plan Summary Plan Description.

The Total Health PPO Plan and Health Savings Plan (HDHP for PreMedicare Retirees, Surviving Spouses, and LTD Terminees) are maintained at the discretion of NTESS and are not intended to create a contract of employment and do not change the at-will employment relationship between you and NTESS. The NTESS Board of Managers (or designated representative) reserve the right to amend (in writing) any or all provisions of the Total Health PPO Plan and Health Savings Plan (HDHP for PreMedicare Retirees, Surviving Spouses, and LTD Terminees), and to terminate (in writing) the Total Health PPO Plan and Health Savings Plan (HDHP for PreMedicare Retirees, Surviving Spouses, and LTD Terminees) at any time without prior notice, subject to applicable collective bargaining agreements.

The terms of the Total Health PPO Plan and Health Savings Plan (HDHP for PreMedicare Retirees, Surviving Spouses, and LTD Terminees) cannot be modified by written or oral statements to you from human resources representatives or other NTESS personnel.

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Section 1. Introduction

This is a summary of highlights of the Total Health PPO Plan and the Health Savings Plan (HDHP for PreMedicare Retirees, Surviving Spouses, and LTD Terminees) (collectively, "the "Programs"). The Programs are components of the NTESS Health and Welfare Benefits Plan for Active Employees (the "Employee H&W Plan") (ERISA Plan 540) and the NTESS Post-Employment Health and Welfare Benefits Plan (the "Post-Employment H&W Plan") (ERISA Plan 545). This Benefit Summary is part of the Employee H&W Summary Plan Description (the "Employee H&W Plan SPD") and the Post-Employment H&W Plan Summary Plan Description (the "Post-Employment H&W Plan SPD"). It contains important information about Your NTESS or "Sandia" healthcare benefits. Note: The Health Savings Plan option is available to eligible Active Employees only. Although eligible PreMedicare Retirees, LTD Terminees, and Surviving Spouses may participate in the High Deductible Health Plan (HDHP) option; there is no health savings account ("HSA") through NTESS. PreMedicare Retirees, LTD Terminees, and Surviving Spouses must independently establish their HSAs and make any contributions directly with an HSA provider.

Certain capitalized words in this Benefit Summary have special meaning. These words havebeen defined in Section 13: Definitions.

When the words "we", "us", and "our" are used in this document, we are referring to NTESS. When the words "You" and "Your" are used throughout this document, we are referring to people who are Covered Members as defined in Section 13: Definitions.

Many sections of this Benefit Summary are related to other sections of the Benefit Summary and to information contained in the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD. You will not have all of the information You need by reading only one section of one Summary.

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for information abouteligibility, enrollment, disenrollment, premiums, termination, coordination of benefits, subrogation and reimbursement rights, when coverage ends, continuation of coverage provisions, and Your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the Affordable Care Act (ACA).

To receive a paper copy of this Benefit Summary, other benefit Summaries, the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD, contact HR Solutions at 505-284-4700. These documents are also available electronically at hr.sandia.gov.

Since these documents will continue to be updated, it is recommended to check back on a regular basis for the most recent version.

Section 2. Accessing Care

This section describes how to access medical and behavioral healthcare under the in-network and out-of-network options, Prior Authorization requirements, predetermination of benefits, accessing non-Emergency or non-Urgent Care while away from home, the Employee Assistance Program, the No Surprises Act requirements, the UnitedHealthcare (UHC) and United Behavioral Health (UBH) provider networks, and other general information. For information on the Prescription Drug Program, refer to Section 7: Prescription Drug Program.

In-Network and Out-of-Network Options

The Programs provide both in-network and out-of-network benefits. You may select providers either in-network or out-of-network, however using Your in-network benefit allows You to receive the maximum available benefit.

Note: You can use the in-network or out-of-network option at any time during the year, anytime You need medical care.

The in-network option provides You access to physicians, facilities, and suppliers who are contracted with UHC/UBH contracted network to provide their services at negotiated fees. No referrals are required. Some procedures may require Prior Authorization or precertification, which You are responsible for asking Your physicians to obtain from UHC (refer to this section for more information). For the most updated in-networkprovider listings in Your area, contact UHC Customer Service at 877-835-9855 or access the website at www.myuhc.com.

The advantages of using the in-network option include:

- Lower Coinsurance
- Lower Deductible
- Lower Out-of-Pocket Limits No responsibility for amounts exceeding Eligible Expenses
- Certain preventive care services covered at 100%
- Generally, no claims to file

Except for Surprise Billing Claims, the out-of-network option offers a lower level of benefit but enables You to get services from licensed providers outside the contracted network. No referrals are required. You are responsible for Deductibles, Coinsurance, and amounts exceeding Eligible Expenses. You are also responsible for filing all claims not filed by the provider and must obtain Prior Authorization or precertification for all hospital care and certain medical care in order to be eligible for full benefits.

Depending on the geographic area and the service You receive, You may have access through UnitedHealthcare's Shared Savings Program to out-of-network

providers who have agreed todiscounts negotiated from their charges on certain claims for Covered Health Services. Referto the definition of Shared Savings Program in Section 3: Accessing Care for more information about how the Shared Savings Program applies.

If You are admitted to a hospital on an Emergency basis that is not in the network and services are covered, in-network benefits will be paid until You are stabilized. Once stabilized, You must be moved to a network hospital to continue in-network benefits. You may elect to remainin the out-of-network hospital and receive out-of-network benefits, as long as UHC confirms the treatment to be Medically Necessary. Refer to Section 3 ("No Surprises Act Requirements") for detailed information regarding Surprise Billing Claims and Post-Stabilization Services.

Eligible Expenses

NTESS has delegated to UnitedHealthcare (UHC) the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses willbe determined and otherwise covered under the Plan.

Eligible Expenses are the amount UHC determines that will be paid for Benefits. For NetworkBenefits, You are not responsible for any difference between Eligible Expenses and the amountthe provider bills. For Non-Network Benefits, You are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills You and the amount UHC will pay for Eligible Expenses, unless otherwise required under the No Surprises Act requirements. Eligible Expenses are determined solely in accordance with UHC's reimbursement policy guidelines, as described as below.

> NTESS has delegated to UnitedHealthcare the discretion and authority to decidewhether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.
>
> Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, You are not responsible for anything except Your cost sharing obligations. For Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services and services that are subject to No Surprises Act requirements or otherwise arranged by UnitedHealthcare), You are responsible to work with the non-Network physicianor provider to resolve any amount billed to You that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

Eligible Expenses are determined solely in accordance with UnitedHealthcare'sreimbursement policy guidelines, as described in the Employee H&W SPD and Post-Employment H&W SPD.

When Covered Health Services are received from a non-Network provider, Eligible Expenses are an amount negotiated by UnitedHealthcare, a specific amount required by law (when required by law), or an amount UnitedHealthcarehas determined is typically accepted by a healthcare provider for the same or similar service. Please contact UnitedHealthcare if You are billed for amounts inexcess of Your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

Advocacy Services

The Plan has contracted with UnitedHealthcare to provide advocacy services on Your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at the number on Your ID card to access these advocacy services, or if You are billed for amounts in excess of Your applicable Coinsurance or Copayment. In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and UnitedHealthcare, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes overpayment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

In-Network Benefits
In-Network Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expensesare UHC's contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as a result of anEmergency, as arranged by UHC, or at a Network Facility, Eligible Expenses are billed charges unless a lower amount is required by the No Surprises Act, negotiated or authorized by law. As required by the No Surprises Act, certain services received out of Network will be paid at the in-Network benefit level subject to applicable Deductible and Co- insurance. Refer to Section 3 (“No Surprises Act Requirements”) for detailed information regarding the No Surprises Act.

- **Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select

a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a Primary Care Physician or PCP.

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

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

- **Non-Network Benefits** apply to Covered Health Services that are provided by a non- Network Physician or other non-Network provider or Covered Health Services that areprovided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits

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

Prior Authorization Requirements

When You choose to receive certain Covered Health Services (listed below), You are responsible for notifying Personal Health Support[SM] before You receive these services, otherwise Your benefits will be reduced. Personal Health Support[SM] ensures You and/or Your Covered Dependents receive the most appropriate and cost-effective services available.

IMPORTANT: Just because a service or procedure does not require Prior Authorization doesnot mean that it is a covered benefit. In order to ensure that services and procedures are covered, You are encouraged to obtain a predetermination of benefits.

The first $300 of covered charges will not be reimbursed if You, a family member, or Your provider does not contact Personal Health Support[SM] within the applicable time frames to obtain Prior Authorization. An exception to this requirement would be, if You have primary healthcare coverage for these services under Medicare or another non-Company healthcare program.

You or Your provider must notify Personal Health Support℠ for:

- Non-Emergency admissions: at least five business days before admission
- Emergency admissions: within two business days, or as soon as reasonably possible
- Other than admissions: at least five business days before receipt of services or purchaseor rental of DME

IMPORTANT: Although Your provider may obtain Prior Authorization, it is ultimately Your responsibility to call UHC at 877-835-9855 to initiate the review process. Thisis required for both in- or out-of-Network facilities used by You or Your covered Dependent.

Medical Services
Medical services (whether in- or out-of-Network) that require Personal Health Support℠ PriorAuthorization:

- Air ambulance services
- Clinical trials
- Congenital heart disease services
- Dental services stemming from illness or injury
- Durable Medical Equipment with a purchase or cumulative rental value of $1,000 or more
- External insulin pumps and continuous glucose monitoring systems, regardless of cost
- Gender affirming services
- Genetic testing (including breast cancer genetic testing [BRACA])
- Home healthcare
- Hospice care
- Hospital inpatient stay
- Immunoglobulin infusion (IVIG) therapy
- Injectable outpatient chemotherapy
- Maternity care that exceeds the delivery time frames as described in Section 6: Covered Medical Plan Services & Limitations. **Note:** if delivery is at home but requiresadmission to the hospital, notification is required.
- Obesity surgery
- Reconstructive procedures
- Surgery-only for the following outpatient surgeries: diagnostic catheterization andelectrophysiology implant and sleep apnea surgeries

- Skilled Nursing Facility/inpatient rehabilitation facility services
- Sleep disorder studies
- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound.
- Transplantation Diagnostic cardiac catheterization, electrophysiology implant, and sleep apnea surgeries
- MR guided focused ultrasound

You are encouraged to notify Personal Health Support[SM] prior to receiving the followingservices in order for Personal Health Support[SM] to determine if they are Covered Health Services:

- Breast reduction and reconstruction (except following cancer surgery)
- Vein stripping, ligation, VNUS® Closure, and sclerotherapy (an injection of achemical to treat varicose veins)
- Blepharoplasty (surgery to correct aging of the eyelids)

These services will not be covered when determined to be Cosmetic Procedures or notMedically Necessary and You may be responsible for the entire cost.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining Prior Authorization on your behalf before they provide these services to You. However, You should verify that Your provider will obtain Prior Authorization.

IMPORTANT: Although the provider may obtain Prior Authorization, it is ultimately Your responsibility to call UHC at 877-835-9855 to initiate the review process. Thisis required for both in- or out-of-Network facilities used by You or Your covered Dependent.

It is recommended that You confirm with the Claims Administrator that all Covered Health Services listed in the SPD have been preauthorized as required. Before receiving these services from a Network provider, You should contact the Claims Administrator to verifythat the Hospital, Physician and other providers are Network providers and that they have obtained the required Prior Authorization. Network facilities and Network providers cannot billYou for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the toll-free telephone number on Your ID card.

When You choose to receive certain Covered Health Services from non-Network providers, You are responsible for obtaining prior authorization before You receive these services. Note that Your obligation to obtain prior authorization is also

applicable when a non-Network provider intends to admit You to a Network facility or refers You to other Network providers.

To obtain prior authorization, call the toll-free telephone number on Your ID card. This call starts the utilization review process. Once You have obtained the authorization, please review itcarefully so that You understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

Network providers are responsible for obtaining prior authorization from the ClaimsAdministrator before they provide certain services to You.

If You fail to obtain prior authorization as required, Benefits will be subject to a $300 reduction in covered charges.

Predetermination of Benefits

The Programs cover a wide range of medical care treatments and procedures. However, medical treatments that are Investigational, Experimental, or Unproven to be medically effective are not covered by the Programs. Contact UHC before incurring charges that may not be covered.

In addition, some services may be covered only under certain circumstances and/or may be limited in scope, including but not limited to speech therapy, occupational therapy, temporomandibular joint (TMJ) syndrome, infertility, procedures that may have a cosmetic effect, and physical therapy. Predetermination of benefits is recommended to help You determine Your Out-of-Pocket Expense. Also, some benefits require Prior Authorization or precertification; therefore, it is important that You call UHC forinformation on covered services. If You have any questions about how to obtain a predetermination of benefits, contact UHC customer service at 877-835-9855.

Provider Networks

Network availability depends on the ability of the administrator to contract with provider networks. UHC and UBH have contracted with networks across the country. The network ofbehavioral healthcare Specialists is managed by United Behavioral Health (UBH), the company within UHC that handles mental health and Substance Abuse. You may access in- network PPO providers in most areas nationwide.

The in-network and/or network providers are contracted by UHC and UBH. UHC/UBH is responsible for maintaining these provider networks. Neither NTESS nor UHC/UBH can guarantee quality of care. Employees always have the choice of what services they receive andwho provides their healthcare regardless of what the program covers or pays.

UHC/UBH's credentialing process confirms public information about the providers' licensesand other credentials but does not assure the quality of the services provided.

UHC has established direct contracts with providers within the greater Albuquerque area and throughout New Mexico to offer in-Network care. The participating providers work with UHC and UBH toorganize an effective and efficient healthcare delivery system.

In Northern California, the providers, specialty care physicians, hospitals, and other healthcareproviders/facilities participating in the UHC/UBH network are affiliated with multiple facilities.

In other areas, UHC and UBH contract with provider networks all over the United States.

Note: If Your provider is interested in becoming an in-network provider, the provider can call UHC customer service to inquire about the process. There is also a provider nomination formlocated on the www.myuhc.com website with user ID and password of SNL.

UnitedHealth Premium® Designation Program

The UnitedHealth Premium® Designation Program is a program developed by UHC, for informational purposes only, to be used as a guide to choose a physician. Please note that thisProgram is available in 41 states (148 markets) across the United States.

The Premium Designation Program for physicians uses criteria and measures from nationally recognized organizations, such as the National Quality Forum, Ambulatory Care Quality Alliance and the National Committee for Quality Assurance, that identify evidence-based and/or consensus-based standards for treating medical conditions across 25 specialty areas.

To be evaluated, a physician must have at least five patients or surgical procedures treatingUHC members within the period evaluated for the conditions and surgical procedures we evaluate in the program. Physicians who do not have at least five patients or procedures treating UHC members are displayed as having "insufficient data with UHC."

Designation is a two-stage process. The first stage is an evaluation of quality based

on analysisof 12-36 months of collected claims and/or practice data for UHC members compared to specialty specific national quality standards. Physicians whose claims data demonstrates that they meet or exceed quality criteria, as measured against national quality standards, are designated as having met quality criteria.

Physicians are also evaluated for the cost efficiency of the care that they provide. Cost efficiency is based on factors such as the use and price of diagnostic testing, prescribed medications, procedures and follow-up care in comparison to other physicians in the same specialty in the same geographic area. To make an "apples to apples" comparison in the cost efficiency for doctors, we make an adjustment to account for the types of patients, severity ofillness and patients' conditions that the particular doctor treats.

Patients are grouped based on similar characteristics using complete "episodes of care," whichincludes physician care, inpatient and Outpatient hospital services, laboratory testing, X-rays, drug and other available claims associated with each patient for treatment of a condition.

A cost efficiency score is calculated by comparing a doctor's actual episode costs to the local market average for similar episodes treated by similar Specialists. Doctors who are more efficient in comparison to the local market average will receive the UnitedHealth Premium cost efficiency designation. Refer to www.myuhc.com for more information on this program.

IMPORTANT: The information from the Premium designation program is not an endorsement of a particular physician or healthcare professional's suitability for Your healthcare needs. UHC does not provide healthcare services nor practice medicine. Physicians are solely responsible for medical judgments and treatments. The designation of a physician does not guarantee the quality of healthcare services You will receive from a doctor and does not guarantee the outcome of any healthcare services You will receive. Likewise, the fact that a physician may not be designated by this program does not mean that the physician does not provide quality healthcare services. All physicians in the UnitedHealth Network have met certain minimum credentialing requirements. Regardless of whether a physician has received adesignation, You have access to all physicians in the UnitedHealth Network, as described in this Benefit Summary.

UnitedHealth Premium® Designation Program
To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality.The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® designation program including how to locate aPremium Care Physician, log onto www.myuhc.com or call

the number on Your ID card.

Provider Directories

UHC/UBH provider directories list providers, facilities, and auxiliary services that have contracted to participate in the network. You can select Your physician from family care physicians, internists, pediatricians, and other Specialists. Specialty care and hospital servicesgenerally are provided by the hospital with which the physician and Specialists You select areaffiliated.

To obtain a hard copy provider directory, at no cost to You, for any network within the United States, You can contact UHC customer service at 877-835-9855. Directories are current as of the date printed. The provider networks change often. For the most current information, it is recommended that You use the online provider search at www.myuhc.com.

Provider Searches Online
To search for a provider online, go to www.myuhc.com. It is easy and only takes a few minutes. All that is needed is access to the Internet. If You are not enrolled with UHC, visit www.myuhc.com and click Search for a Provider.

1. Click Find Care & Cost

2. Click Medical Directory or Behavioral Health Directory

Search options include by provider, service, or condition

Employee Assistance Program (EAP)

NTESS offers employees enrolled in the Programs and their covered Dependents an Employee Assistance Program (EAP) for counseling services. The EAP counseling services are designed to provide assessment, referral, and follow-up to Employees experiencing impairment from personal concerns such as health, marital, family, financial, substance abuse, legal, emotional, stress, or other personal concerns that may adversely affectday-to-day activity.

Your EAP benefit allows up to eight visits a year to in-network EAP providers at no cost to You. Obtain a referral to an EAP counselor by contacting UHC EAP 800-622-7276, 24 hours aday, seven days a week.

You also have access to an interactive website that provides electronic access and delivery of Your EAP benefit, as well as resources and tools to help You enhance Your work, health, and life. You can access this website by either registering on www.myuhc.com, selecting Physicians & Facilities, or by going to www.liveandworkwell.com (without registering) and enter SNL as the access code. This website allows You to:

- Check Your EAP benefits information and request services online
- Look up health facts and read articles on Life Event issues
- Use a host of financial calculators and other interactive tools
- Join interactive discussions, chats, and message boards on a variety of health andwellness topics
- Take quizzes and participate in customized self-improvement programs

Note: Retirees, Surviving Spouses, and LTD Terminees and their covered Dependents are not eligible for EAP benefits.

Virtual Visits

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

You can utilize the virtual visits benefit for commonly treated conditions when Your primary care doctor is not available, You are traveling, or before visiting the emergency room or urgentcare facility for a non-emergency health condition. Commonly treated conditions include:

- Allergies/asthma
- Bladder infection/urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Ear infection
- Fever
- Joint aches
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomachache

You can find a Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on Your ID card. For members of the Total Health PPO plan, coverage is a flat copay amount without having to meet the annual deductible. For members of the Health Savings Plan or High Deductible Health Plan, the annual deductible must be met before the copay is applicable.

Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

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

IMPORTANT: If You have a Medical Emergency, call 911.

UnitedHealth Personal Health Support Program

UnitedHealthcare offers those who are living with a chronic condition or dealing with complex healthcare needs the UnitedHealth Personal Health Support℠ Programs. The goal of these programs is to provide a high level of support and help You become as informed as possible. These programs can be accessed at no additional cost to You. If You have questions about or feel You may benefit from these programs, call 877-835-9855.

Case Management Program
If You are living with a chronic condition or dealing with complex healthcare needs, upon notification to Personal Health Support℠, UHC may assign You a primary 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. Your primary nurse will provide You with a direct telephone number so You can contact him/her about Your conditions, or Your overall health and well-being.

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 Yourcovered family members receive appropriate medical care. Program components are subject to

change without notice. When the Claims Administrator is called as required, they will work with You to implement the Personal Health Support process and to provide You with informationabout additional services that are available to You, such as disease management programs, healtheducation, and patient advocacy. The Personal Health Supportprogram includes:

- **Admission Counseling** – For upcoming inpatient hospital admissions for certain conditions,a UHC primary nurse may call You to help answer Your questions and to make sure You havethe information and support You need for a successful recovery. Personal Health Support Nurses are available to help You prepare for a successful surgical admission and recovery. Call the numberon Your ID card for support.
- **Inpatient Care Management** – If You are hospitalized, a Personal Health Support nurse willwork with Your Physician to make sure You are getting the care You need and that Your Physician's treatment plan is being carried out effectively.
- **Readmission Management** – This program serves as a bridge between the Hospital and Your home ifYou are at high risk of being readmitted. After leaving the Hospital, if You have a certain chronic or complex condition, You may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate, and reinforce discharge instructions,and support a safe transition home.
- **Risk Management** – Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** – You have the opportunity to engage with a nurse that specializes in cancer,education and guidance throughout Your care path.
- **Kidney Management** – You have the opportunity to engage with a nurse that specializes in kidneydisease, education and guidance with CKD stage 4/5 or ESRD throughout Your care path.

Additional benefits of having a primary nurse include:

- Individualized information to help You find ways to improve Your health

- A plan to help You learn about preventive care and treatment options
- Proactive outreach to Your physicians and Specialists
- Answering questions about certain procedures, treatment options, and
- Working with Your doctor during a hospital stay to reduce delays on tests and procedures

If You do not receive a call from a UHC nurse, but feel You could benefit from case management services,call 877-835-9855.

Disease Management Program
If You and/or Your covered Dependents are living with a chronic condition such as coronary artery disease, diabetes, heart failure, or asthma, the Disease Management Program provides voluntary disease managementservices to include:

- Assignment of a UHC nurse
- Mailing of information about Your condition to Your home

UHC uses a variety of internal sources, such as claims, calls to Personal Health Support^{SM}, health risk assessments, etc., to identify potential candidates for disease management services. Therefore, You may receive an outreach call from a nurse to ask if You would like to join this program. This program is voluntary; if You do not wish to participate at the time You receive a call, You can inform the nurse of Yourelection. If You are interested in this program, call 877-835-9855 to learn more.

When You are enrolled in the Disease Management Program, You have phone access to a registered nursewho is assigned to You and Your family members and will be Your main point of contact. You will be provided with a direct phone number to Your nurse.

Disease Management Services

If You have been diagnosed with certain chronic medical conditions, You may be eligible to participate in a disease management program at no additional cost to You. UHC offers the following disease management programs:

- Asthma Disease Management Program: Provides information and resources to help pediatric and adult participants avoid asthma triggers, reduce risk factors, improve medication adherence and monitor warning signs.
- Coronary Artery Disease (CAD) Management Program: Through stratification, members are targeted for interventions based on acuity level and potential for impact.
- Diabetes Disease Management Program: Helps deliver optimal clinical and financial outcomes by targeting the areas with the greatest potential for impact.
- Heart Failure Disease Management Program: Comprehensive assessments, personalized plans, at-home biometric symptom monitoring and other

services to reduce unnecessary hospitalizations and health care costs.

- Chronic Obstructive Pulmonary Disease (COPD) Management Program: Based on acuity level, nurses educate members on how to manage their condition and risk factors and improve quality of life.

This means that You will receive free educational information and may even be called by a registered nurse who is a specialist in Your specific medical condition. This nurse will be a resource to advise and help You manageYour condition. These programs also offer:

- Educational materials that provide guidance on managing Your specific chronic medicalcondition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with Your Physician to ensure thatYou are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in Your condition.Examples of support topics include:

    - Education about the specific disease and condition.
    - Medication management and compliance.
    - Reinforcement of on-line behavior modification program goals.
    - Preparation and support for upcoming Physician visits.
    - Review of psychosocial services and community resources.
    - Caregiver status and in-home safety.
    - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If You think You may be eligible to participate or would like additional information regarding the program, pleasecontact the number on Your ID card.

UHC also provides the following services to help support Your health care management:

- Decision Support: Nurse advocates equip members with information to enable them to actively participate in decisions about their health care and treatment options.
- Emergency Room Decision Support: Helps members make informed decisions regarding emergency room visits.
- Physical Health Provider Network: Provides members with access to chiropractors and physical, occupational and speech therapists offering conservative treatment options for musculoskeletal conditions.

Centers of Excellence

UHC offers designated Centers of Excellence (COE) programs for congestive heart disease, cancer services,and organ transplants for You. Individuals with complex, unusual, or rare medical conditions have a likelihood of better outcomes when they are diagnosed and treated by medical professionals with precise clinical expertise. The COE programs were developed to support safe, successful, and cost-effective supportof individuals with these conditions. These programs are optional and are not required in order to receive benefits; however, Your costs may be lower due to typically better COE Program negotiated rates with UHC.In addition, You may have access to additional facilities on an in-network basis through these programs. Finally, for transplants, cancer and congenital heart disease services, You may be eligible for a travel and lodging benefit through these programs as described on the following page. To COE will assist the patientand family with travel and lodging arrangements related to:

Congenital heart disease
Transplantation services
Cancer-related treatments

IMPORTANT: For travel and lodging services to be covered, the patient must be receiving services at a designated provider through the Transplant Resource Services Program, the Congenital Heart Disease Resource Services Program, or the Cancer Resource Services Program, as described on the following pages.

The Programs cover expenses for travel and lodging for the patient and a companion as follows:

Transportation of the patient and one companion who is traveling on the same day(s) to and/or fromthe site of the cancer-related treatment, the congenital heart disease service, or the transplant for thepurposes of an evaluation, the procedure, or necessary post-discharge follow-up.

Eligible Expenses for lodging for the patient (while not a hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion.

If the patient is an enrolled Dependent minor child (i.e., under the age of 18), the transportation expenses of two companions will be covered, and lodging expenses will be reimbursed at a per diem rate of up to $100 per day.

UHC must receive valid receipts for such charges before You will be reimbursed. Reimbursement for certainlodging expenses for the patient and their companion(s) may be included in the taxable income of the subscriber if the reimbursement

exceeds the per diem rate**.**

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the designatedprovider that is being accessed through the Transplant Resource Services Program, the Congenital Heart Disease (CHD) Resource Services Program, or the Cancer Resource Services Program. UHC must receive valid receipts for such charges before You will be reimbursed. Examples of travel expenses may include:

Airfare at economy or coach rate
Taxi or ground transportation (not including limos or car services)
Parking
Boat
Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and designated provider, and/or
Tolls

A combined overall maximum benefit of $10,000 per covered patient applies for all travel and lodging expenses reimbursed under the Programs in connection with all cancer treatments and transplant proceduresand CHD treatments during the entire period that person is covered under the Programs.

Travel and Lodging Assistance Program

Your Plan Sponsor may provide You with Travel and Lodging assistance. Travel and Lodging assistance is only available for You or Your eligible family member if You meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from Your home address to the facility. Eligible Expenses are reimbursed after theexpense forms have been completed and submitted with the appropriate receipts.

If You have specific questions regarding the Travel and Lodging Assistance Program, pleasecall the Travel and Lodging office at 800-842-0843.

Travel and Lodging Expenses
The Plan covers expenses for travel and lodging for the patient, provided he or she is notcovered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s)to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow- up.
- The Eligible Expenses for lodging for the patient (while not an Hospital inpatient) andone companion.
- If the patient is an enrolled Dependent minor child, the transportation

expenses of twocompanions will be covered.

- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, congenital heart disease and transplant programs offer a combined overall maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by You and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before You will bereimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient isin the Hospital.
- A per diem, up to $100.00 per day, for the patient and one caregiver. When a child isthe patient, two persons may accompany the child.
- Examples of items that are not covered:
  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

Transportation

Automobile mileage (reimbursed at the IRS medical rate) for the most direct route betweenthe patient's home and the Designated Provider.

- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Transplant Resource Services Program (Organ and Tissue Transplantation)

The Transplant Resource Services (TRS) Program employs a three-tiered approach to transplant benefitmanagement:

- The Transplant Resource Services (TRS) Choice Plus Premier Network provides access to clinical and financial excellence in transplantation. Patients benefit from network usage with the opportunity for improved outcomes and significant cost savings associated with transplantation, along with the wealth of clinical information available on each network physician and/or healthcare professional to assist in the patient referral process.
- Benefits are available to the donor and the recipient when the recipient is covered under the Programs. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven.

Examples of transplants for which the Programs will pay for include but are not limited to:

- Blood/Marrow
- Heart/Lung
- Intestinal/Liver
- Kidney/Pancreas
- Liver/Kidney
- Pancreas
- Heart
- Intestinal
- Kidney
- Liver
- Lung
- Pancreas after kidney

Transplant Resource Services' contracts apply to the entire transplant event, with pre-negotiated rates for transplant-related services performed at the contracted medical center, including:

- Pre-transplant evaluation
- Hospital and physician fees
- Organ acquisition and procurement, blood/marrow acquisition and donor search charges
- Transplant procedure
- Up to one year of follow-up care for transplant-related services
    - The Transplant Access Program – for geographic access, economic value and administrative relief. The Transplant Access Program provides discounted rates for transplantation at a number of medical centers throughout the United States that are not in the Transplant Resources Choice Plus Premier Network. Participating Transplant Access Program physicians and other healthcare professionals do not undergo Transplant Resource Services' rigorous credentialing process; therefore, clinical information regarding these providers is not available to promote referral.
    - Extra Contractual Services – for contracting expertise on a case-by-case basis. These services areavailable on a case-by-case basis for

patient referrals that fall outside of The Transplant ResourceServices Choice Plus Premier Network or The Transplant Access Program.

For information on coverage, refer to Section 6: Covered Medical Plan Services & Limitations.

Transplant Resource Services (TRS) Program

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

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on Your ID card. Coverage for transplant and transplant-related services are based on Your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirementsand coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing You with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

Cancer Resource Services Program
The Cancer Resource Services Program and associated nurse consulting services help manage rare, complex, and potentially high-cost cancers while providing access to a full range of comprehensive cancer treatment services through the program's centers of excellence cancer treatment facilities. The benefits of utilizing thisprogram include:

- Consultation from nurses about options to help You make an informed decision about which cancercare provider is best for You
- In-network coverage for care at cancer centers that have passed rigorous criteria
- Access to information about coverage, scheduling appointments, finding lodging, and other services
- Accurate diagnosis and few complications
- Care that is planned, coordinated, and provided by a team of experts who specialize in the patient'sspecific cancer
- Appropriate therapy
- Higher survival rates, shorter length of stay and decreased costs

For information on coverage, refer to Section 6: Covered Medical Plan Services & Limitations.

Cancer Resource Services (CRS) Program

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

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call thenumber on Your ID card or call the program directly at 866-936-6002.
Coverage for oncology services and oncology-related services are based on Your healthplan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.
Your Plan Sponsor is providing You with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

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

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease.As a participant in the KRS program, You'll work with a nurse who will provide You withsupport and information. The nurse can help You manage other conditions, such as diabetes and high blood pressure. He or she can also help You find doctors, specialists and dialysis centers. This program is available at no extra cost to You.

With KRS, You have access to a registered nurse who specializes in kidney health. Thisprogram is designed to help You be Your own best advocate for Your health. You may have been referred to the KRS program by Your medical provider or from past claim information. As part of Your health insurance benefits, it's available at no extra cost to You.

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

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

Congenital Heart Disease Resource Services Program
The Congenital Heart Disease (CHD) Resource Services Program complements the heart programs within the Transplant Resource Services Program to help You manage congenitalheart disease cases.

Goals of CHD Resource Services include:

- Provide access to quality care for individuals with CHD
- Provide information regarding "best practice" in CHD care
- Build awareness among treating physicians regarding the availability of CHD

ResourceServices Program
- Promote identification of individuals with CHD in-utero or at birth. This allows timefor education and guidance offering the opportunity for improved outcomes and decreased CHD days, resulting in lower-cost CHD events

Designated cardiothoracic surgeons are available to discuss clinical issues and potentialreferrals with referring physicians.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with You and Your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit http://www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on Your ID card or You can call the CHDResource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on Your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If You are considering any CHD surgeries, You must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing You with Travel and Lodging assistance.Refer to the Travel and Lodging Assistance Program.

Out-Of-Network Program

UHC offers Naviguard, a reference-based pricing reimbursement program, to assist You with out of network claims through comprehensive member advocacy and balance billing support.

Behavioral Health

UHC offers behavioral health solutions that integrate behavioral, medical, and pharmacy into a whole-person approach designed to help You receive comprehensive support regardless of Your needs, including:

- AbleTo: AbleTo provides virtual support for the depression, anxiety and stress that typically may accompany health issues such as cardiac conditions, diabetes, chronic pain and cancer. AbleTo engages employees in both

behavioral coaching and personalized therapy, via phone or video, twice a week for up to 8 weeks.

- Sanvello: Sanvello is a top-rated self-help mobile app that uses clinically validated techniques such as Cognitive Behavioral Therapy (CBT), a type of psychotherapy that has been shown to be especially effective for individuals experiencing a high level of stress or symptoms of anxiety and depression. The app empowers members to engage in activities to improve their mental health from the convenience of their mobile device anytime, anywhere.
- Talkspace: With Talkspace online therapy, You can regularly communicate with a therapist, safely and securely from your phone or desktop. Talkspace offers unlimited text messaging with access to licensed clinicians, master's level and higher.
- Employee Assistance Program (EAP): Consultation by master's level counselors and, if needed, 1:1 counseling to address personal challenges, problems of daily life or workplace concerns of members and their families. Support is available 24/7 for employees and managers/supervisors.
- WorkLife: Assessment, consultation, and referrals for child/parenting; adult/eldercare; education/life learning; chronic condition; and convenience services.
- Life Solutions: Life Solutions is designed to effectively engage with members who have a chronic medical condition and co-occurring behavioral condition that is unrecognized or undertreated. Members work with a Life Coach to identify goals and resources, with the intention of addressing behavioral health concerns and better manage medical issues.

Health and Wellness

UHC offers the following programs to help support your health and wellness journey:

- Rally: Rally is designed to help you improve and maintain your health by providing personalized recommendations and a reward program designed to help You move more, eat better, and stress less.
- Wellness Coaching: Personal coaching for a variety of topics including family wellness, heart health, general wellness, diabetes lifestyle, fit for life, tobacco cessation, weight and wellness, sleeping well, stress management, eating smart, happiness, meditation, and financial wellbeing.
- Maternity Support Program: Augmented personalized and proactive outreach to support both low risk and high-risk members before, during and after pregnancy. Includes UnitedHealthcare maternity support app.

Member Experience

UHC provides the following services to support and enhance member experience:

- Digital Services:

    - myuhc.com is a comprehensive online consumer resource You can use to obtain provider quality and price transparency data, access health and wellness resources and manage Your health care benefits 24 hours a day, 7 days a week. You can also view and print a copy of Your ID card.
    - The UnitedHealthcare app mobile app enables You to access critical health and benefits information for Yourself and each family member, find the appropriate care, personalize the interface, and talk to someone directly if You have questions.
    - Rally health and wellness employs industry-leading technologies, gaming and social media to help engage You in new ways. The interactive capabilities challenge You to take greater daily ownership of Your health. The Rally platform offers an experience designed to help You feel empowered and motivated through simple, fun interactions and personalization.
- Advocate4Me: Provides You care through end-to-end health, wellness and benefits support including benefits and claims questions, finding the right doctor, proactive support and information, health education, clinical program enrollment and much more. Advocate4Me features a team of health care experts who provide support by helping You coordinate all aspects of Your care. The team uses the most advanced data and analytics to anticipate Your needs and connects You seamlessly to the solutions that are right for You. Advocate4Me also provides intensive 1:1 support for families with special needs.
- Health Care Spending Card: Enables members with FSAs, HRAs or HSAs to pay for many eligible expenses quickly and conveniently at the point-of-sale or point-of-service.

Healthcare Fraud Information

Healthcare and insurance fraud results in cost increases for healthcare plans. You can help by:

- Being wary of offers to waive copays, coinsurance, and Deductibles. These costs arepassed on to You eventually.
- Being wary of mobile health testing labs. Ask what Your healthcare insurance will becharged for the tests.
- Reviewing the bills from Your providers and the Explanation of Benefits (EOB) formYou receive from UHC. Verify that services for all charges were received. If there areany discrepancies, call UHC Customer Service.
- Being very cautious about giving information about Your healthcare insurance over thephone.

If You suspect fraud, contact the UHC Fraud Department at 877-835-9855.

No Surprises Act Requirements

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes certain requirements relating to surprise billing claims under the No Surprises Act (NSA). This section explains the requirements and Your rights under the NSA.

Surprise Billing Claims
Surprise Billing Claims are claims that are subject to the NSA requirements (as applicable to each type of claim listed below):

- Emergency Services provided by out-of-network providers;
- Covered services provided by an out-of-network provider at an in-network Health Care Facility; and
- Out-of-network air ambulance services.

Emergency Services
Emergency Services (i.e., services relating to a Medical Emergency in an emergency department of a hospital or in an Independent Freestanding Emergency Department) are covered without the need for prior authorization and regardless of whether the services are received from an in-network provider or an out-of-network provider. If Emergency Services are received from an out-of-network provider, the following NSA protections will also apply:

- Any applicable administrative requirements or coverage limitations will not be more restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and in-network emergency facilities.
- Your cost-sharing payments will count toward any in-network deductible or Out-of-Pocket Limits under Your medical plan, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider or facility.
- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider or in-network emergency facility.

Additionally, Your out-of-network provider may not balance bill You for Emergency Services, meaning the out-of-network provider may not charge You for any difference between the maximum allowable amount payable under Your medical plan and the out-of-network provider's billed charges.

Refer to Section 6 ("Covered Medical Plan Services & Limitations") for information regarding Emergency Services.

Post-Stabilization Services
Post-Stabilization Services are additional Covered Health Services that are provided by an out-of-network provider or out-of-network emergency facility after

You have received Emergency Services and are stabilized, and as part of outpatient observation or an inpatient or outpatient stay for such services. Post-Stabilization Services are subject to the same NSA protections as Emergency Services unless excepted under the Notice and Consent Exception (see "Notice and Consent Exception for Certain Services" section below for specific requirements). The Notice and Consent Exception requires that the out-network provider supply You with proper notice of the Post-Stabilization Services and that You provide informed consent to receive such services. The out-of-network provider must also determine that You are:

- stable;
- able to travel to an in-network facility within a reasonable travel distance by non-medical or non-emergency transport, taking into account Your medical condition; and
- in a condition to receive the information and provide informed consent.

If the out-of-network provider meets the Notice and Consent Exception requirements and You continue to receive services from the out-of-network provider after You are stabilized, You will be responsible for the out-of-network provider cost-shares, and the out-of-network provider will also be able to balance bill You (i.e., charge You any difference between the maximum allowable amount payable under Your medical plan and the out-of-network provider's billed charges). However, there are certain services that cannot be excepted under the notice and consent exception even if the out-of-network provider meets all the requirements (refer to Ancillary Services in the "Notice and Consent Exception for Certain Services" section below).

Non-Emergency Services from an Out-of-Network Provider at an In-Network Health Care Facility

If You receive non-Emergency Services covered under the Plan from an out-of-network provider at an in-network Health Care facility, the following NSA protections will apply:

- Any applicable administrative requirements or coverage limitations will not be more restrictive than the requirements or limitations that would apply if the services were received from an in-network provider.
- Your cost-sharing payments will count toward any in-network deductible or Out-of-Pocket Limits under the Plan, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider.
- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider.

Additionally, Your out-of-network provider may not balance bill You for the non-Emergency Services (i.e., charge You any difference between the maximum allowable amount payable under the Plan and the out-of-network provider's billed charges).

However, the NSA protections will not apply if the Notice and Consent Exception applies (see "Notice and Consent Exception for Certain Services" section below for specific requirements). Under the Notice and Consent Exception, the out-of-network provider must provide You with proper notice of the non-Emergency services and You must provide informed consent to receive such services. However, there are certain services that cannot be excepted under the notice and consent exception even if the out-of-network provider meets all the requirements (refer to Ancillary Services in the "Notice and Consent Exception for Certain Services" section below).

Notice and Consent Exception for Certain Services
For certain Post-Stabilization Services and certain non-Emergency Services, applicable NSA protections will not apply if the out-of-network provider provides You with proper notice and You provide written informed consent to such services that meet the requirements discussed below. The provider's notice is required to inform You about Your NSA protections from unexpected medical charges, give You the option to give up those protections and potentially pay more for out-of-network care, and provide an estimate of what Your out-of-network care might cost.

"Proper notice" from a provider requires that at least 72 hours before the day of the appointment, or three (3) hours in advance of services rendered in the case of a same-day appointment, the provider supplies You with a written notice disclosing:

- the provider is an out-of-network provider with respect to Your medical plan;
- the good faith estimated charges for Your covered services;
- any advance limitations that Your medical plan may put on Your treatment (e.g., any prior authorization requirements, etc.); and
- You may elect to seek care from an available in-network provider instead.

Note: If the notice relates to Post-Stabilization Services (see "Post-Stabilization Services" section above), the notice must also include a list of the names of any in-network providers at the facility who are able to treat You and a statement that You may elect to be referred to one of the in-network providers.

"Informed consent" requires that You give the provider written consent to any charges disclosed in the provider's notice, acknowledging that You understand that continued treatment by the out-of-network provider may result in greater cost to You. This means You will be responsible for out-of-network provider cost-shares for those services and the out-of-network provider can also balance bill You for such services (i.e., charge You any difference between the maximum allowable amount under Your medical plan and the out-of-network provider's billed charges).

The notice and consent exception does not apply to the following services, which are always covered by the NSA protections:

- Ancillary Services, which means:
    - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
    - Items and services provided by assistant surgeons, hospitalists, and intensivists;
    - Diagnostic services, including radiology and laboratory services; and
    - Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Current Provider Directory
UHC updates the list of in-network providers in its provider directory every 90 days. You may request information from UHC regarding whether a provider or facility is in the Programs' networks or otherwise has a contractual relationship with the Programs. If You request such information through a telephone call, email or other electronic web-based or Internet-based means, UHC will respond to You no later than one business day after Your request is received, through a written electronic communication or, if requested, paper communication. The Programs are required to retain this communication in Your file for at least two years afterwards.

If You can show that You received inaccurate information from the Programs that a provider was an in-network provider on a particular claim, then You will only be liable for in-network cost-shares applicable to in-network providers (i.e., copayments, deductibles, and/or coinsurance) for that claim. Your cost-sharing payments will be counted toward any in-network deductible or Out-of-Pocket Limits under the Programs, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider or facility.

Refer to Section 3 ("Accessing Care") for information regarding how You can access in-network provider information.

How Cost-Shares Are Calculated
Your cost-shares for NSA-protected Emergency Services or covered non-Emergency Services received by an out-of-network provider at an in-network facility are calculated using the median in-network contract rate that the medical plan applies to in-network providers for the geographic area where the covered service is provided. Any out-of-pocket cost-shares You pay to an out-of-network provider for either Emergency Services or covered non-Emergency Services provided by the out-of-network provider at an in-network facility will be applied to Your in-network out-of-pocket limit and Your in-network deductible in the same manner as if such cost-sharing payment was made with respect to items and services furnished by an in-network provider or facility.

Coverage of Air Ambulance Services
If You receive Air Ambulance Services (i.e., medical transport by helicopter or airplane for patients) from an out-of-network provider, and such services would have been covered under the Plan if provided by an in-network provider, then the Plan will cover the services as follows:

- Your cost-sharing payments will be counted toward any in-network deductible or Out-of-Pocket Limits under the medical plan, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider.
- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider.
- Cost-sharing will be calculated based on the lesser of the qualifying payment amount (i.e., the median in-network contract rates the medical plan applies to in-network providers for the geographic area where the covered service is provided) or the out-of-network provider's billed amount.
- Not later than 30 calendar days after all information necessary to decide Your claim for the services has been received, UHC will send the provider an initial payment or a notice of denial of payment.

Refer to Section 6 ("Covered Medical Plan Services & Limitations") for information regarding Air Ambulance services.

Appeals and External Reviews
If You have a claim that is denied and You believe the claim is protected by the surprise billing and cost-sharing protections under the NSA, You have the right to appeal Your claim under the Programs' internal claims and appeals process.

If You have exhausted, or are deemed to have exhausted, the Programs' internal claims and appeals process or You have requested an expedited external review, You may request external review for any adverse determination involving consideration of whether Your Program is complying with the surprise billing and cost-sharing protections under the NSA.

Examples of NSA Adverse Benefit Determinations Eligible for External Review

- Patient cost-sharing and surprise billing for emergency services;
- Patient cost-sharing and surprise billing protections related to care provided by nonparticipating providers at participating facilities;
- Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections; and
- Whether a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.

Refer to Section 10 ("How to File a Claim") and Section 11 ("How to File an Appeal") of this Benefit Summary for information regarding the Programs' claims and appeals process and external review procedures.

Continuity of Care
If You are a continuing care patient, and the contract with Your in-network provider or facility terminates:

- You will be notified in a timely manner of the contract termination and of Your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to 90 days of continued coverage at in-network cost-sharing to allow for a transition of care to an in-network provider.

The term "Continuing Care Patient" means an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

The term "Serious and Complex Condition" means, with respect to a participant under the plan, one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is—
    - is life-threatening, degenerative, potentially disabling, or congenital; and
    - requires specialized medical care over a prolonged period of time.
    -

Note: the right to elect continued transitional care described in this section does not apply if the contract with an in-network provider or facility is terminated for failure to meet applicable quality standards or for fraud.

Transparency

The following information is publicly available at hr.sandia.gov (search "Plan Documents"). The following information is also provided on each explanation of benefits for any item or service You receive that is covered by the NSA:

- Protections with respect to Surprise Billing Claims by providers;
- Estimates on what out-of-network providers may charge for a particular service;
- Information on contacting state and federal agencies in case You believe a provider has violated the No Surprises Act's requirements.

You may obtain the following information through hr.sandia.gov (under "Publicly Available Files"):

- Cost sharing information that You would be responsible for, for a service from a specific in-network provider;
- Cost sharing information on an out-of-network provider's services based on the medical plan's reasonable estimate based on what the medical plan would pay an out-of-network provider for the service;
- A list of all in-network providers (refer to "Finding Network Providers" above for additional information).

In addition, You may access the following information online at hr.sandia.gov (under "Publicly Available Files"):

- In-network negotiated rates;
- Historical out-of-network rates; and
- Drug pricing information.

Section 3. Deductibles, Out-of-Pocket Limits and Lifetime Limits

This section summarizes the annual Deductibles and Out-of-Pocket Limits that apply to the in-network option and the out-of-network option, as well as any lifetime limits under the Programs.

Deductibles

This section describes Your Deductibles. You must first pay the annual Deductible before the Programs begin to pay for Covered Health Services. Your annual deductible begins on January 1. When You meet the full Deductible amount, the Programs begin to pay for eligible, covered expenses at the applicable Coinsurance amount. Deductibles are not prorated for mid-year enrollments and reset every January.

If You retire mid-year and qualify for Post-Employment H&W Plan, any amounts applied toward Your Deductibles under Your active employee coverage will transfer to Your NTESS retiree coverage provided you keep the same coverage into retirement.

If You change medical plans mid-year (e.g., You move from the Kaiser STH Program to either of these Programs), any amounts applied toward Your Deductible under your current NTESS plan will be applied to the applicable new NTESS Program; however, You must coordinate the transfer of Your Deductible through HR Solutions at the time of enrollment.

IMPORTANT:
Amounts above Eligible Expenses, charges not covered by the Programs, prescription drug Coinsurance, virtual visit copay, and penalties incurred because of failure to obtain required Prior Authorization or precertification do not apply toward the Deductible. If You are enrolled in the Total Health PPO Plan, there is no deductible for prescription drugs and prescription drug Coinsurance amounts do not apply to the annual Deductible described in the Summary of Benefits and Coverage (SBC). However, the Health Savings Plan and High Deductible Health Plan Deductibles described in the Summary of Benefits and Coverage (SBC) accumulate with covered medical and prescription drug costs.

For the Total Health PPO: This Program has an embedded Deductible, which means:

- If You are the only person covered by this Plan, only the Primary Covered Member Only (also referred to as individual) Deductible applies to You.

- If You are enrolled in Primary + Spouse/Child or Primary + Spouse + Child(ren) coverage, both the individual and the Family amounts apply. The family Deductible amounts can be satisfied by any combination of family members, but You could satisfy Your own individual Deductible amount before the family amount is met. You will never have to satisfy more than Your own individual Deductible amount. If You meet Your individual Deductible amount, Your other family member's claims will still accumulate towards their own individual Deductible as well as the overall family amounts. This continues until Your other family members meet their own individual Deductible or the entire family Deductible is met.

For the Health Savings: If You are enrolled in either Primary Covered Member + either Spouse or Child(ren), or Primary Covered Member + Spouse + Child(ren) coverage, then the family Deductible must be satisfied before the Program will begin to pay for Covered Health Services. The family Deductible amounts can be satisfied by a single Member or any combination of family members.

Deductibles for Admissions Spanning Two Calendar Years
If a Deductible has been met while You are an inpatient and the admission continues into a newyear, no additional Deductible is applied to that admission's Covered Health Services. All other services received during the new year are subject to the applicable Deductible for the new year.

Coinsurance

In addition to Your Deductible, if applicable, You pay Coinsurance of 10% of the Covered Charge for the Choice Plus Premier Provider Network, or 20% of the Covered Charge for UHC PPO Provider Network in-network services, and 40% of the Covered Charge for out-of-network services. Please be aware: the difference between the Covered Charge and a provider's billed charge can be significant; an out-of-network provider can bill You for this difference.

Certain preventive care as outlined under Coverage Details is provided at 100% coverage when You receive the services from an in-network provider, or if You receive services out-of- network, coverage is at 60% of the Medicare-Allowed Amount or equivalent as determined by the claims administrator, after the Deductible (out-of- network balance billing may apply). For information on non-covered services, refer to 8: What's Not Covered – Exclusions.

IMPORTANT: You are responsible for any amount above the Medicare-Approved Amount if You receive services out-of-network. Some services require Prior Authorization (see Section 3: Accessing Care for a completelisting of these services). If Prior Authorization is not obtained, You will receive reduced benefits.

Out-of-Pocket Limits

This section describes Your Out-of-Pocket Limits.

Note: Out-of-Pocket Limits are not pro-rated for mid-year enrollments.

If You retire mid-year and are PreMedicare, any amounts applied toward Your out-of-pocket limits under Your employee coverage will transfer to Your retiree coverage, provided You keep the same coverage into retirement.

If You change your medical carrier mid-year (e.g. You move from the Kaiser STH Program to either of these Programs), any amounts applied toward Your Out-of-Pocket Limits under your current NTESS plan will not be transferred to the new carrier and you limits start over. If you change plans within the same carrier (e.g. you move from the Health Savings Plan to the Total Health PPO plan within UHC, then the out-of-pocket limit will be applied to the applicable new medical Plan.

For details regarding annual Out-of-Pocket Limits, please refer to the Summary of Benefits and Coverage (SBC).

The following table identifies what does and does not apply toward in-network and out-of-network Out-of-Pocket Limits:

Features	Applies to the In-Network, Out-of-Pocket Limit?	Applies to the Out-of-Network, Out-of-Pocket Limit?
Payments toward the annual Deductible	Yes	Yes
Member Coinsurance payments	Yes	Yes
Charges for non-covered Healthcare Services	No	No
Amounts of any reductions in benefits You incur by not following Prior Authorization or precertification requirements	No	No
Amounts You pay toward behavioral health services	Yes	Yes
Charges that exceed Covered Expenses	Not applicable	No
Prescription drugs and other items obtained through Express Scripts (NTESS Total Health PPO Plan)	No	No
Prescription drugs and other items obtained through Express Scripts (Health Savings Plan)	Yes	No

Prescription Drug Expenses Incurred through Express Scripts

Your medical and prescription drug costs combine and accumulate toward a single Out-of-Pocket Limit for the Health Savings Plan and the High Deductible Health Plan (described above).

For the Total Health PPO Plan, the prescription drug program has a separate Out-of-Pocket Limit, which is as follows:

Total Health PPO Plan	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Limit	$1,500 per person	None

Once a Covered Member has met his/her $1,500 Prescription Drug Out-of-Pocket Limit (or $5,950 per family) for the year, no additional co-insurance will be required for covered in-network prescription drugs for the remainder of the calendar year.

IMPORTANT: The Prescription Drug in-network Out-of-Pocket Limit does not apply to prescription drugs and other items purchased out-of-network, therefore, if You have met Yourin-network per person annual Out-of-Pocket Limit, and You purchase a prescription at an out- of-network retail pharmacy, You will be responsible for the applicable Coinsurance amount. Refer to Section 7: Prescription Drug Program for information on Your prescription drug benefits.

Lifetime Limits

The Programs do not have any lifetime limits, with the exception of the infertility benefit, travel and lodging, and bone marrow and stem cell donor search.

Infertility benefit: When You reach the $30,000 lifetime limit benefit, no additional reimbursement for any procedures incurred to treat infertility are payable. Other covered procedures related to familyplanning or reproduction (excluding infertility) may be payable.
Travel and lodging: a combined overall maximum benefit of $10,000 per covered recipient applies for all travel and lodging expenses reimbursed. This applies to all treatments during theentire period that the recipient is covered under this medical plan.
Bone Marrow and Stem Cell Donor Search: An overall maximum benefit of $25,000 percovered recipient in-network or out-of-network combined.
Refer to Section 6: Covered Medical Plan Services & Limitations.

Section 4. Health Reimbursement Account and Health Savings Account

The Total Health PPO Plan is paired with a health reimbursement account (HRA) and the Health Savings Plan is paired with a health savings account (HSA). Although the HRA and HSA are similar because they are both accounts that reimburse certain health care expenses, there are important differences between the HRA and HSA. The HRA and HSA are described below.

Note: PreMedicare Retirees, Surviving Spouses, and LTD Terminees enrolled in the HDHP, if they are eligible to contribute to an HSA, they must establish and contribute to an HSA directly with an HSA provider (i.e., the HDHP for PreMedicare Retirees, Surviving Spouses, and LTD Terminees does not include HSA contributions through the Company).

Health Reimbursement Account (HRA)

To be eligible for HRA funding, You must be enrolled in the Total Health PPO.

The HRA is an arrangement that will allow You to determine how some of Your health care dollars are spent. NTESS will allocate an amount to the account that is based on:

- Your coverage and enrollment status (active, PreMedicare/single, family, etc.),
- Whether or not You and Your covered Spouse have completed a Health Assessment through the Virgin Pulse Program website, and
- Whether or not You and Your covered Spouse have participated in the Virgin PulseIncentive Program.
- Whether or not You and Your covered Spouse have participated in a Health Action Plan.

Annual Allocation of HRA Contributions

Coverage Category / Tier	Virgin Pulse Activity Completion	Health Action Plan Completion	Health Assessment is Taken	Health Assessment is NOT Taken	Total Possible HRA allocation[1]
Employee only	Maximum $300	$100	$100	$0	$500
Employee + Spouse	Maximum $600[2] ($300 max each employee and spouse)	Maximum $200 ($100 each employee and spouse)	Maximum $200 ($100 each employee and spouse)	$0	$1,000
Employee + Child(ren)	Maximum $300	$100	$100 (employee completes)	$250	$750
Employee + Spouse + Child(rent)	Maximum $600 ($300 max each employee and spouse)	Maximum $200 ($100 each employee and spouse)	Maximum $200 ($100 each employee and spouse)	$250	$1,250
	[1] This is the maximum amount that may be placed in Your HRA in January of the following calendar year and may be used for allqualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses.				

The HRA is entirely funded by NTESS and not taxable to You. You are not permitted to make any contribution to Your HRA, whether on a pre-tax or after-tax basis. Your HRA is an "unfunded" account, and benefit dollars are payable solely from NTESS's general assets.

Both the primary covered member and covered Spouse are responsible for completing thehealth assessment to receive the HRA contributions associated with that activity. Other covered Dependents are not required to complete a health assessment.

Note: In order to receive HRA funding for the following calendar year, **Employees and their Spouses**must complete their Health Assessments by **October 31 by 9:59 PM MST** of the current year and remain covered on the Total Health PPO plan as of January 1 of the next year. Employees who switch from the Total Health PPO plan to the Health Savings Plan as part of the annual open enrollment will have all earned Virgin Pulse incentives deposited into their HSA for the following year provided their HSA is active as of the date of transfer.

If You don't spend all Your HRA dollars in a calendar year, and You remain enrolled in the Total Health PPO Plan for the following year, any remaining HRA balance remains inthe HRA for the next calendar year. The maximum balance in an HRA is capped at:

- $1,500 for Primary Covered Member only coverage
- $3,000 for Primary Covered Member plus Spouse or plus child(ren)
- $4,500 for family coverage

Events Resulting in Loss of HRA Funds
The maximum balance in an HRA at the beginning of any new year is capped at the amounts shown above. If You have an event which forces You to change coverage, Your HRA balance will be adjusted accordingly at the beginning of the next calendar year. Example: You are enrolled as Primary Covered Member + Spouse and get divorced. At the time of the divorce, You have $2,500 in Your HRA. You may keep the HRA funds through the end of the calendar year, however the HRA balance will be reduced to $1,500 after the rollover period of the following calendar year, as that is the maximum balance for Primary Covered Member Only coverage.

Note: Expenses incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.

If You terminate employment or lose coverage, You have 90 days to file claims for expenses incurred while You were covered under the Total Health PPO Plan. If You do not use Your HRA funds and do not elect COBRA coverage, You forfeit any remaining HRA funds. Refer to Employee H&W Plan SPD for information on continuing coverage under COBRA.

If You are a PreMedicare Retiree, and You become Medicare- eligible, You have 90 days from date of Medicare eligibility to file claims for expenses incurred while You were under the Total Health PPO Plan. Any HRA funds remaining after 90 days will be forfeited.

Note: If You are new to this plan at the start of the plan year and were previously enrolled in a different medical carrier, any HRA funds will not rollover until 90 days after the end of the previous calendar year. This ensures that Your current carrier has access to Your prior year HRA funds to pay for claims for medical services received in the previous year but processed during this 90-day window.

New Hires
NTESS will automatically make the full applicable Health Assessment portion of the HRAcontribution (see Annual Allocation of HRA Contributions table) for the calendar year in which You hire. To receive the Health Assessment portion of the HRA contribution for thenext calendar year, You and Your covered Spouse must complete the Health Assessment by **October 31, by 9:59 PM MST** to receive funds in January of the new calendar year.

Eligible Mid-Year Election Change Events
NTESS will automatically make the applicable HRA contribution for any Employees and/or their Dependents who enroll in the Total Health PPO Plan during

thecalendar year as a result of an eligible mid-year election change event. Examples include:

- If You have waived coverage because You have coverage elsewhere, and You lose that coverage and enroll in the Total Health PPO Plan within 31 calendar days of theloss of coverage, NTESS will contribute the applicable HRA contribution.
- If You get married mid-year, NTESS will contribute the applicable additional HRAcontribution ($100 to include Spouse coverage or $250 for children) if You enroll Your new eligible family members within 31 calendar days of marriage.

Open Enrollment Changes for Dual Sandians

If You change Primary Covered Members during Open Enrollment, the total HRA will be assigned to the new Primary Covered Member in the month of April up to the allowed maximum.

If You have Primary Covered Member + Spouse or Primary Covered Member + Family coverage and change to Primary Covered Member only coverage, the HRA funds will remain with the original Primary Covered Member. HRA funding will remain with the original Primary Covered Member.

Dual Sandians who split coverage will result in the HRA funds remaining with the original Primary Covered Member.

What Healthcare Expenses are Eligible for HRA Reimbursement

Your Health Reimbursement Account may only be used for all qualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses. For example, if You receive elective cosmetic surgery that is not eligible under the Total Health PPO Plan, these claims are not eligible for payment by the HRA.

How the HRA Works

Your HRA dollars can be used to pay for Eligible Expenses, including eligible dental, vision or prescription drugs, up to the amount allocated to Your HRA. HRA funds are available for use by any Covered Member and are not apportioned on a per person basis. For example, if there is $750 in available HRA funds and a claim is submitted for one member in the amount of $1,000, and the member has a $750 Deductible, the full HRA funds of $750 will be pulled to cover the Deductible portion of the claim.

The plan year begins on January 1 of each year and ends December 31.

1. Usually, in January newly earned funds are deposited into the HRA. For example, incentives earned in 2023 will be deposited in January 2024.

2. You can start using these funds once they have been deposited for current year claims.
3. Unused HRA funds from the previous can be rolled over up, to the maximum allowed, into the next year.
4. At the beginning of each new plan year, you have a 90-day runout period to submit claims incurred in the previous year, for reimbursement, before the balance rolls over to the new plan year.
5. The debit card issued by the carrier for HRA expenses can only be used for current year expenses. All claims submitted during the runout period for previous years services, must be filed manually online directly with the carrier.
6. Once the previous year's funds have rolled over to the new plan year, you can no longer submit claims for the previous year.

NOTE: If you change carriers' mid-year or at Open Enrollment, you may have the opportunity to transfer your unused HRA funds to the new carrier. Please contact HR Solutions at 505-284-4700 for more information on how this may apply to you.

UHC Healthcare Spending MasterCard

UHC will issue You a debit card called the UHC Healthcare Spending MasterCard (debit card). Two cards are sent for convenience. Additional cards may be requested by calling 866-755-2648. Additional cards are at no cost to You. The debit cards are issued with thePrimary Covered Member's name; however, any covered member can use them.

There is no fee for You to use the card, nor does owning this card affect Your credit rating.

This debit card can be used for paying eligible 213(d) expenses. See the Claims Processing with an HCFSA and/or HRA section below for important information on how and when to usethe card.

Note: If You enrolled in a Healthcare Flexible Spending Account (HCFSA), the same debit card will be used to pay for eligible HCFSA expenses. You will use the debit card to withdraw funds from Your HCFSA to help offset healthcare expenses You incur under the Total Health PPO Plan as well as eligible expenses under the HCFSA. Refer to the NTESS Cafeteria Plan Document for more information.

Even though it says debit on the front of the card, it does not require a PIN (personal identification number) for processing, so You should select "credit" at the point of purchase.

If a merchant allows partial authorizations, the card will access only the remaining funds in the account. For example, if the item cost is $20, and there is only $10 in the account, You can use the card to fund $10, and then pay for the remainder of the transaction out-of-pocket. Not all merchants allow partial authorization.

If Your debit card doesn't work, or is declined, You should choose another payment method, save the receipt, and submit the claim manually using the claim reimbursement request form.

Reasons why Your card may be declined include:

- The card is not activated
- One business day has not passed since activation
- The transaction is not for an eligible service
- The transaction is for a non-eligible charge
- The transaction cannot be substantiated in real time at the pharmacy
- The retailer does not accommodate partial authorization and the remaining funds in theaccount do not cover the expense
- There is a problem with the merchant's card terminal
- It is an invalid location, e.g., a gas station or electronics store
- The card has been deactivated due to pending unsubstantiated claims

Medical transactions only can be viewed on the HCFSA/HRA statement. You can also goonline at www.myuhc.com to view Your medical and prescription drug transactions.

Note: When using a debit card to pay for HCFSA/HRA claims, there are certain claims which are not automatically substantiated and require additional documentation (receipts that indicatethe date of service, the vendor, the nature of the service and cost). For unsubstantiated claims identified by the HRA administrator, You will receive 3 notifications requesting additional documentation. Following the second notice, debit cards will be inactivated until claim receipt documentation is received. For any unsubstantiated FSA claim expenses not validated at the end of the plan year, the amount will be reflected as income on Your form W2 and taxed accordingly. For any unsubstantiated HRA claim expenses not validated at the end of the plan year, the full amount of the unsubstantiated claim will be garnished from Your paycheck.

Please remember to save all HCFSA and HRA claim receipts.

Claims Processing with an HCFSA and/or HRA

Generally, UHC in-network providers will not collect a payment at the time of service. The provider will bill UHC and UHC will process Your claim. Funds will automatically be taken from the HCFSA, if enrolled in the UHC FSA, and then from the HRA to pay the provider. IfYou do not want this to occur, please visit the Turning off the Auto-Rollover Feature section for instructions on how to disable this feature.

If You are using an out-of-network provider, they may require payment at the time of service. In this case You may want to use Your debit card to make the payment.

Remember that only theamount available in the HCFSA and HRA may be paid with the debit card.

The HCFSA and HRA will only pay if You have funds available.

You can keep track of the dollars in Your HCFSA and HRA by going to www.myuhc.com,calling the toll-free number on the back of Your ID card, or checking a monthly member statement sent to You by UnitedHealthcare.

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g., HCFSA and HRA) for any single expense. If You receive excess reimbursement, contact UHC Customer Service at 877-835-9855.

Medical Expenses
When You or Your covered Dependent seek eligible healthcare services, You must present YourUHC identification card.
If You see an in-network provider:

1. The provider will file a medical claim with UHC.
2. If the service requires the Deductible or Coinsurance, UHC will look to see if You havefunds in Your HCFSA first (if enrolled), then Your HRA.
    a. If You do, UHC will pull the member responsibility share of the cost of theservice from Your HCFSA and/or HRA.
    b. HCFSA funds will be paid directly to the provider for in-network medical expenses (otherwise, Your HCFSA will reimburse You directly – see Setting up Direct Deposit).
    c. HRA funds are paid directly to the provider.
3. Once Your UHC claim is processed, all claim and HCFSA and/or HRA activity will be documented and sent to You on Your UHC Health Statement. Additionally, if the fundscome from Your HCFSA You will receive an EOB as well.
4. Review the statements for accuracy and contact UHC if You believe there are errors.

If You see an out-of-network provider who does not file a claim:

1. You are responsible for filing the medical claim with UHC.
2. If the service requires the Deductible or Coinsurance, UHC will look to see if You havefunds in Your HCFSA first (if enrolled), then Your HRA.
    a. If You do, UHC will pull the member responsibility share of the cost of theservice from Your HCFSA and/or HRA.
    b. HCFSA and HRA funds will be paid directly to You by check (see Setting up Direct Deposit).
3. Once Your UHC claim is processed, all claim and HCFSA and/or HRA activity will be documented and sent to You on Your UHC Health Statement. Additionally, if the fundscome from Your HCFSA You will receive an EOB as well.
4. Review the statements for accuracy and contact UHC if You believe there

are errors.

Prescription Drugs
When You or Your covered Dependent needs to purchase a prescription through a pharmacy,You must present Your Express Scripts identification card.

If You receive in-network services and You use Your debit card to pay Your applicable Coinsurance, UHC will pay the pharmacy Your portion first out of Your HCFSA (if You haveenrolled in one and have funds available), second out of Your HRA (if You have funds available). If no funds are available in either the HCFSA or HRA, You will need to pay Your Coinsurance through another method.

Once Your claim is processed, all HCFSA and HRA activity will be documented and sent toYou on Your UHC Health Statement. You should review this statement for accuracy and contact UHC if You believe there are errors.

Setting up Direct Deposit
If You would like to set-up direct deposit:

1. Go to www.myuhc.com and sign in
2. Go to the Claims & Accounts tab
3. Click **Direct Deposit** under member actions, then complete the Direct Deposit fields

Turning off the Auto-Rollover Feature

If You have an HRA
Your HRA will automatically be used to pay for eligible medical expenses unless You elect tohave this feature turned off. To access HRA funds for prescription drug purposes, You can either use Your debit card or file the claim manually. If You want to turn off the automatic payment feature:

1. Go to www.myuhc.com and sign in
2. Select the Claims & Accounts tab
3. Click Health Reimbursement Account
4. Click Automatic Payment then Add/Change Automatic Payment Settings
5. Click **Discontinue** for Health Reimbursement Account

If You turn off the automatic HRA feature, You will have to submit claims manually to obtainreimbursement from Your HRA. You can download the claim form here.

Note: Whether You turn off the automatic payment feature or not, You can still use Your debit card.

If You have both an HCFSA and HRA

You can discontinue the automatic payment from Your HCFSA/HRA: Go to

www.myuhc.com and sign in:

1. Select the Claims & Accounts tab
2. Click Health Reimbursement Account
3. Click Automatic Payment then Add/Change Automatic Payment Settings
4. Click **Discontinue** for Flexible Spending Account **and** Health Reimbursement Account

IMPORTANT: If You select to only discontinue the HCFSA, please note that the HRA willalso turn off. A member may not override the payment hierarchy of HCFSA pays first then HRA pays second.

If You leave the auto-rollover feature off, You may use Your debit card for payment or submitpaper claims for payment from Your HCFSA/HRA funds.

Health Savings Account (HSA)

HSA for Health Savings Plan Participants

When You elect coverage under the Health Savings Plan, You can set aside money (up to the IRS-established limits) through payroll deductions on a pretax basis to help cover qualified out-of-pocket health expenses through an HSA. Unlike the HRA, the HSA also has investment features similar to a retirement account because HSA amounts grow tax-free (some states may tax HSA earnings). Additionally, an HSA is a portable individual account meaning that if You do not forfeit the HSA amounts if You terminate participation or employment. Accordingly, HSA funds can be used now or in the future to offset health expenses during retirement. NTESS also provides a contribution towards Your HSA based on when You enroll in the Health Savings Plan. The Company contribution is based on Your effective date of coverage. You must timely establish an account with the HSA custodian (Optum Bank) before the HSA contributions can be posted. Note: Although the HSA is available to Health Savings Plan participants, the HSA is not sponsored by NTESS and is not an ERISA benefit provided under the Plan. The information in this section is provided only as an overview of the HSA benefit and should not be taken as tax advice.

Note: PreMedicare Retirees, Surviving Spouses, and LTD Terminees who are enrolled in the High Deductible Health Plan will not have an HSA administered by Optum Bank and cannot make HSA contributions through NTESS. PreMedicare Retirees, Surviving Spouses, and LTD Terminees who meet the IRS rules regarding eligibility to make and receive HSA contributions can independently establish and contribute to an HSA, but it is Your responsibility to do so directly with an HSA provider of Your choice. Retirees, Surviving Spouses, and LTD Terminees moving from the Total Health PPO Plan to the High Deductible Health Plan will need to exhaust all of their HRA funds prior to moving to the High Deductible Health Plan in order to comply with IRS rules or forfeit the balance.

How the HSA Works

An HSA works in conjunction with a "high deductible health plan" (HDHP) as defined by the IRS, that covers eligible health care expenses. NTESS may contribute an annual amount, if any (as shown in Your enrollment materials) to Your HSA. The HSA contribution amounts are not taxable for Federal tax purposes; however, it may be taxable for state purposes, depending on Your state of residence.

Funds must be deposited into Your HSA before eligible expenses can be reimbursed. You can use funds in Your account to pay for current and future qualified health care expenses. These include medical and prescription drug expenses, as well as deductible and coinsurance amounts, for Yourself and Your eligible Dependents.

In addition, You can use these funds for other qualified expenses, such as dental, vision, and alternative medicine expenses, and for certain non-health care expenses. However, if You use the money in Your account for non-health care expenses, the amount is subject to ordinary income tax, plus a tax penalty if You are under age 65. The tax penalty generally does not apply if the distribution occurs after You reach age 65, become disabled, or die; however, ordinary income tax may still apply.

HSA Contribution Limits

The annual maximum HSA contribution amount (a combination of NTESS contributions and Your contributions) is set each year by the IRS. You may wish to discuss Your individual tax situation with Your tax advisor or obtain IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans.

The annual HSA contribution limits for 2023:

- If You are enrolled in **Employee-only** Health Savings Plan coverage, the contribution limit is $3,850.
- If You are enrolled in **Employer + Children, Employee + Spouse, or Employee + Spouse and Children** Health Savings Plan coverage, the contribution limit is $7,750.

Catch-Up Contributions

If You are age 55 or older, You are also permitted to make a 'catch-up' contribution to Your HSA. The amount You are eligible to contribute is determined annually by the IRS (for 2023, the limit is $1,000).

Annual Allocation of HSA Contributions

Coverage Category / Tier	Virgin PulseActivity Completion	Health Action Plan Completion	Health Assessment is Taken	Health Assessment is NOT Taken	Matching Contribution[1]
Employee only	Maximum $300	$100	$100	$0	Maximum $600
Employee + Spouse	Maximum $600 ($300 max eachEmployee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	$0	Maximum $1000
Employee + child(ren)	Maximum $300	$100	$100 (Employee completes)	$250	Maximum $1000
Employee + Spouse + Child(ren)	Maximum $600($300 max eachemployee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	$250	Maximum $1000
	[1] The Employee can contribute up to the applicable federal maximum limit. NTESS matches 66 2/3% of employee's contribution. The limit for 2023 is $3,850 (Employee only) and $7,750 (Employee + family). The maximum includes both NTESS contributions and employee contributions.				

The HSA may be funded by NTESS and Your employee contributions, which are not taxable to You.

Both the primary covered member and covered Spouse are responsible for completing the health assessment to receive the full HSA contribution. Other covered Dependents are notrequired to complete a health assessment.

Note: In order to receive HSA funding for each calendar year, **Active Employees and their Spouses** must complete their Health Assessments by **October 31 by 9:59 PM MST**. Health Assessments completed in the current year prior to the deadline will earn incentives for the following year.

If You don't spend all Your HSA dollars in a calendar year, any unused balance rolls over from year to year, and earns interest. Your HSA balance is available to You indefinitely, even if You change plans, changes jobs, leave NTESS, or retire.

New Hires

NTESS will automatically make the full applicable Health Assessment portion of the HSAcontribution (see Annual Allocation of HSA Contributions table) for the calendar year in which You are hired. To receive the Health Assessment portion of the HSA contribution for the next calendar year, You and Your covered Spouse must complete the Health Assessment by **October 31 by 9:59 PM MST** to receive funds within the new calendar year.

Eligible Mid-Year Election Change Events

NTESS will automatically make the applicable HSA contribution for any Employees, and/or their Dependents who enroll in the Health Savings Plan during the calendar year as a result of an eligible mid-year election change event. Examples include:

- If You have waived coverage because You have coverage elsewhere, and You lose that coverage and enroll in the Health Savings Plan within 31 calendar days of theloss of coverage, NTESS will contribute the applicable Virgin Pulse Incentives based on who you cover on your medical plan.
- If You get married mid-year, NTESS will contribute the applicable additional HSA contribution ($100 to include Spouse coverage or $250 for children) if You ecorrectednroll Your new eligible family members within 31 calendar days of marriage.

IRS HSA Eligibility Requirements

The IRS sets the requirements for whether an individual is eligible to make and receive HSA contributions. Although You can continue to use amounts already contributed to Your HSA even if You are not HSA eligible, You cannot continue to make/receive HSA contributions to Your account.

Below is a summary of the HSA eligibility requirements:

- You must be enrolled in HDHP coverage (such as the UHC Health Savings Plan) on the first day of the month for which You make/receive HSA contributions.
- You cannot be enrolled in other medical coverage (including a plan through Your Spouse's employer) that is not considered a 'high-deductible health plan,' even as a Dependent. However, You can participate in a limited-purpose HRA or health care FSA that reimburses or pays dental and vision expenses, or preventive care expenses that can be paid without satisfying the deductible.
- You cannot be enrolled in Medicare coverage (such as Medicare Part A). Beginning with the first month You are enrolled in Medicare, You cease to be eligible to make/receive HSA contributions. Note: the interactions between Medicare and HSA eligibility are complicated, particularly because Medicare coverage is sometimes retroactive. We recommend consulting with Your tax advisor if You are or will soon be eligible for Medicare coverage.

How to File an HSA Claim to Reimburse Qualifying Health Expenses

You will receive information about how to file a claim for reimbursement when You open Your account. Optum Bank will send You a debit card to pay for eligible

expenses. It is important for You to keep receipts in order to document expenses for any tax year that may come under review.

When Participation Ends - Health Savings Account

If Your Health Savings Plan coverage terminates, the funds in Your HSA are Yours. Your HSA is portable which means You can continue to use the funds You have accumulated. You can also make tax-free contributions to Your HSA (directly to the HSA administrator, not through payroll deductions) if You participate in another high-deductible health plan. You may continue to use Your HSA to pay for eligible medical, prescription drug, dental, and/or vision expenses, or You may elect to leave the money in Your account to grow on a tax-free basis to use for future health care expenses. However, once You enroll in Medicare or otherwise cease to be HSA eligible, You are not permitted to make contributions to Your HSA.

Virgin Pulse Incentive Management Program

With Virgin Pulse, Employees and their covered Spouses may participate in healthy activities and get rewarded - with better health and with points! Participants simply track their activitieswith tracking devices and apps of Your choice listed within the Virgin Pulse Program. Visit join.virginpulse.com/Sandia for more details.

Health Action Plan
Active Employees and their covered Spouses are responsible for enrolling into a health action plan by September 30 of the current year to each receive $100 HRA or HSA contributions in the following year. Health action plans are available only for active employees through Employee Health Services by visiting healthactionplan.sandia.gov until September 30. Child Dependents are not required to complete a health action plan.

For spouses who need to complete the Health Action Plan, then they need to complete that directly with the carrier.

Retirees, Surviving Spouses, and LTD Terminees, and their Dependents, are not eligible for the Virgin Pulse Program. If You participated in the Virgin Pulse Program, as an Employee, and retired at the beginning of a calendar year, You will **not** receive any HRA or HSA funds in the subsequent calendar year. However, if You participated as an Employee and retire on or after February 1 of the subsequent calendar year, any Virgin Pulse that You earned in the previous year will be transferred if there is an applicable balance to Your Employee account (so long as You have no break in coverage) and You will be eligible to keep those funds or the funds will be rolled over to the Retiree PreMedciare HRA.

Health Assessment and Biometric Screenings

A Health Assessment is a confidential online questionnaire that asks You about Your health history, lifestyle behaviors (such as smoking and exercise habits) and Your willingness to make changes. You will receive a personalized report of Your health status and any health risks You may have now or possibly down the road, and how You can take steps to prevent or manage those risks. If You have no health risks, the report will make suggestions for improving or better managing Your health and well-being.

When completing a Health Assessment, You will be asked to enter Your cholesterol, glucose, height, weight, waist measurement, and blood pressure. Although this information is not required to submit the Health Assessment, You are strongly encouraged to obtain a biometric screening to input into the Health Assessment so that You have an accurate picture ofYour health risks.

Note: The Health Assessment data will be reviewed only in aggregate to determine the needfor health management programs.

Health Assessment Process
Active Employees and their Spouses enrolled in NTESS medical plans must complete a Health Assessment by logging into their Virgin Pulse account to receive HRA/HSA incentives. Health Assessments must be completed by **October 31st by 9:59 PM MST** of the current year to receive funding for January of the following year.

If an employee retires on or after February 1st, retiree will receive their previous years Virgin Pulse earnings.

Biometric Screenings Process
Employees can get a biometric screening at the Sandia Onsite Clinic (at no cost) or throughtheir personal physician.

To obtain the biometric screenings through the Sandia Onsite Clinic, You can schedule an appointmentby calling HR Solutions at 505-284-4700.

When You get a biometric screening, a trained technician takes Your blood pressure, measurements, and draws blood for analysis. You may be asked if You want fasting or non- fasting lab tests. Fasting lab test results will typically include Total cholesterol, HDL, LDL, Triglycerides, and Glucose. Non-fasting tests report only Total Cholesterol and HDL. Fasting labs yield the most comprehensive lab test results, but either option will provide what is needed for the Health Assessment.

Retirees are not eligible to use the Sandia Onsite Clinic and will need to get their biometric screenings done through their personal physician.

Tools and Resources to Become a More Informed Consumer

In addition to the many resources listed in this Benefit Summary (such as Virtual Visits and the Maternity Support Program, You can also access important tools and resources from UHC and Express Scripts through their websites.

My UHC Website
The UHC member website, www.myuhc.com, provides information at Your fingertips anywhere and anytime You have access to the Internet. Myuhc.com offers practical and personalized tools and information so You can get the most out of Your benefits. Once You have registered at www.myuhc.com, You can:

- Learn about health conditions, treatments, and procedures
- Search for in-network providers
- Access to Virtual Visits for Covered Health Services
- Complete a health risk assessment to identify health habits You can improve, learn about healthy lifestyle techniques, and access health improvement resources
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in Your geographical area
- Use the hospital comparison tool to compare hospitals in Your area on various patientsafety and quality measures
- Make real-time inquiries into the status and history of Your claims
- View eligibility and benefit information
- View and print EOB statements online
- Ask a question regarding a claim
- Print a temporary ID card or request a replacement ID card
- Update Dependent coordination of benefits status
- Organize Your health information in one place with Your online Personal HealthManager and Personal Health Summary

Note: If You have not already registered as a www.myuhc.com subscriber, go to www.myuhc.com and click on Register Now. Have Your UHC ID card ready.

Express Scripts Website
The Express Scripts member website, www.express-scripts.com, provides information at Yourfingertips anywhere and anytime You have access to the Internet. Express-Scripts.com offers practical and personalized tools and information so You can get the most out of Your benefits.Log on to:

- Locate retail network pharmacies
- Price prescription drugs at retail network pharmacies and mail service
- Refill prescriptions through mail service
- Find out what drugs are covered under the Programs

You can also access the above information on the Express Scripts phone app from any smartphone. Simply enter Express-scripts.com into Your smartphone browser or download theapp by going to the Apple App Store, Google Play, Android Market or Blackberry World.

Section 5. Covered Medical Plan Services & Limitations

The Programs provides a wide range of medical care services for You andYour family. This section outlines the benefits available under the Programs. For information on Your prescription drug benefits administered by Express Scripts, refer to Section 7: Prescription Drug Program.

Program Highlights

The Programs do not have any pre-existing condition limitations. This means, for example, that if You have a condition such as pregnancy or cancer before You begincoverage, You are not required to wait a specific amount of time before You are eligible for medical plan benefit coverage.

If a health service is not listed in this section as a Covered Health Service or listed in the Exclusion Section as a specific exclusion, it may or may not be a Covered Health Service. Contact the UHC Dedicated Advocate. Information can be found on hr.sandia.gov by searching for "Get to Know Your Providers" or by contacting UHC Customer Service at 877-835-9855 for information.

If You do not have access to any UHC network providers within a 30-mile radius of Your home, You will be covered under the in-network level of benefits under the Out-of-Area Planwhen You access providers. UHC determines who will be placed in the Out-of-Area Plan Reimbursement is based on billed charges, unless otherwise required under the No Surprises Act.

The Programs have a Network Gap Exception provision for Covered Health Services. Under this provision, if there are no in-network providers in the required specialty within a 30-mile radius from Your home, contact UHC prior to receiving the service (if possible) to request an exception under this provision to allow in-network benefits for servicesprovided by an out of network provider.

IMPORTANT: Covered Health Services are those health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating Sickness, Injury,mental illness, Substance Abuse, or their symptoms
- Medically Necessary
- Included in this section (subject to limitations and conditions and exclusions asstated in this Benefit Summary)
- Provided to You, if You meet the eligibility requirements as described in the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD.

If a health service is not listed in this section as a Covered Health Service, or in Section 8: What's Not Covered – Exclusions as a specific exclusion, it may or may not becovered. Contact UHC Customer Service at 877-835-9855 for information.

Coverage Details

The following information provides detailed descriptions of the Covered Health Services. Refer to Section 8: What's Not Covered – Exclusions, for information on what is excludedfrom coverage.

Acupuncture Services
Acupuncture services are covered as follows:

- Services provided by a licensed acupuncturist, doctor of oriental medicine, medical doctor, licensed chiropractor, or doctor of osteopathy, either in- or out-of-network, with no review by UHC required
- A maximum paid benefit of $750 for acupuncture treatment per calendar year, per Covered Member. This maximum applies to in- and out-of-network acupuncture treatment combined

Allergy Services
Services related to allergies are covered as follows:

- Office visits
- Allergy testing
- Allergy serum
- Allergy shots

Ambulance Services
Ambulance services provided by a licensed ambulance service are covered as follows:

Ground Ambulance Services

- For Emergency transportation to the nearest hospital where Emergency health servicescan be performed is paid at the in-network Benefit Level subject to applicable Deductible and co-insurance.
- Transportation from one facility to another is considered an Emergency when orderedby the treating physician at the in-network Benefit Level subject to applicable Deductible and co-insurance.
- If there is documentation from the ambulance service provider that it does not differentiate between advanced life support and basic life support, the Programs willcover the services as billed.

Air Ambulance Services
IMPORTANT: Prior authorization to Personal Health Support[SM] is required at least five business days before receiving services or as soon as reasonably possible. If Personal HealthSupport[SM] is not notified, benefits will be reduced by $300. See Section 3: Accessing Care.

- Air ambulance is covered only when ground transportation is impossible or would putlife or health in serious jeopardy.
- Transport by air ambulance to a contracted facility nearest to Your established home isa Covered Health Service if Your condition precludes his/her ability to travel by a nonmedical transport.
- If You are in line for a transplant and the transplant has been approved by UHC and there are no commercial flights to the city in which the organ is available, the Programswill cover the medical transport of the patient via air ambulance or jet (whichever is less expensive).

Refer to Section 3 ("No Surprises Act Requirements") for information regarding Surprise Billing Claims relating to Air Ambulance Services.

Auditory Integration Training
Auditory integration training services are covered if the results of the evaluation fall withinone of the following guidelines:

- A difference of 20dB or more between the most sensitive and least sensitive frequencies.
- The presence of at least one peak of processes, or an air-bone gap of more than 15 dB;
- Less than 6/11 frequencies perceived at the same intensity level.

Behavioral Health Services
Behavioral health services are subject to reimbursement with demonstrated improvement asdetermined by UHC.

IMPORTANT: Prior authorization to United Behavioral Health is required for some services.Refer to Section 3: Accessing Care.

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

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

Mental Health and Substance Use Disorder Services (also known as substance-related andaddictive disorders services) include those received on an inpatient or outpatient basis in aHospital and an Alternate Facility or in a provider's office.

Special Mental Health Programs and Services
Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to You as part of Your Mental Health ServicesBenefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of Your Mental Illness which may not otherwisebe covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating Your careor through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission for Mental Health Services (includingan admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain prior authorization from the MH/SUD Administrator prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions, unless otherwise required under the No Surprises Act). If you fail to obtain prior authorization from the MH/SUD Administrator as required, benefits will be subject to a $300 reduction.

The Programs cover Outpatient mental health and Substance Abuseservices as follows:

- Evaluations and assessments
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Individual and group therapeutic services
- Intensive Outpatient therapy programs
- Crisis intervention
- Psychological testing, including neuropsychological testing

The Programs cover inpatient, Partial Hospitalization, and ResidentialTreatment Facilities for mental health and Substance Abuse services as follows:

- Services received on an inpatient or Partial Hospitalization basis in a

hospital or analternate facility that is licensed to provide mental health or Substance Abuse treatment.

- If You are admitted to a facility and do not meet inpatient criteria, UBH will review todetermine whether You meet Partial Hospitalization criteria. If You do meet Partial Hospitalization criteria, only the cost for Partial Hospitalization in that area will be allowed, and You will be responsible for the remainder of the cost.
- Room and board in a semi-private room (a room with two or more beds). **Note:** ThePrograms will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by United Behavioral Health.
- Two Partial Hospitalization days are counted as one 24-hour hospitalization day.

Types of services that are rendered as a medical service, such as laboratory or radiology, arepaid under the medical benefits.

Cancer Services
Oncology services are covered as follows:

- Office visits
- Professional fees for surgical and medical services
- Inpatient services
- Outpatient surgical services

For oncology services and supplies to be considered Covered Health Services, they must beprovided to treat a condition that has a primary or suspected diagnosis relating to cancer.

IMPORTANT: Prior authorization to Personal Health Support^{SM} is required for injectable outpatient chemotherapy and clinical trials. Refer to Section 3: Accessing Care.

UHC provides You with access to designated (COE) provider through the Cancer ResourceServices Program. It is not mandatory that You receive services through this program but ifYou do, You may be eligible for additional benefits. Refer to Section 3: Accessing Care, formore information.

Clinical Trials
The Programs cover routine patient care costs incurred during participation ina qualifying clinical trial for the treatment of:

- cancer;
- cardiovascular disease (cardiac/stroke);

- surgical musculoskeletal disorders of the spine, hip, and knees.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinicaltrials.

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

- for which benefits are typically provided absent a clinical trial;
- required solely for the provision of the investigational item or service, the clinicallyappropriate monitoring of the effects of the item or service, or the prevention of complications; and
- needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
    - certain Category B devices;
    - certain promising interventions for patients with terminal illnesses; or
    - other items and services that meet specified criteria in accordance withUnitedHealthcare's medical and drug policies.
    - items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
    - items and services provided by the research sponsors free of charge for anyperson enrolled in the trial.

To be a qualifying clinical trial participant, a clinical trial must meet all the following criteria:

- be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center orbe sponsored by any of the following:
    - National Institutes of Health (NIH), includes National Cancer Institute (NCI);
    - Centers for Disease Control and Prevention (CDC);
    - Agency for Healthcare Research and Quality (AHRQ);
    - Centers for Medicare and Medicaid Services (CMS);
    - Department of Defense (DOD); or
    - Veterans Administration (VA).
- have a written protocol that describes a scientifically sound study and have

been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation aboutthe trial; and
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Programs.

Note: Benefits are available when the Covered Health Services are provided by either Network or non-Network providers; however, the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically forthe patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)

You must obtain prior authorization from Personal Health Support as the possibility of participation in a clinical trial exist. If you fail to obtain Prior Authorization as required, benefits will be subject to a $300 reduction.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials.
- If You have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational Service to be a covered healthservice for that sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Chiropractic Services
Chiropractic services are covered as follows:

- Services provided by a licensed chiropractor, doctor of oriental medicine, medical doctor, doctor of osteopathy, licensed acupuncturist, or physical therapist, either in- orout-of-network, with no review by UHC required.
- A maximum paid benefit of $750 for spinal manipulation treatment per calendar year,per Covered Member. This maximum applies to in- and out-of-network benefits combined.

Dental Services
The Programs cover dental services due to Sickness or Injury whenprovided by a Doctor of Dental Surgery (DDS) or Doctor of Medical dentistry (DMD) as follows:

- As a result of accidental Injury to sound, natural teeth and the jaw
- As a result of tooth or bone loss, due to a medical condition (e.g.,

osteoporosis, radiationto the mouth, etc.)

- Oral surgery, if performed in a hospital because of a complicating medical condition thathas been documented by the attending physician
- Anesthesia, hospital and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for young children asdetermined by the attending physician
- Dental implants, implant related surgery, and associated crowns or prosthetics arecovered in situations where:

    1. Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely forcosmetic reasons
    2. Tooth loss occurs as a result of accidental Injury
    3. Tooth loss occurs due to a medical condition such as osteoporosis or radiation ofthe mouth

- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:

    1. Both functional and aesthetic
    2. Not adequately treatable by conventional orthodontic therapy

- Dental services related to medical transplant procedures
- Initiation of immunosuppressive therapy
- Direct treatment of cancer or cleft palate

IMPORTANT: If You receive coverage under the Programs for implants, or crowns or other prostheses required as a result of implants, You cannot submit any remaining portion to the Dental Care Program for coordination of benefits. If You receive coverage under the Dental Care Program for implants, crowns or other prostheses required as aresult of implants, You cannot submit any remaining portion to the Programs.

For services that are provided as a result of an accident, initial treatment must have been started within one year of Injury regardless of whether You were covered under a NTESS medical plan or another employer plan.

Diabetes Services/Devices/Supplies
The Programs cover diabetes services as follows:

- Outpatient self-management training and education*
- Medical nutrition therapy services*
- Medical eye examinations (dilated retinal examinations)
- Preventive foot care

*Services must be ordered by a Physician and provided by appropriately licensed

or registeredhealth professionals.

The Programs cover diabetes devices and supplies as follows:

- Continuous glucose monitoring system (see "Important" note below). Criteria includes:
    - Type 1 diabetes or type 2 diabetes requiring basal and bolus insulin AND
    - Willingness to wear the rt-CGM device at least 60% of the time AND
    - Have demonstrated the ability to perform self-monitoring of blood glucose frequently and to adjust the diabetes regimen based on the data obtained withmonitoring
    -
- Supplies for external insulin pump and continuous glucose monitoring system.
- Blood glucose meters, if You are diagnosed with diabetes Type I or Type II
- External insulin pumps (see note below). Criteria includes:
    - Type 1 diabetes or type 2 diabetes requiring basal and bolus insulin AND
    - Inability to achieve adequate glycemic control with intensive insulin therapy*using multiple daily injections (MDI) as evidenced by:
        - A1c >7% and/or
        - Frequent hypoglycemia and/or
        - Marked dawn phenomenon and/or
        - Marked glycemic variability (this may be related to lifestyle issues suchas participation in athletics or frequent travel) AND
    - Demonstrated ability and motivation to monitor glucose frequently (at least four times daily), count carbohydrates, and adjust the insulin regimen as neededto achieve glycemic control

IMPORTANT: Prior authorization to Personal Health Support[SM] is required for insulin pumps and continuous glucose monitoring systems. Refer to Section 3: Accessing Care. For items with a purchase or cumulative rental value of $1,000 or more, Personal Health Support[SM] will decide if the equipment should be purchased or rented, and You must purchaseor rent the device from the vendor Personal Health Support[SM] identifies.

Diagnostic Tests
Diagnostic tests are covered as follows:

- Laboratory and radiology
- Computerized Tomography (CT) scans
- Position Emission Tomography (PET) scans
- Magnetic Resonance Imaging (MRI)

- Nuclear medicine
- Echocardiograms
- Electroencephalograms
- Sleep studies
- Other diagnostic tests
- Additional requirement for members to obtain prior authorization for MR-guidedfocused ultrasound

Durable Medical Equipment (DME)
IMPORTANT: Prior authorization to Personal Health Support[SM] is required. Refer to Section 3: Accessing Care.

Durable medical equipment is covered as follows:

- Ordered or provided by a physician for Outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a Sickness, Injury, or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home
- The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding. Personal double electric breast pumps/supplies at no cost share from a network doctor or an approved DME provider. Hospital grade breast pumps/supplies (rental only) covered at deductible/coinsurance.
- Rental of a hospital-grade breast pump following childbirth (not to exceed the total costof the pump). No coverage for rental of hospital grade breast pump under Preventive Care benefit.

IMPORTANT: For items with a purchase or cumulative rental value of $1,000 or more, Personal Health Support[SM] will decide if the equipment should be purchased or rented, andYou must purchase or rent the DME from the vendor Personal Health Support identifies.

Examples of DME include, but are not limited to:

- Wheelchairs
- Hospital Beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Orthotic appliances when custom manufactured or custom fitted to You
- Oxygen

- Orthopedic shoes:
  - Up to two pairs of custom-made orthopedic shoes per year when necessary due toillness such as diabetes, post-polio, or other such conditions
- Post-mastectomy bras
- C-PAP machine
- Bilirubin lights
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Delivery pumps for tube feedings, including tubing and connectors
- Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclerashells (white supporting tissue of eyeball)
- Cochlear devices and systems. Surgery to place a cochlear implant is also covered bythe Plan. Cochlear implantation can either be an inpatient or outpatient procedure

One educational training session will be allowed to learn how to operate the DME, ifnecessary. Additional sessions will be allowed if there is a change in equipment. More than one piece of DME will be allowed if deemed Medically Necessary by PersonalHealth Support^{SM} (e.g., an oxygen tank in the home and a portable oxygen tank).

At UHC's discretion, benefits are provided for the replacement of a type of durable medical equipment once every three years. If the purchased/owned DME is lost or stolen, the Programs will not pay for replacement unless the DME is at least three years old.The Programs will not pay to replace leased/rented DME; however, some rental agreements may cover it if lost or stolen.

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

Note: DME is different from prosthetic devices. Refer to Prosthetic Devices/Appliances in thissection.

Emergency Care
IMPORTANT: If You have a Medical Emergency, go to the nearest hospital Emergencyroom. These facilities are open 24 hours a day, seven days a week
Medical Emergency care worldwide is covered as follows:

- Emergency services obtained from an in-network provider will be considered at the in-network level of benefits if it is a Medical Emergency.
- Emergency services obtained from an out-of-network provider within the United Stateswill be considered at the in-network level of benefits if it is a Medical Emergency.
- Emergency services obtained from a provider outside the United States will be considered at the in-network level of benefits if it is a Medical Emergency.
- If You are hospitalized in an out-of-network hospital, You will be transferred to an in-network hospital when medically feasible, with any ground ambulance charges reimbursed at the in-network level of benefits.

  If You decline to be transferred, coverage will be provided under the out-of-network benefit level.

Non-Emergency care worldwide is covered as follows:

- Non-Emergency services received in an in-network hospital Emergency room will becovered at the applicable in-network benefit.
- Non-Emergency services received in an out-of-network hospital Emergency room willbe covered at the applicable out-of-network benefit.

Follow-up care worldwide is covered as follows:

- Follow-up care that results from a Medical Emergency while on travel outside theUnited States will be covered at the out-of-network level of benefit.
- Follow-up care that results from a Medical Emergency while on travel within the United States will be covered at the in-network level of benefits only if the place of care is not located within 30 miles of any in-network provider. Expenses for healthcareservices that You should have received before leaving the Service Area or that could have been postponed safely until Your return home are eligible for coverage at the out-of-network benefit level.

Note: If You are on NTESS-authorized business travel, You may be eligible to have Emergency and/or non-Emergency services covered at the in-network level of benefits. Contact the UHC Dedicated Advocate for details.

Employee Assistance Program (EAP)
IMPORTANT: Precertification to UBH is required. Refer to Section 3: Accessing Care.

The Programs cover up to eight visits (in-network only) per calendar yearat no cost to the Employee for assessment, referral, and follow-up counseling for Employees and their covered Dependents experiencing some impairment from personal

concerns that adversely affects their day-to-day activities. Such concerns include, but are not limited to:

- Health
- Marriage
- Family
- Finances
- Substance Abuse
- Legal issues
- Stress

Note: Retirees, Surviving Spouses, and LTD Terminees and their covered Dependents are not eligible for Employee Assistance benefits.

Eye/Vision Services

Eye Exam/Eyeglasses/Contact Lenses

For active Employees, the Programs cover eye exams for non-refractive care due to Sickness or Injury of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts. An initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery is allowed.

Vision Therapy

The Programs cover eye exercise therapy, optometric visual (or vision) therapy, vision training, orthoptic training and pleoptic training when:

- The services are performed by a Physician or a licensed therapy provider; and
- The services are determined to be proven"

Employees and their covered Dependents that are enrolled in the NTESS Vision Care Program are eligible to receive services related to refractive care under that program. Refer to the Preventive Care benefits in this section for information on vision screenings.

Family Planning

Family planning services are covered as follows:

- Sterilization procedures such as vasectomies and tubal ligations
- Medically Necessary ultrasounds and laparoscopies
- Family planning devices that are implanted or injected by the physician such as IUDs,Norplant, or Depo-Provera
- Reversals of implanted Family planning devices
- Reversals of prior sterilizations
- Surgical, nonsurgical, or drug-induced pregnancy termination
- Health services and associated expenses for elective and therapeutic abortion

Diaphragms and any other birth control obtained at a pharmacy are eligible for coverage underExpress Scripts.

Gender Dysphoria
Treatment for Gender Dysphoria must be deemed medically necessary in order to be covered. Refer to Section 8: What's Not Covered – Exclusions for information on what isexcluded under Gender Dysphoria**.**

The Programs cover the treatment of Gender Dysphoria as follows:

- Gender Reassignment surgery:
  - Below waist surgery
    - **Male to female** – clitoroplasty, labiaplasty, penile skin inversion, vagina construction, bilateral orchiectomy, penile amputation, urethromeatoplasy,plastic repair of intoitus, vaginoplasty
    - **Female to male** – hysterectomy, salpingo oopherectomy, colpectomy, vaginectomy, phalloplasty, urethroplasty and extension, scrotoplasty, plasticglans formation, insertion of penile and testicular prosthesis
  - Above waist surgery
    - **Male to female** – tracheal shave and facial hair removal, medically necessary breast augmentation if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatmentis not sufficient for comfort in the social role
    - **Female to male** – mastectomy with chest reconstruction and nipple/areolarreconstruction
- Hormone therapy
- Physician office visits
- Laboratory testing
- Psychotherapy/behavioral health services
- Puberty suppression

The Covered Person must provide documentation of the following for Gender Reassignment Surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
- Persistent, well-documented Gender Dysphoria
- Capacity to make a fully informed decision and to consent to treatment.
- Must be 18 years or older
- If significant medical or behavioral health concerns are present,

they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated)
- Prior Authorization is required for Out-of-Network services

Genetic Testing

The Programs cover Medically Necessary genetic testing. Examples of covered genetic tests include testing related to breast and ovarian cancer. Genetic testing for breast cancer is covered under Preventive Care. Refer to the Exclusions section for informationon what is excluded under genetic testing/counseling.
New requirement for members to obtain prior authorization Genetic testing – BRCA (breastcancer susceptibility).

Hearing Aids/Exam

The Plan will cover one (1) hearing aid per hearing-impaired ear every thirty-six (36) monthsfor Dependent children under the age of 21. This coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by a licensed audiologist, a hearing aid dispenser, or a physician.

For members over the age of 21, hearing aid(s) are covered ONLY if the hearing loss resulted from an illness or injury.

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

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

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

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

Hearing aid testing, repair and battery purchase are not covered. Refer to the Preventive Care section for information on hearing screenings.

Home Healthcare Services
IMPORTANT: Prior Authorization to Personal Health Support[SM] is required. Refer to Section 3: Accessing Care.

Covered Health Services are services that a home health agency provides if You arehomebound due to the nature of Your condition. Services must be:

- Ordered by a physician
- Provided by or supervised by a registered nurse in Your home
- Not considered Custodial Care in nature
- Provided on a part-time, intermittent schedule when skilled home healthcare is required

Hospice Services
IMPORTANT: Prior Authorization to Personal Health Support[SM] is required. Refer to Section 3: Accessing Care.

Hospice care is covered as follows:

- Provided on an inpatient basis
- Provided on an Outpatient basis
- Physical, psychological, social, and spiritual care for the terminally ill person
- Short-term grief counseling for immediate family members

Benefits are available only when Hospice care is received from a licensed Hospice agency orhospital.

Infertility Services
In general, the Programs pay benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a physician.

A maximum lifetime benefit of $30,000 per Covered Member is allowed for infertility treatments. This maximum is accumulated from any expenses related to infertility treatmentpaid following a confirmed diagnosis of infertility. Expenses for infertility services incurred without a diagnosis of infertility will not be

reimbursed. There are limitations to eligible procedures (refer to Section 8: What's Not Covered – Exclusions for more information).

The maximum lifetime benefit does not include expenses related to diagnosing infertility, testing relating to determining the cause of infertility or the diagnosis and treatment of an underlying medical condition (e.g., endometriosis) that causes infertility. However, testing and treatments after a confirmed diagnosis of infertility will be applied to the $30,000 lifetime limit

Therapeutic services for the treatment of Infertility when provided by or under the direction ofa Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage ofembryos.
- ICSI - (intracytoplasmic sperm injection).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination(IUI)).
- Embryo transportation related network disruption.
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures: laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty.
- Electroejaculation.
- Pre-implantation Genetic Diagnosis (PGD) - when the genetic parents carry a genemutation to determine whether that mutation has been transmitted to the embryo.

Prescription Drugs for Infertility Treatments

Prescription drugs related to infertility are covered under the Prescription Drug Program with a prior authorization. Prescription drugs obtained through the Prescription Drug Program and used for infertility treatment may require a diagnosis of infertility. The cost of these drugs is not applied to the $30,000 infertility limit if received through the Prescription Drug Program.

If the prescription drug or device is provided by the physician and billed through the provider's office or facility charges, UHC will review the charge to determine eligibility forreimbursement. If categorized as an infertility treatment, the charges will be applied to the $30,000 limit. These charges may also be applied to the appropriate Program Deductibles and Out-of-Pocket Limits. Coverage for prescriptions for donors is not covered.

Infusion Therapy
IMPORTANT: Prior Authorization to Personal Health Support℠ is required. Refer to Section 3: Accessing Care.

Outpatient infusion services for immunoglobulin therapy for conditions including but not limited to severe asthma, bone marrow transplants and diabetes mellitus. UnitedHealthcarewill review the medical necessity of the site of service (outpatient facility, physician office, home) in addition to prior authorization review for immunoglobulin infusion therapy.

Injections in Physician's Office
Injections in a physician's office are covered as follows:

- In-network:
    1. Allergy shots – 20% of Eligible Expenses**,** after the Deductible
    2. Immunizations/vaccines – no cost to You as outlined under the Preventive Carebenefit in this section
    3. All other injections (e.g., cortisone, etc.) – 20% of Eligible Expenses**,** after the Deductible
- For out-of-network services, You pay 40% of Eligible Expenses, after the Deductible

Inpatient Care
IMPORTANT: Prior Authorization to Personal Health Support℠ is required. Refer to Section 3: Accessing Care.

Inpatient services in a hospital are covered as follows:

- Services and supplies received during an inpatient stay room and board in a semi-private room (a room with two or more beds)
- Intensive care

Note: The Programs will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by UHC or UBH.

Benefits for an Inpatient Stay in the hospital are available only when the Inpatient Stay isnecessary to prevent, diagnose, or treat a Sickness or Injury.

If You are admitted to a hospital on an Emergency basis that is not in the network and services are covered, in-network benefits will be paid until You are stabilized. Once stabilized, You must be moved to a network hospital to continue in-network benefits. You may elect to remainin the out-of-network hospital and receive out-of-network benefits, as long as UHC/UBH confirms the treatment to be Medically Necessary.

Surgeries (resulting in an Inpatient Stay) performed outside the United States will be coveredat the out-of-network level of benefits if they are considered a covered procedure.

Maternity Services
IMPORTANT: Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns that are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section. Notification to Personal Health Support^{SM} is ONLY required ifYour stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section. Refer to Section 3: Accessing Care.

Maternity services are covered as follows:

- Initial visit to the physician to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery
- Charges for newborn delivery services, paid as follows:

    1. Charges billed for well-baby care are paid under the newborn but at the mother's level of benefit, subject to her Deductible and Out-of-Pocket Limit(e.g., if mom has met her Out-of-Pocket Limits, well-baby charges will be reimbursed as if the newborn's Out-of-Pocket Limit was met as well)
    2. Charges billed for the newborn under any other non-well baby ICD-10 code are paid under the newborn and subject to the newborn's Deductible and Out-of- Pocket Limit

Note: The Programs will pay for Covered Health Services for the newbornfor the first 31 calendar days of life. This is regardless of the newborn's condition or whether You enroll the Dependent within the applicable time frame as referenced in Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for continued coverage. If You submit enrollment paperwork after the 31st calendar day but before the 61st calendar day of the birth, the coverage effective date will not be retroactive. For example, if You submit enrollment paperwork on the 41st calendar day after birth, the Plan will cover the first 31 days and 41st day and beyond. Themember will be responsible for any charges incurred between the 32nd and 40th day. This does not apply to third generation Dependents such as grandchildren.

The Programs will pay for maternity services for You, Your covered Spouse and Your covered Dependent children.

Licensed birthing centers are covered to include charges from the birthing center,

physician, midwife, surgeon, assistant surgeon (if Medically Necessary), and anesthesiologist. Benefits for birthing services rendered in the home will be paid according to the network status of the physician with whom the licensed nurse midwife is affiliated. If the licensed nurse midwife is not affiliated with a physician and is not a part of the network, reimbursement will be paid onan out-of-network level. If You are admitted to hospital, You must notify Personal Health Support℠ within two business days or as soon as reasonably possible. Refer to Section 3: Accessing Care, for more information.

Refer to the Preventive Care section for information on preventive services related tomaternity.

Maternity Support Program

The voluntary Maternity Support Program offers free personal support through all stages of pregnancy and delivery. This program is offered at no cost to You. To enroll, call 888-246-7389 between 8 a.m. and 10 p.m. MST, Monday through Friday. If You or Your covered Dependents are enrolled in the Maternity Support Program, You can get valuable educational informationand advice. You or Your covered Dependent is encouraged to enroll within the first 12 weeks ofpregnancy; however, You can enroll at any time, up to Your 34th week.

When You call to enroll, a maternity nurse will fill out a pregnancy assessment with You overthe telephone. The maternity nurse will review Your completed assessment and determine if You have special pregnancy needs. If You or Your Dependent is identified as a mother-to-be with special health needs, the Maternity Support Program offers additional resources to help You.

This Maternity Support Program offers:

- Maternity nurses on duty 24 hours a day
- A free copy of the Maternity Support Program Guide
- A phone call from a maternity nurse halfway through the pregnancy to see how things are going
- A phone call from a nurse approximately four weeks postpartum to provide information on topics such as infant care, feeding, nutrition, and immunizations
- A copy of an available publication, for example, Healthy Baby Book, which focuses onthe first two years of life

Medical Supplies

Certain medical supplies are covered, to include, but not limited to:

- Ostomy supplies
- Six pair or twelve compression stockings
- Aero chambers, aero chambers with masks or nebulizers (You can obtain

these eitherunder the medical benefits or the Prescription Drug Program but not both)
- Lancets, alcohol swabs, diagnostic testing agents, syringes, Novopen and insulin auto-injectors, and allergic Emergency kits can be obtained under the prescription drug benefits (refer to Section 7: Prescription Drug Program).

Nutritional Counseling
The Programs cover certain services provided by a registered dietician in an individual session if You have a medical condition that requires a special diet. Some examples of such medical conditions include:
- Diabetes mellitus
- Coronary artery disease
- Congestive heart failure
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

Diet counseling for adults at higher risk for chronic diseases is covered under the preventivebenefits. Refer to the Preventive Care section.

Obesity Surgery
IMPORTANT: Prior Authorization to Personal Health Support^{SM} is required. Refer to Section 3: Accessing Care.

Surgical treatment of morbid obesity received on an inpatient basis provided all the followingare true:

Body Mass Index (BMI) of 35 to 39.9 with one or more obesity-related co-morbid medical conditions OR BMI equal or greater than 40 and demonstration that dietary attempts at weight control have been ineffective and the individual is 18 years of age or older or has reached full expected skeletal growth. Documentation of a structured diet program includes physician or other healthcare provider notes and/or diet or weight loss logs from a structured weight loss program for a minimum of six (6) months.

Office Visits
The following services provided in the physician's office are covered as follows:
- Consultations
- Second opinions
- Post-operative follow-up
- Services after hours and Emergency office visits (allowed separately)
- Office surgery
- Supplies dispensed by the provider
- Diagnostic tests

- Laboratory services
- Radiology services
- Chemotherapy
- Radiation therapy
- Additional requirement for members to obtain prior authorization for intensitymodulated radiation therapy

Organ Transplants
IMPORTANT: UHC provides You with access to designated United Resource Networks provider through the Transplant Resource Services Program. It is not mandatory that You receive services through this program, but if You do You may be eligible for additional benefits. Prior Authorization to Personal Health Support[SM] or the Transplant Resource Services Program is required as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed). Refer to Section 3: Accessing Care.

Benefits are available to the donor and the recipient when the recipient is covered under the Programs. The transplant must meet the definition of a Covered Health Service andcannot be Investigational, Experimental, or Unproven. Examples of transplants for which the Programs will pay for include but are not limited to:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service. If a separate charge is made for a bone marrow/stem cell search, the Programs will pay up to $25,000 for all charges made in connection with the search.

Outpatient Surgical Services
Outpatient Surgery and related services are covered as follows:

- Facility charge
- Anesthesia
- Supplies related to the surgery
- Equipment related to the surgery

Benefits for professional fees are described under Professional Fees for Surgical Procedures inthis section. Surgeries performed outside the United States will be covered at the out-of- network level of benefits if they are considered a covered procedure.

Members receiving diagnostic cardiac catheterization, electrophysiology implant, and sleepapnea surgeries must obtain Prior Authorization.

Prescription Drugs (other than those dispensed by Express Scripts)
Enteral nutrition/nutritional supplements/prescription drugs under UHC are covered asfollows:

- Enteral nutrition/nutritional supplements for:
    1. Diagnosis of dysphagia (difficulty swallowing)
    2. As the sole source of nutrition
    3. In cases of the genetic disorder of Phenylketonuria (PKU)
    4. In cases of RH factor disorders
    5. Terminal cancer
- Intravenous medications
- Medication that is dispensed and/or administered by a licensed facility or provider, such as a hospital home healthcare agency, or physician's office, and the charges areincluded in the facility or provider bill

Note: Medication obtained through a mail order service is not eligible for reimbursement under UHC. Please check Section 7: Prescription Drug Program for more information aboutthe mail service program.

You can receive coverage for intravenous medications, enteral nutrition or nutritional supplements through either UHC or Express Scripts, but not both. Refer to Section 7: Prescription Drug Program, for information on coverage of prescription drugs not mentionedabove.

Preventive Care
Preventive care benefits are based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your physician may recommend additional services based on Your family or medical history. The Programs will not cover all care that is preventive in nature but will covercertain services under the preventive care

benefit.

See Section 7: Prescription Drug Program for information about covered preventivemedications.

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network for the services listed below.

IMPORTANT: To receive the preventive care benefit, the service must be submitted with apreventive ICD-10 diagnostic code. If the service is submitted with a non-preventive ICD-10diagnostic code, it will be reimbursed up to the allowed non-preventive benefit amount (depending on network), and You may be required to pay the difference.

It is solely up to the provider as to whether the service is coded as preventive or diagnostic.Neither NTESS nor UHC can direct the provider to bill a service in any particular way. Theissue as to how it is billed is between You and Your provider.

Well Baby Care (0-2 years)

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network for the following services:

- Routine physical exams (including height and weight) at birth, one, two, four, six, nine,12, 15, 18, and 24 months
- Autism screening at 18 and 24 months
- Behavioral assessment as needed
- Congenital Hypothyroidism screening for newborns
- Development screening – surveillance throughout childhood as needed
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Hemoglobinopathies or sickle-cell screening for newborns
- Lead screening as needed
- Phenylketonuria (PKU) screening in newborns
- Thyroid screen as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed

Refer to the Immunizations/Vaccines section for information on these covered services.

Well Child Care (3-10 years)

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network for the following

services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previousroutine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams andsports physicals.
- Behavioral assessment as needed
- Development screening — surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Lead screening as needed
- Obesity screening and counseling as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed

Refer to the Immunizations/Vaccines section for information on these covered services.

Well Adolescent Care (11-18 years)

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previousroutine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams andsports physicals.
- Alcohol and drug use assessment as needed
- Behavioral assessment as needed
- Chlamydia infection screening as needed
- Development screening — surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hematocrit or hemoglobin screening as needed
- HIV screening as needed for adolescents at higher risk
- Lead screening as needed
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling as needed for adolescents athigher risk
- Tuberculin testing for adolescents at higher risk of tuberculosis
- Vision screening as needed

Refer to the Immunizations/Vaccines section for information on these covered services.

Well Adult Care (19 and older)

The Programs will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for the following services:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year, regardless of the date of the previous routine physical/annual exam, and no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams andsports physicals
- Abdominal aortic aneurysm one-time screening for men between the ages of 65 and 74who have ever smoked
- Alcohol misuse screening and counseling as needed
- Blood pressure screening as needed
- Breast Cancer (BRCA) testing for women at higher risk (UHC will require pre-servicegenetic counseling prior to testing for the BRCA1 or BRCA2 gene mutations)
- Breast cancer chemoprevention counseling for women at higher risk
- Brest-feeding support, supplies and counseling for women who are lactating
- Chlamydia infection screening as needed
- Contraception methods and counseling - the new requirement covers prescribed FDA- approved contraception methods, sterilization procedures and patient education and counseling for all women with reproductive capacity without cost-share. Condoms andspermicidal agents, for example, are not covered under the health reform law because they are available without a prescription. In addition, the law only covers women's contraception, so male contraception and sterilization are not included in preventive care services benefits
- Depression screening as needed
- Domestic violence screening and counseling - annual screening and counseling for interpersonal and domestic violence is covered at no cost at age-appropriate preventive visits including risk identification and guidance for risk reduction. Domestic violence screening is included in the wellness examination codes provided under preventive careservices benefits
- Diet counseling for adults at higher risk for chronic disease
- Gestational Diabetes Screening
- Gonorrhea screening for women at higher risk
- HIV screening and counseling as needed for adults at higher risk
- FDA-approved preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons at high risk of HIV acquisition, (when prescribed by a Plan provider), including the following baseline and monitoring services for the use of PrEP.
- HPV DNA testing - high-risk human papillomavirus (HPV) DNA testing in womenbegin at 30 years of age and need not occur more frequently than

every three years
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling as needed for adults at higherrisk; counseling and screening for human immunodeficiency virus for *all* sexually active women, not just women at risk
- Syphilis screening as needed for adults at higher risk
- Tobacco use screening as needed and cessation interventions for tobacco users
- Well woman exam annually

Refer to the following sections for more information on these covered services: Immunizations/Vaccines, Laboratory Services, Cancer Screening Services, Pregnancy-Related Preventive Care Services, and Bone Density Testing (Osteoporosis screening).

Immunizations/Vaccines

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network for non-travel related immunizations, vaccines, and flu shots. Flu shots and some immunizations/vaccines are available at no cost to You at an in-network retail pharmacy. Immunizations for personal travelwill pay 80% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the deductible.

IMPORTANT: Immunizations for NTESS -business-related travel must be given at the NTESS's onsite clinic; however, if NTESS's onsite clinic directs the Employee to obtain immunizations offsite for NTESS-business-related travel, You will be reimbursed at 100% of the charge, regardless of whether You obtain the immunizations in- or out-of-network. Contactthe UHC Dedicated Advocate if this exception is required to ensure proper reimbursement. Information can be found on hr.sandia.gov by searching for "Get to Know Your Providers. Members."

Laboratory Services

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network, for the following laboratory services for those age 19 and older:

- Complete blood count (CBC) with differential, which includes white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monosite, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, difftype, platelet estimate, red blood cell morphology.
- Complete urinalysis, which includes source, color, appearance, specific gravity, urinePH, protein, urine glucose, urine ketones, urine bilirubin,

blood, nitrate, urobilinogen,leukocyte estrase, red blood count, white blood count, squamous epithelial, calcium oxylate

- Complete metabolic profile, which includes sodium, potassium, chloride, CO_2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt
- Diabetes screening, which includes a two-hour postprandial blood sugar and HbA1c
- Thyroid screening, which includes free T4 and TSH
- Lipid panel, which includes triglycerides, total cholesterol, HDL, and calculated LDLcholesterol
-

As ordered by the physician, You are entitled to one of each of the above category once everycalendar year. If the physician orders one or more components within one of the above categories but not the complete set, and it is submitted with a preventive code, it will still be eligible for reimbursement under the preventive benefit.

Cancer Screening Services

The Programs will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network, for the following services:

Service	Allowed Frequency	Allowable Age
Pap Test	As needed	Age 11 and older
Prostrate Antigen Test	Annual	Upon turning 50
Mammogram*	Baseline, Annual	Between age 35-39, upon turning 40 For those patients identified as high risk, annual visits age 25 and older.
Fecal Occult Blood Test	Annual	Upon turning 50
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every ten years	N/A if preventive care service
Barium Enema**	Once every five years	Upon turning 50

* High-risk women with an immediate family history (mother or sister) of breast cancer are eligible for an annual mammogram upon turning 25. The mammogram preventive benefit also includes the computer-aided detection test. The preventive benefit also includes the charge by the provider for interpreting the test results.

**You are entitled to the following:

- A sigmoidoscopy once every five years, OR
- A colonoscopy once every 10 years, OR
- A sigmoidoscopy or colonoscopy under age 44 or more frequently if You have an immediatefamily history (mother, father, sister, brother only) of colorectal cancer or You have a personal history of colonic polyps. Polyp removal during a preventive colonoscopy will be covered under the preventive colonoscopy benefit.

**A barium enema once every five years in lieu of a colonoscopy or sigmoidoscopy

Note: From time to time, NTESS will sponsor mobile mammogram screenings at NTESS or inthe community through the Programs. Screenings are available to Covered Members aged 35 and above (or for high-risk

women as outlined above). In addition, the annual requirement is waived for these screenings.

Pregnancy-Related Preventive Care Services

The Programs will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network, for the following pregnancy-related services, on an as needed basis:

- Multiple marker screening between weeks 15 and 18 for pregnant women aged 35 andolder
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors
- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18in women who are 35 and older and at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes between 24 and 28 weeks
- Screening for group B strep between 35 and 37 weeks
- Anemia screening on a routine basis
- Bacteriuria urinary tract or other infection screening
- Breast feeding interventions to support and promote breast feeding
- Breast Pumps - The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding. Personal double electric breast pumps/supplies at no cost share from a network doctor or an approved DME provider. Hospital grade breast pumps/supplies (rental only) covered at deductible/coinsurance Hepatitis B screening at first prenatal visit
- Rh incompatibility screening and follow-up testing for women at higher risk
- Syphilis screening
- Tobacco use screening and counseling as needed

Bone Density Testing (Osteoporosis screening)

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network, for bone density testing once every three years upon turning age 50.

Professional Fees for Surgical Procedures

The Programs pay professional fees for surgical procedures and othermedical care received from a physician in a hospital, Skilled Nursing Facility, inpatient rehabilitation facility, or Outpatient Surgery facility.

The Programs will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia.
- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.

- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, theyare usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: When bilateral surgical procedures are performed by one or two surgeons, the Programs will consider the first procedure at the full allowed amount, and the secondprocedure will be considered at half of the allowed amount of the listed surgical unitvalue.
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on thesame foot, the Programs will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amountfor the third procedure; and a quarter of the full amount for each subsequent procedure. Also, if procedure 11721 is billed in conjunction with 10056 and 10057, these will be reimbursed separately without bundling when billed with a medical diagnosis.

Prosthetic Devices/Appliances

The Programs cover prosthetic devices and appliances that replace a limbor body part or help an impaired limb or body part work. Examples include:

- Artificial limbs
- Artificial eyes
- Breast prosthesis following a mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras (see Durable Medical Equipment) and lymphedema stockings. There are no limitations on the number ofprostheses and no time limitations from the date of the mastectomy. Refer to Reconstructive Procedures for more information.

If more than one prosthetic device can meet Your functional needs, benefits are available only for the most Cost-effective prosthetic device. The device must be ordered or provided either bya physician, or under a physician's direction.

Benefits are provided for the replacement of each type of prosthetic device once every five calendar years. At UHC's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement, if thedevice or appliance breaks, or is otherwise irreparable, or when a change in Your medical condition occurs sooner than the five-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. If the prosthetic device or appliance is lost or stolen, the Programs will not pay for replacement unless the device or appliance is at least five years old.

Reconstructive Procedures
IMPORTANT: Prior Authorization to Personal Health Support[SM] is required. Refer to Section 3: Accessing Care.

The Programs cover certain Reconstructive Procedures where a physical impairment exists, and the expected outcome is a restored or improved physiological functionfor an organ or body part.

Improving or restoring physiological function means that the organ or body part is made to work better. The fact that You may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better; however, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a Reconstructive Procedure, but in other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure and is not covered. Refer to Section 8: What's Not Covered – Exclusions for more information.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy.Coverage is provided for all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Replacement of an existing breast implant is covered if the initial breast implant followed mastectomy.

Rehabilitation Services (Outpatient Therapies)
Outpatient rehabilitation services for the following types of therapy are covered:

- Physical
- Occupational
- Speech
- Pulmonary rehabilitation
- Cardiac rehabilitation

Rehabilitation services must be provided by a licensed therapy provider and be under the direction of a physician. Physical, occupational, and speech therapy are subject to reimbursement with demonstrated improvement as determined by UHC. Maintenance therapyis not covered.

Speech, physical, and occupational therapies rendered for develop mental Disorders are covered until the patient is at a Maintenance level of care as determined by UHC.

Manual therapy techniques for lymphatic drainage, including manual traction, etc., are covered when performed by a licensed chiropractor, physical therapist, or physician.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
IMPORTANT: Prior Authorization to Personal Health Support[SM] is required. Refer to Section 3: Accessing Care

Facility services for an Inpatient Stay in a Skilled Nursing Facility or inpatient rehabilitationfacility are covered. Benefits include:

- Services and supplies received during the Inpatient Stay.
- Room and board in a semi-private room (a room with two or more beds). The Programs will pay the difference in cost between a semi-private room anda private room only if a private room is necessary according to generally accepted medical practice as determined by UHC.

Benefits are available when Skilled Nursing and/or inpatient rehabilitation facility services areneeded daily. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a hospital.

The intent of skilled nursing is to provide benefits if, as a result of an Injury or Sickness, Yourequire:

- An intensity of care less than that provided at a general acute hospital but greater thanthat available in a home setting
- A combination of skilled nursing, rehabilitation, and facility services

The Programs do not pay benefits for Custodial Care, even if ordered by a physician.

Temporomandibular Joint (TMJ) Syndrome
The Programs cover diagnostic and surgical treatment of conditionsaffecting the temporomandibular joint, including splints, when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Urgent Care
The Programs will cover Urgent Care as follows:

- If You receive care at an in-network Urgent Care Facility within the United States, Youwill be reimbursed under the in-network level of benefits.
- If You receive care at an out-of-network Urgent Care Facility within the United States,You will be reimbursed under the out-of-network level of benefits. If You are travelingwithin the United States and there are no in-network facilities available within a 30- mile radius, Your claim will be processed at the in-network benefit level.
- If You are traveling outside the United States, Your claim will be processed at the in-network benefit level.

- Follow-up care while traveling outside the United States will be covered at the out-of-network level of benefit.
- Follow-up care while traveling within the United States will be covered at the applicable in-network level of benefits only if the place of care is not located within 30miles of any in-network provider.

Section 6. Prescription Drug Program

The Prescription Drug Program, although part of the Programs, is administered separately by Express Scripts. For information on filing claims, claim denials, and appeals, refer to Section 10: How to File a Claim and Section 11: How to File an Appeal.

IMPORTANT: Generally, claims must be submitted within one year after the date of service to be eligible for consideration of payment. However, due to the COVID-19 pandemic, this one-year requirement is extended until the earlier of: 1) one year from the normal deadline; or 2) the end of the Outbreak Period (i.e., 60 days after the end of the National Emergency period (or other date announced by the Department of Labor, Department of the Treasury, the Internal Revenue Service, or Plan Administrator in the future)). This one-year requirement will not apply if You are legally incapacitated.

Note: Although the Programs generally cover the same services, there are several differences between the prescription drug coverage provided under the Programs.

For the Total Health PPO Plan, the following chart summarizes Your Coinsurance responsibility as well as coverage for purchases under the Smart90 Retail & Mail-Order Program and the Express Scripts network and out-of-network retail pharmacies.

TOTAL HEALTH PPO PLAN			
Express Scripts Smart90 Retail/Mail-OrderPharmacy (for maintenance prescription drugs)		**Express Scripts NetworkRetail Pharmacies**	**Out-of-Network Retail Pharmacies**
Refer to Specialty Drug Management Program for information on coverage for specialty drugs.			
Generic prescription drugs	Coinsurance of 20% of Walgreens Pharmacy/mail order discount price with a $12.50 minimum and $25 maximum for generic prescription drugs	Coinsurance of 20% of retail discount price with a $5 minimum and $10 maximum for generic prescription drugs	50% reimbursement
Preferred brand name prescription drugs (formulary)	Coinsurance of 30% of Walgreens Pharmacy/mail order discount price with a $75 minimum and $112.50 maximum for preferred brand name prescription drugs	Coinsurance of 30% of retail discount price with a $30 minimum and $45 maximum for preferred brand name prescription drugs	50% reimbursement
Non-preferred brand name prescription drugs (non- formulary	Coinsurance of 40% of Walgreens Pharmacy/mail order discount price with a $125and $187.50 maximum for non-preferred brand name prescription drugs	Coinsurance of 40% of retail discount price with a $50 minimum and $75 maximumfor non-preferred brand name prescription drugs	50% reimbursement

Days' Supply	Maximum of 90-day supply	Maximum of 30-day supply	Maximum of 30-day supply File claims with Express Scripts
Out-of-Pocket Limit	Out-of-Pocket Limit is $1,500 per person per year or $5,950 perfamily). There is not an Out-of-Pocket limit for Out-of-Network prescription drugs or Smart90 eligible prescription drugs purchased outside of the program after two courtesy fills.		Out-of-Pocket Limit does not apply
If a multi-source generic drug is reclassified as a single-source brand name, the Coinsurance will change from 20% to 30% or 40% with the applicable minimum and maximum copays. For the Total Health PPO Plan, there is no prescription drug Deductible; the Coinsurance does not apply to the towards the medical Deductible and medical Out-of-Pocket Limit. Reimbursement for prescriptions purchased outsidethe United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.			

For the Health Savings Plan (HDHP for PreMedicare Retirees, LTD Terminees, and Surviving Spouses), the following chart summarizes Your Coinsurance responsibility as well as coverage for purchases under the Smart90 Retail & Mail-Order Program and the Express Scripts network and out-of-network retail pharmacies.

HEALTH SAVINGS PLAN FOR ACTIVE EMPLOYEES (HDHP FOR PREMEDICARE RETIREES, SURVIVING SPOUSES, AND LTD TERMINEES)			
Express Scripts Smart90 Retail/Mail-Order Pharmacy (for maintenance prescription drugs)		**Express Scripts NetworkRetail Pharmacies**	**Out-of-Network Retail Pharmacies**
Refer to Specialty Drug Management Program for information on coverage for specialty drugs.			
Generic prescription drugs	After the Deductible is met, Coinsurance of 20% of Walgreens Pharmacy/mail order discount price with a $12.50 minimum and $25 maximum for generic prescription drugs	After the Deductible is met, Coinsurance of 20% of retail discount price with a $5 minimum and $10 maximum for generic prescription drugs	50% reimbursement
Preferred brand name prescription drugs (formulary)	After the Deductible is met, Coinsurance of 30% of Walgreens Pharmacy/mail order discount price with a $75 minimum and $112.50 maximum for preferred brand name prescription drugs	After the Deductible is met, Coinsurance of 30% of retail discount price with a $30 minimum and $45 maximum for preferred brand name prescription drugs	50% reimbursement
Non-preferred brand name prescription drugs (non-formulary	After the Deductible is met, Coinsurance of 40% of Walgreens Pharmacy/mail order discount price with a $125and $187.50 maximum for non-preferred brand name prescription drugs	After the Deductible is met, Coinsurance of 40% of retail discount price with a $50 minimum and $75 maximum for non-preferred brand name prescription drugs	50% reimbursement
Days' Supply	Maximum of 90-day supply	Maximum of 30-day supply	Maximum of 30-day supply File claims with Express Scripts

Out-of-Pocket Limit	Out-of-Pocket Limit is $3,000 per person per year or $8,700 per family) (combined medical and prescription drug).	There is not an Out-of-Pocket limit for Out-of-Network prescription drugs or Smart90 eligible prescription drugs purchased outside of the program after two courtesy fills.
If a generic drug is reclassified as a single-source brand name, the Coinsurance will change from 20% to 30% or 40% with the applicable minimum and maximum copays. For the Health Savings Plan (HDHP for PreMedicare Retirees, Surviving Spouses, and LTD Terminees), the Out-of-Pocket limit aggregates medical and prescription drug costs. Reimbursementfor prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.		

Eligibility

If You are eligible for coverage under the Programs, then You are eligible for the Prescription Drug Program. If You have primary prescription drug coverage under another group healthcare plan or Medicare, You are not eligible to use the Mail-Order Program or purchase drugs from retail network pharmacies at the Coinsurance benefit.

Coordination of Benefits applies. If You or Your Dependent has primary prescription drug coverage elsewhere, file the claim first with the appropriate plan, and then file with ExpressScripts, attaching a copy of the EOB. Express Scripts will allow 50% of the price submitted,with no days-supply limit, up to the amount You pay Out-of-Pocket.

Covered Prescriptions

IMPORTANT: FDA approval of a drug does not guarantee inclusion in the Prescription DrugProgram. New drugs may be subject to review before being covered under the Prescription Drug Program or may be excluded based on program guidelines and policies.

Only licensed providers authorized to prescribe medications in the United States may issue Your prescription(s). To be covered, the prescription must be considered Medically Necessary. Consideration of Medical Necessity occurs when a clinician's request falls outside standard criteria. Medical Necessity is a case-by-case assessment based upon substantiated justification as documented by the treating healthcare professional. It must be in accordance with standard medical practice and clinical appropriateness to include but not limited to off-label and non-indicated uses. The Prescription Drug Program covers the following categories of drugs:

- Federal Legend Drugs – A medicinal substance that bears the legend "Caution: FederalLaw prohibits dispensing without a prescription"
- State Restricted Drugs – A medicinal substance that, by state law, may be dispensed byprescription only

- Compound Medications A compound medication is a compounded prescription in a customized dosage form that contains at least one federal legend drug. You should contact Express Scripts at 877-817-1440 to determine if a compound medication is covered before You fill the prescription.
- The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alterthe ingredients of a medication when filling a prescription. The FDA does not verify the quality, safety and/or effectiveness of compound medications.
- Pharmacies must submit all ingredients in a compound prescription as part ofthe claim for both online and paper claim submissions. All ingredients submitted with the compound prescription claim must be covered and at leastone of the ingredients must require a physician's prescription for reimbursement.

  The following prescription devices/supplies:
  1. Insulin auto-injectors
  2. Lancet auto-injectors
  3. Glucagon auto-injectors
  4. Epi-Pens
  5. Aero-chambers, aero-chambers with masks, nebulizer masks (You may receivecoverage under either the Programs or the Prescription Drug Program but not both)

Note: Medicare covers lancets and test strips. Continuous Glucose Monitoring Systems (CGMS), Insulin Pumps, and supplies for CGMS and Insulin Pumps are not covered underthe Prescription Drug Program. Please refer to Section 3: Accessing Care for coverage information.

- The following over the counter (OTC) medications/supplies:
  - Nutritional supplements (requires Prior Authorization)
  - Insulin and Diabetic Supplies – Supplies, including lancets, alcohol swabs, ketone test-strips (both blood and urine), and syringes, can be purchased at theappropriate Coinsurance level, in-network with a prescription, or in-network without a prescription by paying the full price and submitting the claim to Express Scripts for reimbursement. (You will be reimbursed at the appropriateCoinsurance level.) The Mail-Order Program is also available for insulin and diabetic supplies purchased with a prescription.

    Note: Medicare covers lancets and test strips.

Note: The Prescription Drug Program covers immunizations obtained and/or administered at retail network pharmacies at no cost to You. In addition, Express Scripts maintains a programin which certified pharmacists within the U.S. are licensed to prescribe and administer certainvaccinations. To inquire about this

program, contact Express Scripts at 877-817-1440.

Covered Preventive Medications

All benefits are subject to the definitions, limitations, and exclusions. Certain preventative drugs are covered at 100% of the cost by the Programs; please check coverage and pricing details before ordering any prescription!

Existing Members: Please check the coverage and pricing details prior to filling any prescription by registering and logging in at express-scripts.com. Select Price a Medication from the Prescriptions menu. Enter Your drug's name and view cost and coverage informationon the results page. Or You can contact Member Services at 877-817-1440.

Prospect Members: To find coverage and pricing details, please log in at express-scripts.com/sandia. Select Price a Medication, follow the prompt and enter Your drug's nameand view cost and coverage information on the results page. Or You can contact Member Services at 877-817-1440.

List of Consumer Directed Healthcare (CDH) preventive drugs (standard plus generic only) covered by the Plan:

- Asthma/COPD
- Bone Disease and Fractures
- Cavities
- Colonoscopy Preparation*
- Depression
- Diabetes
- Heart Disease and Stroke
- Cholesterol Lowering
- High Blood Pressure
- Malaria
- Obesity
- Smoking-Cessation*
- PreP for HIV Prevention

Please check with the Claims Administrator for more details about the drugs that may be covered by the Plan. Your cost share will be determined by Your plan's drug coverage and formulary plan.

*Please note that some of these medications are also subject to the Affordable Care Act (ACA) and may be covered by Your plan at 100%.

Note: All preventive medications require a prescription, whether they are over the counter ornot. You can find a comprehensive list for 2023 when You visit the NTESS dedicated site, express-scripts.com/sandia. There choose Your plan, the PDF is located under the right menu.

National Preferred Formulary

The Programs utilize the Express Scripts' National Preferred Formulary. Preferred Drugs are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. Non-Preferred drugs are also on the Formulary, but at a higher cost sharing tier. Drugs that are excluded from Formulary are not covered by the prescription drug program unless approved through a Formulary exception process managed by Express Scripts. If approved through the process, the non-preferred copayapplies.

The Formulary is the same for both the Mail-Order Pharmacy and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance medications. To compare drug prices, check formulary status of a drug or switch to a covered alternative, please log on to express-scripts.com or call Express Scripts at 877-817-1440.

If, for some reason, You are unable to take any of the preferred alternatives, You, Your pharmacist or Your physician can initiate an exception request by contacting Express Scripts directly and requesting a Prior Authorization (PA) for the medication. Refer to the informationbelow for PA information. Express Scripts will contact Your doctor and request the information necessary for a non-preferred brand name drug. Express Scripts will review the letter and make the decision as to whether You will be able to receive the non-preferred drug for the preferred brand name Coinsurance amount or excluded drugs at the non-preferred Coinsurance amount.

Prescriptions Requiring Prior Authorization

A Prior Authorization (PA) is a clinical program that ensures appropriate use of prescription medications. You, Your pharmacist or Your physician can initiate a PA for the medication by contacting Express Scripts Prior Authorization department directly at 800-417-8164 and requesting a PA for the medication. Medications subject to a PA require a clinical review and pre-approval from the Express Scripts Prior Authorization Team before they can qualify for coverage under the Programs. Medications requiring Prior Authorization are subject to change.Therefore, if You have questions about a particular drug, please contact Express Scripts customer service at 877-817-1440.

Prescriptions Subject to Step Therapy Program

Step Therapy (Step)
Step Therapy is a program in which certain drug classes are organized in a set of "steps", first line drugs used first prior to second line alternatives. Drug classes

included in this program aresubject to change. If You have questions about a particular drug or this program, please contactExpress Scripts customer service at 877-817-1440.

Prescriptions Subject to Quantity Limits

Drug Quantity Management (DQM) is a program in Your pharmacy benefit that's designed to make the use of prescription drugs safer and more affordable. It provides You with medicinesYou need for Your good health and the health of Your family, while making sure You receive them in the amount – or quantity – considered safe. Medications included in this program are subject to change. Therefore, if You have questions about a particular drug or this program, please contact Express Scripts customer service at 877-817-1440.

Smart90 Retail Program

Express Scripts partners with Walgreens Pharmacy to offer the Smart90 Program. Smart90 is aprogram for members taking long-term prescriptions to receive them in a 90-day supply at lower cost than 30-day supply.

Smart90 offers two options to receive medications:

- Prescriptions may be filled and delivered by Express Scripts Pharmacy HomeDelivery, or
- Filled by a participating Walgreens Pharmacy

You can request that Your provider submit an e-prescription for a 90-day supply of medicationwith exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to Walgreens Pharmacy or Express Scripts Pharmacy at the time of the appointment, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a local in-network pharmacy of Your choice for pickup. Smart90 provides two courtesy months of refills at a 30-day supply.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scriptsat 877-817-1440 or fax it to 888-327-9791. Prescriptions preferred to be filled at Walgreens Pharmacy can be called in our hand carried to any local Walgreens Pharmacy.

See the Mail Order Program below on more information about Home Delivery from ExpressScripts Pharmacy.

Note: For medications that are eligible for the Smart90 Program, You will receive two courtesymonths of refills at the retail coinsurance amount at any In-Network retail pharmacy.

However, if You do not elect one of the above options, You will be responsible to pay 100% ofthe cost of the prescription(s) afterwards. These costs do not apply to the prescription drugs Out-of-Pocket limit. The Smart90 Retail Program does not

apply to controlled substances, narcotic medications, or specialty medications dispensed through Accredo Pharmacy. See Specialty Drug Management Program for more details.

Mail Service Program

Express Scripts partners with Express Scripts Pharmacy to offer a Mail Service Benefit. Express Scripts Pharmacy is a licensed pharmacy specializing in filling prescription drug orders for maintenance prescriptions. Maintenance prescription drugs are those taken routinely over a long period of time for an ongoing medical condition. Let Your physician know that Youare planning to use the Mail Service Program and request a 90-day prescription (with up to three refills). Verify that the prescription specifies the exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills.

Registered pharmacist and technicians are available 24 hours a day, seven days a week, at 877-817-1440, to answer medication-related questions. Prescriptions are delivered to Your home. (You are not responsible for shipping and handling fees unless You request special shipping arrangements.) To obtain a maintenance prescription through the Mail Service Program, You pay the appropriate Coinsurance for each prescription up to a 90-day supply.

If You send in a prescription through the Mail Service Program and Express Scripts Mail Service does not carry the medication or if it is out of stock and Express Scripts Mail Service does not anticipate getting the medication in a timely manner, You will be able to receive a 90-day supply at a retail network pharmacy for the applicable mail-order Coinsurance. Contact Express Scripts at 877-817-1440 for assistance.

Note: If You are a patient in a nursing home that does not accept mail-order prescriptions, contact Express Scripts to make arrangements to receive up to a 90-day supply of medicationat a retail network pharmacy for the applicable mail-order Coinsurance. You must provide proof of residency in a nursing home.

Steps for Ordering and Receiving Mail Order Prescriptions (other than Specialty Medications)

You can request that Your provider submit an e-prescription for a 90-day supply of medicationwith exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to Express Scripts Pharmacy at the time of the appointment, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a local in-network pharmacy of Your choice forpickup.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scriptsat 877-817-1440 or fax it to 888-327-9791.

If You would prefer to mail in Your original prescription, follow the steps for

ordering andreceiving below:

Step	Action	
1	Forms	Obtain an Express Scripts Mail Service Registration & Prescription Order Form from www.express-scripts.com.
2	Ordering Original Prescriptions	Complete the Express Scripts Mail Service Registration & Prescription Order Form. Attach Your original written prescription (with Your Member Identification number and address written on the back). Make sure Your physician has written the prescription for a 90-day supply with applicable refills. Enclose the required Coinsurance using a check or money order or complete the credit card section onthe form. Mail all to Express Scripts Mail Service, PO Box 66568, St. Louis, MO 63166-9819. Your physician may also call in the prescription to Express Scripts at877-817-1440 or fax it to 888-327-9791. **Note:** If You need medication immediately, ask Your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy,and one to be filled by mail service. Wait and send in Your mail service prescription two weeks after You fill Your prescription at the retail network pharmacy to avoid any delays with Your mail service prescription.
3	Delivery	Expect delivery to Your home by first-class mail. A physical street address isneeded. There are additional charges for requesting express shipping.
4	Refills	Refilling a mail service order prescription can be done by phone, mail, or throughthe web. It is recommended that You order three weeks in advance of Your current mail service prescription running out. **Refill-by-Phone:** Call 877-817-1440 to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available Monday through Sunday 24/7. **Refill-by-Fax:** Have Your physician contacts Express Scripts for the Fax Order Form. The physician (not You) must fax the number on the form. **Note:** ScheduleII prescriptions cannot be faxed. **Refill-by-Mail:** Complete the Prescription Order Form (attached to the bottom ofYour customer receipt), making sure You adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-required envelope. **Refill through the Web:** Go to www.express-scripts.com. Log on to this site. On the left-hand side of Your screen, select "Order Prescriptions". From there, follow the instructions to place Your refill order. You will need to use one of the acceptedcredit cards for payment. **Refill-by-Mobile App:** Download the free app, log in with Your www.express-scripts.com username and password. If You haven't yet registered with www.express-scripts.com, You can create a username and password right fromthe app – and use the same username and password to access the website.

Brand-To-Generic Substitution

Every prescription drug has two names: the trademark, or brand name; and the chemical or generic name. By law, both brand name and generic drugs must meet the same standards forsafety, purity, strength, and quality.

Example: Tetracycline is the generic name for a widely used antibiotic.

Achromycin is the brand name.

Many drugs are available in generic form. Generic drugs offer substantial cost savings over brand names; therefore, the Mail-Service Program has a generic substitution component.

Unless Your doctor has specified that the prescription be dispensed as written, Your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law. If You receive a generic medication in place of the brand name medication, and You want the brand name medication, You will need to obtain a new prescription stating, "no substitution" or "dispense as written" and resubmit it along with therequired Coinsurance.

Exception: This provision does not apply to brand name drugs that do not have an FDA A- orAB-rated generic equivalent available.

Retail Pharmacies

This section does not apply to Smart90 Retail Program eligible medications filled at aparticipating Walgreens Pharmacy.

Retail pharmacies are available if You need immediate, short-term prescription medications,and/or prescription medications that cannot be shipped through the mail.

Using the Network Retail Pharmacies
Express Scripts has contracted with specific retail pharmacies across the nation that will provide prescriptions to Sandia at discounted rates. These pharmacies are known as retail network pharmacies. To locate the pharmacy nearest You, call Express Scripts at 877-817-1440or visit www.express-scripts.com.

To obtain a medication through a retail network pharmacy, You will need a written prescription from Your physician. Present the prescription and Your Express Scripts ID card to the pharmacist. The card is required to identify that You are covered under the Program in order to remit the appropriate Coinsurance.

If You request a prescription to be filled in a retail network pharmacy for more than a 30-day supply, the pharmacist will fill only 30 days for the appropriate Coinsurance of 20%, 30%, or40% and hold the rest as refills. When You need a refill, return to the pharmacy, pay another Coinsurance amount, and receive another maximum 30-day supply (or up to the amount prescribed by the physician).

Using the Out-of-Network Retail Pharmacies
If You choose to purchase a prescription through an out-of-network pharmacy, You will be reimbursed 50% of the cost for up to a 30-day supply. Any amounts over a 30-day supply will be denied. Refer to Section 10: How to File a Claim.

Specialty Drug Management Program

Specialty medications must be purchased through the Express Scripts' Specialty Pharmacy, Accredo Specialty Pharmacy (Accredo), in order to be eligible for coverage. Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as cancer, hepatitis C, multiple sclerosis, rheumatoid arthritis, etc. To find out if Your prescription falls into this category, call Express Scripts at 877-817-1440.

Under this program, Your prescription will be limited to a 30-day supply and will be subject tothe retail Coinsurance level of benefits. Any amounts over a 30-day supply will be denied.

There is no additional cost to You above Your required Coinsurance. In addition to Your medication, You will also receive the necessary supplies for administration such as alcohol swabs and syringes at no additional cost. The Specialty Pharmacy is staffed by experienced pharmacists who are specially trained in complex health conditions and the latest therapies toprovide support, counseling and assistance with medication management.

***Steps for Ordering and Receiving Specialty Prescriptions through Accredo**:*

Step	Action	
1	Ordering Original Prescriptions	Your physician submits the prescription for You directly to the Accredo Specialty Pharmacy by e-prescription, fax, telephone or mail. Your information is entered into the ordering system and a pharmacist reviews itfor completeness and contacts Your physician, if necessary.
2	Payment	Accredo will call You to confirm Your insurance and to let You know what the Coinsurance will be. You must have a credit card on file. Accredo will bill the card You have on file for the applicable Coinsurance.
3	Delivery	Accredo will call You to schedule a delivery date. Expect delivery to Your home (unless You made alternative shipping arrangements with Accredo directly) via overnight mail. Most orders ship via UPS or Federal Express fornext day delivery.
4	Refills	Once enrolled, Accredo will call You prior to Your next dose. However, if Youhave not received a phone call, please contact Accredo to avoid any disruption in Your therapy. Accredo will confirm Your information and schedule a delivery date at Your convenience.

SaveonSP Specialty Drug Program:

For the Total Health PPO Plan, NTESS partners with Express Scripts' SaveonSP program tohelp You save money on certain specialty medications.

The SaveonSP Drug list that contains medications eligible for the program can be located at www.saveonsp.com/sandia.

If Your specialty medication is noted on the SaveonSP Drug List, You may participate in the SaveonSP program to receive Your medications free of charge ($0). This program utilizes benefit design and manufacturer copay assistance to achieve these goals. Your prescriptionswill still be filled through Accredo, Your current specialty pharmacy. **Note:** To maintain eligibility to make/receive HSA contributions under IRS rules, participants who are enrolled in the Health Savings Plan or High Deductible Health Plan are not eligible for the SaveonSP program.

Contact SaveonSP at 800-683-1074 to enroll or confirm enrollment participation. These medications will not count towards Your applicable deductible or Out-of-Pocket Limits. Although thecost of the SaveonSP program drugs will not be applied towards satisfying Your accumulators, the cost ofthe SaveonSP program drugs will be reimbursed by the manufacturer at no cost to You as the participant.

Express Scripts, through their exclusive relationship with SaveonSP, reduces the Plan's coston specialty pharmacy drugs while lowering Your cost to $0. This is an important factor in helping to keep Your benefit premiums from increasing due to rising drug costs.

Section 7. What's Not Covered – Exclusions

Although the Programs provide benefits for a wide range of Covered Health Services, there are specific conditions or circumstances for which the Programs will not provide benefit payments. In general, any expense that is primarily for Your convenience or comfort or that of Your family, caretaker, physician, or other medical provider will not be covered. For additional limitations under the Prescription Drug Program,refer to Section 7: Prescription Drug Program.
You should be aware of these exclusions that include, but are not limited to, items in thefollowing table.

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what the Claims Administrator determines are Eligible Expenses Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges Amount You pay as a result of failure to contact UHC for Prior Authorization or precertification, including unauthorized care Employee Assistance Program services when You do not obtain precertification from UBH Charges incurred for services rendered that are not within the scope of a provider's licensure Charges for missed appointments
Ambulance	Non-Emergency ambulance services (e.g., home to physician for an office visit)
Behavioral Health Services	Family therapy, including marriage counseling and bereavement counseling, unless otherwise covered. Family therapy, marriage counseling, and bereavement counseling are covered for Employees and their Dependents only through the Employee Assistance Program. Religious, personal growth counseling or marriage counseling including Services and treatment related to religious, personal growth counseling or marriage counseling unless the primary patient has a mental health diagnosis. Conduct disturbances unless related to a coexisting condition or diagnosisotherwise covered. Educational, vocational, and/or recreational services as Outpatientprocedures. Biofeedback for treatment of diagnosed medical conditions. Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatmentsmay be covered under the medical portion of this Program). Court-ordered placements when such orders are inconsistent with the recommendations for treatment of a BCBS PPO Network provider for mental health or Chemical Dependency. Services to treat conditions that are identified by the most current edition ofthe Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a mental disorder. Gender affirming services Any services or supplies that are not Medically Necessary. Custodial Care. Pastoral Counseling Developmental Care. Non-abstinence-based or nutritionally based treatment for Chemical Dependency.

Exclusions	Examples
Behavioral Health Services	Services, treatments, or supplies provided as a result of a Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which You have a claim for damages or relief, unless You provide BCBSNM Behavioral Health Unit with a lien against the claim for damages or relief in a form and manner satisfactory to BCBSNM Behavioral Health Unit. Non-organic erectile dysfunction (psychosexual dysfunction). Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are notsubject to favorable modification or management according to prevailing national standards of clinical practice, as determined by BCBSNM. Services or supplies that: • Are considered Unproven, Experimental or Investigational drugs, devices, treatments, or procedures. • Result from or relate to the application of such Experimental or Investigational drugs, devices, treatments, or procedures. Services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes may be a contract exclusion under mental health contracts or considered not medically necessary. Services or supplies that are primarily for Your education, training, ordevelopment of skills needed to cope with an Injury or Illness unless the primary patient has a mental health diagnosis.
Biofeedback	Biofeedback is not a Covered Health Service
Congenital Heart Disease	CHD services other than as listed below are excluded from coverage unless determined by United Resource Networks or Personal Health Support SM to be proven procedures for the involved diagnoses: • Outpatient diagnostic testing • Evaluation • Surgical interventions • Interventional cardiac catheterizations (insertion of a tubular device into the heart) • Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology) and • Approved fetal interventions
Dental Procedures	Dental procedures are not covered under the Programs except for injuries to sound, natural teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within one year of Injury. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.
Drugs	In addition to the clinical guideline limitation imposed by Express Scripts (see Section 7: Prescription Drug Program), the Program excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following: Over-the-counter medications unless specifically included Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses Contraceptive foams, jellies, and ointments

Exclusions	Examples
Drugs, cont.	Drugs labeled "Caution: Limited by Federal Law to Investigational use or Experimentaldrugs" • Experimental drugs are defined as "a therapy that has not been or is not scientifically validated with respect to safety and efficacy." • Investigational drugs are defined as "those substances in any of the clinical stages of evaluation which have not been released by the Food and Drug Administration (FDA) for general use or cleared for sale in interstate commerce. Italso includes those drugs that are in any of the clinical stages of evaluation (Phase I, II, and III) which have not been released by the FDA for general use or cleared for sale in interstate commerce." Glucose tablets Drugs used for cosmetic purposes Prescription drugs that may be properly received without charge under local, state, orfederal programs, including Workers Compensation Refills of prescriptions in excess of the number specified by the physicianRefills dispensed after one year from the date of order by the physician Prescription Drugs purchased for those who are ineligible for coverage under the Programs Prescription Drugs taken by a donor who is not insured under the Programs Medicine not Medically Necessary for the treatment of a disease or an Injury The following are excluded by the Prescription Drug Program but may be covered byUHC if Medically Necessary: • Ostomy supplies • Implantable birth control devices such IUDs • Allergy serum • Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home healthcare agency, or physician's office, and the charges are included in the facility or provider bill to UHC
Equipment	Exercise equipment (e.g., exercycles, weights, etc.) Hearing aids for hearing loss (see benefit under hearing aids for illness and Injurycoverage) Braces prescribed to prevent injuries while You are participating in athletic activities Household items, including, but not limited to • Air cleaners and/or humidifiers • Bathing apparatus • Scales or calorie counters • Blood pressure kits • Water beds Personal items, including, but not limited to • Support hose, except Medically Necessary surgical or compression stockings • Foam cushions • Pajamas Equipment rental fees above the purchase price, with the exception of oxygen equipment

Exclusions	Examples
Gender Dysphoria	Gender Dysphoria related services listed below: Reversal of genital surgery or surgery to revise secondary sex characteristics Above waist- (Male to Female-lipoplasty of the waist, facial bone reduction, face lifts, blepharoplasty and facial feminization) or (Female to Male-liposuction and cosmetic chest reconstruction, pectoral implants) Below waist- (Female to Male- liposuction to reduce fat in hips, thighs and buttocks, calfimplants) Other surgeries which have no medically necessary role in gender identification and are considered cosmetic in nature Referral outside US
Genetic Testing /Counseling	Investigational, Experimental, or Unproven genetic testing is not covered. In addition, genetic counseling, including service for evaluation and explaining the implications of genetic, or inherited disease, whether provided by physicians or non-physician health professionals, for the interpretation of family and medical histories to assess the risk of disease occurrence or recurrence, and for assisting in making treatment decisions basedupon the risk of disease occurrence or recurrence is not covered. Refer to Genetic Testing/Counseling and Preventive Care for covered services.
Hospital fees	Expenses incurred in any federal hospital, unless You are legally obligated to payHospital room and board charges in excess of the semi-private room rate unless Medically Necessary and approved by UHC/UBH In-hospital personal charges, unless medically necessary and approved by UHC (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a Covered Health Service
Infertility, Reproductive, and Family Planning	Purchase of eggs Services related to or provided to anonymous donors Services provided by a doula (labor aide) Storing and preserving sperm Donor expenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a covered Employee for a donor are allowed Expenses incurred by surrogate mothers Artificial reproductive treatments done for genetic or eugenic (selective breeding)purposes Over-the-counter medications for birth control/prevention Parenting, pre-natal, or birthing classes. Sperm procurement and storage in anticipation of future Fertility, unless covered underFertility Services Benefit Gamete preservation and storage in anticipation of future Fertility, unless covered underFertility Services Benefit Cryopreservation of fertilized embryos in anticipation of future Fertility, unless coveredunder Fertility Services Benefit

Exclusions	Examples
Investigational, Experimental, or Unproven treatment	Investigational, Experimental, or Unproven Services, unless the Programs have agreed to cover them in Section 6: Covered Medical Plan Services & Limitations. **Note:** This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices, or pharmacological regimens are the only available treatment option for Your condition. **Note:** This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which benefits are provided as described under clinical trials.
Miscellaneous	Eye exams except as outlined under Section 6: Covered Medical PlanServices/Limitations Eyeglasses or contact lenses prescribed, except as outlined under Section 6: Covered Medical Plan Services & Limitations. Contact lenses are not considered a prosthetic device. Modifications to vehicles and houses for wheelchair access Health club memberships and programs or spa treatments Routine foot care unless for systemic disease such as diabetes.Orthotics related to flat feet are not covered Growth Hormone – excluded unless coverage provided by prescription drug plan. Contact Express Scripts for more information. Treatment or services • Incurred when the patient was not covered under the Programs even if the medical condition being treated began before the date Your coverage under the Program ends • For Sickness or Injury resulting from Your intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., Youdid not start the act of aggression) • For job-incurred Injury or illness for which payments are payable under any Workers Compensation Act, Occupational Disease Law, or similar law • While on active military duty • That are reimbursable through any public program other than Medicare or throughno-fault automobile insurance Charges in connection with surgical procedures for sex changes Charges for blood or blood plasma that is replaced by or for the patient Conditions resulting from insurrection, except for injuries inflicted on an innocentbystander who is covered under the Programs Christian Science practitioners and facilities Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), in cases of terminal cancer, or in cases of PKU or RH factor. Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlinedin Section 7: Prescription Drug Program Herbs and over-the-counter medications except as specifically allowed under the Programs Charges prohibited by federal anti-kickback or self-referral statutes Chelation therapy, except to treat heavy metal poisoning

Exclusions	Examples
Miscellaneous, cont.	Diagnostic tests that are: • Delivered in other than a physician's office or healthcare facility • Self-administered home-diagnostic tests, including, but not limited to, HIV and pregnancy tests Domiciliary care Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded. Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when: Required solely for purposes of career, education, camp, employment, insurance,marriage or adoption; or as a result of incarceration • Conducted for purposes of medical research • Related to judicial or administrative proceedings or orders or • Required to obtain or maintain a license of any type of Private duty nursing received on an inpatient basis Respite care Rest cures Storage of blood, umbilical cord, or other material for use in a Covered Health Service,except if needed for an imminent surgery
Not a Covered Health Service and/or not Medically Necessary	These health services, including services, supplies which are not: Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mentalillness, Substance Abuse or their symptoms; • Medically Necessary; • Consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines; • For the convenience of the covered person, physician, facility or any other person; • Included in Section 6: Covered Medical Plan Services & Limitations; • Provided to a covered person who meets the applicable eligibility requirements;and • Not identified in general Program exclusions.
Old claims	Claims received one year after the date charges are incurred. Except as noted for COVID-19.

Exclusions	Examples
Physical Appearance	Breast reduction/augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the claims administrator determines is requested to treat a physiologic functional impairment or coverage requiredby the Women's Health and Cancer Right's Act of 1998. Any loss, expense, or charge that results from cosmetic or reconstructive surgery, exceptafter breast cancer. Exceptions to this exclusion include: • Repair of defects that result from surgery for which You were paid benefits underthe policy • Reconstructive (not cosmetic) repair of a congenital defect that materially correctsa bodily malfunction. Liposuction Pharmacological regimens Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, andother such skin abrasion procedures). Face Lifts Voice modification surgery Blepharoplasty Rhinoplasty Abdominoplasty Cosmetic Surgery Other electrolysis or laser hair removal not specified as covered Vaniqa
Physical Appearance	Replacement of an existing intact breast implant unless there is documented evidence ofsilicon leakage Physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medicalreasons, even if for morbid obesity Wigs regardless of the reason for hair lossTreatments for hair loss
Providers	Services: • Performed by a provider who is a family member by birth or marriage, includingYour Spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with Your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order froma provider • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise)when that provider is not actively involved in Your medical care • Prior to ordering the service or • After the service is received This exclusion does not apply to mammography testing.
Services, supplies, therapy, or treatments	Charges that are: • Custodial in nature • Otherwise, free of charge to You • Furnished under an alternative medical program provided by Sandia • For aromatherapy or rolfing (holistic tissue massage)

Exclusions	Examples
Services, supplies, therapy, or treatments, cont.	• For Developmental Care after a maintenance level of care has been reached • For Maintenance Care • For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • Educational therapy when not Medically Necessary • Educational testing • Smoking-cessation programs. Note: UHC offers online health coaching and health education classes via myuhc.com. • Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and nonsurgical treatment for obesity	Treatment for over-the-counter appetite control, food addictions, or eating disorders thatare not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by UHC/UBH The following treatments for obesity: • Non-surgical treatment, even if for morbid obesity, and • Surgical operations for the correction of morbid obesity determined by UHC not tobe Medically Necessary to preserve the life or health of the member
Transplants	Health services for organ and tissue transplants except as identified under Organ Transplants in Section 6: Covered Medical Plan Services & Limitations, unless UHC determines the transplant to be appropriate according to UHC's transplant guidelines. • Determined by UHC not to be Unproven procedures for the involved diagnoses • Not consistent with the diagnosis of the condition Mechanical or animal organ transplants, except services related to the implant or removalof a circulatory assist device (a device that supports the heart while the patient waits for asuitable donor heart to become available) Donor costs for organ or tissue transplantation to another person unless the recipient is covered under the Programs
Transportation	Non-Emergency ambulance services are not covered Transportation, except ground ambulance and air ambulance services as outlined inSection 6: Covered Medical Plan Services & Limitations
Travel	Travel or transportation expenses, regardless of personal or business travel, even if ordered by a physician, except as identified under Travel and Lodging in Section 3: Accessing Care. Medical repatriation outside of the United States regardless of personalor business travel

Section 8. Coordination of Benefits (COB)

Coordination of Benefits (COB) is the provision that allows families with different employergroup health plan coverage to receive up to 100% coverage for Covered Health Services.

Under COB Your health plan as the Employee provides primary coverage for You and Your Spouse's health plan through his or her employer provides primary coverage for him or her.

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for more information on COB policy and rules for determining which plan provides primary coverage.

The Programs contain a COB provision so that the benefits paidor provided by all employer group plans are not more than the total allowable expenses underthe Programs. The Programs will notpay more than 100% of the cost of the medical treatment, nor will it pay for treatment or services not covered under the Programs.

"Covered Health Expense" means a healthcare expense, including Deductibles, Coinsurance,and Copayments, that is covered at least in part by any of the group health plans covering theperson. An expense or an expense for a Covered Health Service that is not covered by any ofthe group health plans is not a Covered Health Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not a Covered Health Expense. The following are additional examples of expenses or Services that are not Covered Health Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in aprivate hospital room is medically necessary in terms of generally accepted medical practice, or one of the group health plans routinely provides coverage for hospital private rooms) is not a Covered Health Expense.
- If a person is covered by two or more group health plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not a Covered Health Expense.
- If a person is covered by two or more group health plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of thenegotiated fees is not a Covered Health Expense.
- If a person is covered by one group health plan that calculates its benefits or Services on the basis of usual and customary fees and another group health plan that provides itsbenefits or Services on the basis of negotiated fees, the primary plan's payment arrangements shall be the Covered Health

Expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Covered Health Expense used by the secondary plan to determineits benefits.

- The amount a benefit is reduced by the primary plan because a covered person does notcomply with the plan provisions is not a Covered Health Expense. Examples of these provisions are second surgical opinions, precertification of admissions, etc.

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for more information on"Special Rules for Covered Medicare-Primary Members" and "Provision for Covered Members with End-Stage Renal Disease (ESRD)."

Beginning January 1 of every year or if You are a new enrollee, You are required to provide anupdate to UHC on whether any of Your covered family members have other insurance. This notification is also required if Your family member enrolls in another medical plan during the year. If You do not provide this information to UHC, Your covered family members' claims may be denied. You may update Your other insurance information by calling UHC at 877-498-7652.

Refer to Section 7: Prescription Drug Program for information on eligibility to use the Prescription Drug Program, as well as how COB works, if Your covered family member hasother insurance coverage.

COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan Sponsor's Self-Funded group medical benefit plan will be coordinated with those of any other planthat provides benefits to You.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person hashealth care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below governs the order in whicheach Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays sothat payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include hospital indemnity coverage insurance or otherfixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts istreated as a separate Plan.

B. **This Plan**. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other plans. Anyother part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits donot exceed 100% of the total Allowable Expense.

D. **Allowable Expense**. For the purposes of COB, an Allowable Expense is a health care expense, including deductibles, Coinsurance and

Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and aNetwork provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. Ifthis plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relativevalue schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee

or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan**. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, andthat excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining theorder of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision isalways primary unless the provisions of both Plans state that the complying plan is primary.

C. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and providesthat this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-networkbenefits.

A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a Dependent, for example as an Employee, former Employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired Employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an Employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan**.Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:

   a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a Dependent child whose parents are divorced or separated orare not living together, whether or not they have ever been married:

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

      (2) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the

Dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

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

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's Spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's Spouse.

c) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a Spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the Dependent child's coverage under the Spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the Dependent child's parent(s) and the Dependent's Spouse.

3. **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is

ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage**. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount toany Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan. Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicarebenefits are determined as if the person were covered under Medicare.

- The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits

are determined as if the services were covered under Medicare.

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits aredetermined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

- The person is enrolled under a plan with a Medicare MedicalSavings Account. Medicare benefits are determined as if theperson were covered under Medicare.

Important: If You are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), You should enroll for and maintain coverage under both Medicare Part A and Part B. If You don't enrolland maintain that coverage, and if This Plan is secondary to Medicare, This Plan will pay Benefits under this Coverage Plan as if You were covered underboth Medicare Part A and Part B. As a result, Your out-of-pocket costs will behigher.

If You have not enrolled in Medicare, Benefits will be determined as if Youtimely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, the Claims Administrator may, as the Claims Administrator determines, treat the provider’s billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and otherPlans. The Claims Administrator may get the facts the Claims Administrator needs from, or give them to, other organizations or persons for the purpose ofapplying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administratorany facts the Claims Administrator needs to apply those rules and determine benefits payable. If You do not provide the Claims Administrator the information the Claims Administrator needs to apply these rules and determine the Benefits payable, Your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should havebeen paid under This Plan. If it does, the Claims Administrator may process This Plans' payment for that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in whichcase "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments This Plan made is more than This Plan shouldhave paid under this COB provision, This Plan may recover the excess fromone or more of the persons This Plan have paid or for whom This Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for You. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

If the refund is due from You and You do not promptly refund the full amountwed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for You that are payable under the Plan. If the refund is due from a person or organization other than You, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

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

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits firstand Medicare pays benefits second:

- Employees with active current employment status age 65 or older andtheir Spouses aged 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary toMedicare
If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of Your Medicare benefits, the Medicare limiting charge (the most a provider can charge You if they don't accept Medicare – typically 115% of the Medicare approved amount) will bethe allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if You have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Planand will be determined as if You timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services asthe allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and PartB and

Durable Medical Equipment (DME) claims. Under this program, You no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is Your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed Your health care provider, the Medicare carrier will electronically submit thenecessary information to the Claims Administrator to process the balance ofYour claim under the provisions of this Plan.

You can verify that the automated crossover took place when Your copy ofthe explanation of Medicare benefits (EOMB) states Your claim has been forwarded to Your secondary carrier.

This crossover process does not apply to expenses that Medicare does notcover. You must continue to file claims for these expenses.

For information about enrollment or if You have questions about the program,call the telephone number listed on Your ID card.

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "You"or "Your" in this Subrogation and Reimbursement section shall include You,Your estate and Your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on Your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that You may be entitled to pursue againstany third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example

- Suppose You are injured in a car accident that is not Your fault, and You receive Benefits under the Plan to treat Your injuries. Under subrogation, the Plan has the right to take legal action in Your name against the driver who caused the accident and that driver's insurancecarrier to recover the cost of those Benefits.
- The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which Youreceive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan

100% of any Benefits You receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

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

- The following persons and entities are considered third parties:
  - A person or entity alleged to have caused You to suffer a Sickness, Injury or damages, or who is legally responsible forthe Sickness, Injury or damages.
  - Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury ordamages.
  - The Plan Sponsor in a workers' compensation case or othermatter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to aSickness, or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts which caused Benefits to bepaid or become payable.
- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or its agentsreasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident orinjuries.
- Making court appearances.
- Obtaining the Plan's consent or its agents' consent before releasingany party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

The Plan has a first priority right to receive payment on any claim against anythird 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 orliens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, Your estate, Your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan'sexpress 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, thePlan

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 thePlan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

Benefits paid by the Plan may also be considered to be Benefits advanced. If You receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan,You and/or Your representative shall hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

By participating in and accepting Benefits from the Plan, You agree that (i) any amounts recovered by You from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of theCovered Person, (ii) You and Your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii)You shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

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

By participating in and accepting Benefits from the Plan, You agree to assign to the Plan any Benefits, claims or rights of recovery You have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extentof the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, You acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

The Plan may, at its option, take necessary and appropriate action to preserveits rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit torecover the full amount of medical Benefits You receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third partyconsidered responsible and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governedby a six-year statute of limitations.

You may not accept any settlement that does not fully reimburse the Plan,without

its written approval.

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

In the case of Your death, giving rise to any wrongful death or survival claim,the provisions of this section apply to Your estate, the personal representativeof Your estate, and Your heirs or beneficiaries. In the case of Your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

No allocation of damages, settlement funds or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides writtenconsent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation andreimbursement clause shall apply to that claim.

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

In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to You, Your Dependents or the Employee, deny future Benefits, take legal action against You, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any thirdparty to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also berequired to pay interest on any amounts You hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of thePlan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on You or YourDependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar yearDeductible; or
- Advanced during the time period of meeting the Out-of-Pocket Limit for the calendar year.

Benefits paid because You or Your Dependent misrepresented facts are alsosubject to recovery.

If the Plan provides a Benefit for You or Your Dependent that exceeds theamount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for You or Your Dependent by theamount of the overpayment.

If the Plan provides an advancement of Benefits to You or Your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send You or Your Dependent a monthly statement identifying the amount You owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to You or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to You or a covered Dependent to discussany outstanding balance owed to the Plan.

Section 9. How to File a Claim

This section provides an overview of how to file a claim and the receipt of benefit payments under thePrograms.

Filing an Initial Claim
Refer to the Claims and Appeals Section of the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for claim definitions,timeframes for disposition of Urgent Care, pre-service, concurrent care, and post-service claims, and the information that You are entitled to receive from the claim's administrator upon processing of Your claim.

IMPORTANT: All claims must be submitted within one year from the date of service to be eligible for consideration of payment. This one-year requirement will not apply if You are legally incapacitated. If Your claim relates to an Inpatient Stay, the date of service is the date Your Inpatient Stay ends. It is recommendedthat claims be submitted as soon as possible after the medical or prescription expenses are incurred. HRA funds will be rolled over to the subsequent calendar year after 90 days from the end of the plan year; therefore, if You file a claim, for example, in May of 2023 for 2021 services, HRA funds will not be available to pay that claim. If You need assistance in filing a claim, call UHC Customer Service at 877-835-9855 or Express Scripts at 877-817-1440.

In-Network Claims Processing
Generally, when You seek services through an in-network provider, the provider verifies eligibility and submits the claims directly to the claim's administrator for processing. There are generally no claim forms necessary to obtain in-network benefits. Refer to Section 5: Health Reimbursement Account and Health Savings Account for informationon payments from Your HRA or HSA, and Section 7: Prescription Drug Program, for information on how to use network retail and mail order pharmacy benefits.

Out-of-Network Claims Processing
When You seek services through an out-of-network provider, You will need to submit the claim for reimbursement. The provider may not verify eligibility. It is Your responsibility to verify You are eligible for benefits by either calling the claims administrator or going to www.myuhc.com or www.express-scripts.com. You can obtain claim forms from the claim's administrator.

Submit the claim form to the claims administrator immediately after the expense is incurred but no later thanone year from the date of service. Refer to the "Important" note above. Completion and submission of the claim form does not guarantee eligibility of benefits.

If You do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these

items are missing from the bill, You can include them inYour letter:

- Your name and address.
- The patient's name, age and relationship to the [Employee][Participant].
- The number as shown on Your ID card.
- The name, address and tax identification number of the provider of the service(s);
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that You are, or You are not, enrolled for coverage under anyother health insurance plan or program. If You are enrolled for other coverage, You must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due You.For medical claims, the above information should be filed with UHC, at the address on Your ID card.

After UHC has processed Your claim, Your non-Network provider will receive payment for Benefits that the Plan allows. It is Your responsibility to pay the non-Network provider any difference between what You werebilled and what the Plan paid.

Process for Out-of-Network Claims Processing for Medical Care

To obtain reimbursement for medical care, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or the address on Your Program ID card. Itemizedmedical bills should include:

- Patient’s full name
- Date and place of treatment or purchase
- Diagnosis
- Type of service provided
- Amount charged
- Name and address of provider and tax identification number, if available
- If other insurance is primary, the EOB (from the primary insurer) attached to Your claim form

Process for Out-of-Network Claims Processing for Prescription Drugs

If You have a prescription filled by an out-of-network pharmacy, complete a Direct Member Reimbursement Form, attach pharmacy receipts, and send Your claim to Express Scripts.

CLAIMS PROCEDURES

Network Benefits

In general, if You receive Covered Health Services from a Network provider, the Plan will pay the Physician or facility directly. If a Network provider bills You for any Covered Health Service other than Your Copay or Coinsurance, please contact the provider or call the Claims Administrator at thephone number on Your ID card for assistance.

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

Non-Network Benefits

If You receive a bill for Covered Health Services from a non-Network provider, You (or the provider ifthey prefer) must send the bill to the Claims Administrator for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator at the address on the back of Your ID card.

You can obtain a claim form by visiting www.myuhc.com the number on Your ID card. If You do nothave a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, You can include them in Your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on Your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The *Current Procedural Terminology* (*CPT*) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that You are, or You are not, enrolled for coverage under anyother health plan or program. If You are enrolled for other coverage, You must include the name and address of the other carrier(s).

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

For medical claims, the above information should be filed with The Claims Administrator at theaddress on Your ID card.

After The Claims Administrator has processed Your claim, You will receive payment for Benefits thatthe Plan allows. It is Your responsibility to pay the non-Network provider the charges You incurred, including any difference between what You were billed and what the Plan paid.

Benefits Payments

Refer to the Employee H&W Plan SPD or Post-Employment H&W Plan SPD for general information on benefits payments.
UHC will pay benefits to You unless:

- The provider notifies UHC that You have provided signed authorization to assign benefits directly tothat provider, or
- You make a written request for an out-of-network provider to be paid directly at the time You submitYour claim.

Express Scripts will pay benefits to the provider when You use a network or mail order pharmacy. If You usean out-of-network provider, Express Scripts will pay any applicable benefits to You.

Note: The person who receives a service is ultimately responsible for payment of services received from theproviders.

Each month in which UHC processes at least one claim for You or a covered Dependent, You will receive a health statement in the mail. A health statement is a summary of Your recent claims, plus remaining balances for Your HRA, Deductibles, and Out-of-Pocket Limits in one easy-to-read format. It provides a clearer picture of Your healthcare spending, plus includes meaningful tips to help You use Your benefits. A health statement will be mailed within 30 days if You received care and You need to pay for a part of the service.

However, if You received care and the program pays in full, You will receive a Health Statement in the mailwithin 90 days that shows the service You received and the amount that was paid. And, if for any reason, You'd like to view Your claims activity more frequently, You can log on to myuhc.com at any time of day ornight.

If any claims are denied in whole or in part, You will still receive an EOB which will include the reason forthe denial or partial payment. The EOB will let You know if there is any portion of the bill You need to pay.If You would rather track claims online, You may elect to discontinue receipt of paper health statements or EOBs at www.myuhc.com. You may also elect to continue to receive EOBs by making the appropriateelections online or by calling UHC Customer Service at 877-835-9855.

For eligible prescription drug claims processed through a Direct Member Reimbursement Form, You willreceive an EOB with the payment from Express

Scripts.

Recovery of Excess Payment

The Claims Administrator has the right at any time to recover any amount paid by the Programs for covered charges in excess of the amount that should have been paid under the provisions.

Payments may be recovered from You, providers of service, and other medical care plans.

IMPORTANT: By accepting benefits under the Programs, You agree to reimburse payments made in error and cooperate in the recovery of excess payments.

Payment of Benefits

When You assign Your Benefits under the Plan to a non-Network provider with the Claims Administrator's consent, and the non-Network provider submits a claim for payment, You and the non-Network provider represent and warrant that the Covered Health Services wereactually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to allthe Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement but directs that Your benefit payment should be made directly to the provider, the Claims Administrator may in its discretion make paymentof the benefits directly to the provider for Your convenience, but will treat You, rather than the provider, as the beneficiary of Your claim. If Benefits are assigned or payment to a non- Network provider is made, NTESS reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes NTESS (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to*Refund of Overpayments*.

The Plan will pay Benefits to You unless:

- The provider submits a claim form to the Claims Administrator that You have provided signedauthorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time You submit Your claim.

The Claims Administrator will only pay Benefits to You or, with written authorization by You, Your Provider, and not to a third party, even if Your provider purports to have assignedBenefits to that third party.

Form of Payment of Benefits
Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans forwhich The Claims Administrator makes payments, where the Plan has taken an assignmentof the other plans' recovery rights for value.

Health Statements
Each month in which The Claims Administrator processes at least one claim for You or acovered Dependent, You will receive a Health Statement in the mail. Health Statements make it easy for You to manage Your family's medical costs by providing claims information in easy-to-understand terms.

If You would rather track claims for Yourself and Your covered Dependents online, You maydo so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that the Claims Administrator send You a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let You know if there is any portion of the claim You need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If You would like paper copies of the EOBs, You may call the number on Your ID card to request them. You can also view andprint all of Your EOBs online at www.myuhc.com.

Section 10. How to File an Appeal

This section outlines how to file an appeal with either UnitedHealthcare or Express Scripts. The respective claims administrator will notify You of the decision regarding any appeal withinthe applicable time frames. Refer to the Claims and Appeals of the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for information on general appeal time frames under ERISA, as well as Your right to information that You are entitled to receive from the claim's administrator upon the denial of an appeal.

Filing an Appeal

IMPORTANT: Upon denial of a claim, You have 180 calendar days of receipt of the notification of Adverse Benefit Determination to appeal the claim. You must exhaust the appeals process before You can seek other legal recourse. If after exhausting the appeals process, You are still not satisfied, Your remaining remedies include the right to bring suit in Federal Court under Section 502(a) of ERISA and voluntary dispute resolution options, suchas mediation or independent external review."

If a claim for benefits is denied in part or in whole, You have the right to appeal the claim. A request for further information (such as a diagnosis) from the provider of service is not a claimdenial.

IMPORTANT: Regardless of the decision and/or recommendation of the claim's administrator, NTESS, or what the Programs will pay, it is always up to You and the doctor todecide what, if any, care You receive.

The table below outlines who to contact based on the reason for the claim denial:

If You have a claim denied because of…	Then…
Eligibility (except for incapacitation determinations)	See Eligibility Appeals Procedure in the Employee H&W Plan SPD or Post-Employment H&W Plan SPD
Eligibility based on incapacitation determinations	Contact the claims administrator for assistance
Benefit Determinations	Refer to the procedures noted below

Before requesting a formal appeal, You may informally contact customer service. If the customer service representative cannot resolve the issue to Your satisfaction over the phone,You may submit Your question in writing at the address noted below. If You are not satisfiedwith a claim determination, You may appeal it as described below, without first informally contacting customer service.

If You are appealing an Urgent Care claim denial, please refer to Urgent Claims Appeals underUHC or Expedited Appeal under Express Scripts.

If You disagree with a pre-service or post-service claim determination, You can contact the Claims Administrator in writing to formally request an appeal. Written communication shouldinclude:

- Patient's name and ID number as shown on the ID card
- Provider's name
- Date of medical service
- Reason You disagree with the denial
- Any documentation or other written information to support

Your requestYou, or Your doctor, can send the written appeal to:

Medical/Behavioral Health:

UnitedHealthcare – Appeals
PO Box 30432
Salt Lake City, UT 84130-0432

Prescription Drugs:

Express Scripts, Inc.
Attn: Pharmacy Appeals
Mail Route BL 0390
6625 West 78th Street
Bloomington, MN 55439
Fax: 877-852-4070

Prescription Administration Appeals:

Express Scripts, Inc.
Attn: Administrative Appeals Department
PO BOX 66587
St. Louis, MO 63166-6587
Phone: 800-946-3979

Prescription Clinical Appeals:

Express Scripts, Inc.
Attn: Clinical Appeals
DepartmentPO BOX 66588
St. Louis, MO 63166-6588
Phone: 800-753-2851

UnitedHealthcare Appeals Process

A qualified individual who was not previously involved in the claim decision being appealed will be appointed to decide the appeal. If Your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not previously involved in the prior determination. UnitedHealthcare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge You may examine documents relevant to Your claim and/or appeals and submit opinions and comments. UHC will review all claims in accordance with the rules established by the U.S. Department of Labor. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, UHC will provide it to You free of charge and sufficiently in advance of the due date of the responseto the Adverse Benefit Determination. UHC's decision will be final.

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of the decision on Your appeal asfollows:

- For appeals of pre-service claims (as defined in Section 10: How to File a Claim), the first level will be conducted, and You will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal. Your second level appeal request must be submitted to UHC in writing within 60 days from receipt of the first level appeal decision. The second levelappeal will be conducted, and You will be notified by UHC of the decision within 15 days from receipt of the request for review of the first level appeal decision.

- For appeals of post-service claims (as defined in Section 10: How to File a Claim), thefirst level appeal will be conducted, and You will be notified by UHC of the decision within 30 days from receipt of a request for appeal of a denied claim. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal. Your second level appeal request must be submitted to UHC in writing within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted, and You will be notified by UHC of the decision within 30 days from receipt of the request for review of the first level appeal decision.

Urgent Claims Appeals

Your appeal may require immediate action if a delay in treatment could significantly increasethe risk to Your health or the ability to regain maximum function or cause severe pain. The appeal does not need to be submitted in writing.

You or Your physician should call UHC at 877-835-9855 as soon as possible. UHC will provide You with a written or electronic determination as soon as possible, taking into account medical exigencies. The tables below describe the time frames which You and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If Your request for Benefits is incomplete, UnitedHealthcaremust notify You within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify You of the benefitdetermination within:	72 hours
If UnitedHealthcare denies Your request for Benefits, You must appeal the adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify You of the appeal decisionwithin:	72 hours after receiving the appeal
*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon aspossible to appeal an Urgent Care request for Benefits.	

Concurrent Care Claims

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

External Review Program

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

If one of the above conditions is met, You may request an external review of adverse benefitdeterminations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively);
- consideration of whether the Plan complies with the surprise billing and cost-sharing protections under the No Surprises Act; or
- as otherwise required by applicable law.

You or Your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or Your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on Your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date You received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

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

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

Standard External Review

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

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

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

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

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to You. If the request is eligible for external review,

UnitedHealthcarewill assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify You in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date ofreceipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by You after ten business days.

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

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that You or Your Physician submitted. If there is anyinformation or evidence You or Your Physician wish to submit that was not previouslyprovided, You may include this information with Your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

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

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination,the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the healthcare service or procedure.

Expedited External Review

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

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

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for

completion ofan expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function andYou have filed a request for an expedited internal appeal; or

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

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

- is or was covered under the Plan at the time the healthcare service or procedure that isat issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare mayprocess the request.

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

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

You may contact UnitedHealthcare at the toll-free number on Your ID card for more information regarding external review rights, or if making a verbal request for an expeditedexternal review.

Express Scripts Appeals Process

Two levels of appeal are permitted for each type of claim that is denied (called an AdverseDetermination). Appeal determinations will be rendered as specified in the

Claims and Appeals Procedures, of the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD.

Pre-Service and Post-Service Claim:

A. An appeal may be filed by You, Your representative, or by a prescriber (on Your behalf).
B. You, Your representative or prescriber, on Your behalf, may submit written comments, documents, records and other information relevant to Your request for an appeal. All such information is taken into account during the appeal process without regard to whether such information was submitted or considered when making the initial AdverseDetermination.
C. Upon initial receipt of an appeal, a clinical pharmacist will review the appeal (First- Level) and may overturn the initial Adverse Determination, if appropriate. If the initialAdverse Determination is overturned, You and the prescriber, if the prescriber filed theappeal on Your behalf, will be notified of the determination in writing.
D. If the clinical pharmacist does not overturn the Adverse Determination, Express Scripts will forward the appeal request to a physician (Second Level) in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appealdetermination. The clinical pharmacist completing the review of the appeal and the reviewing physician must hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (Doctor of Medicine) or the Advisory Board of Osteopathic Specialists (Doctor of Osteopathic Medicine).
E. If You are not satisfied with the decision following completion of the second-level appeal process, You may request that Express Scripts forward Your appeal request to an Independent Review Organization (IRO). You must submit this request within 120 calendar days of Your receipt of the Second-Level appeal review denial. The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination.
F. As with any Adverse Determination, approved clinical criteria will be employed toevaluate the claim under review during an appeal.
G. If within 5 working days after the filing date of the appeal there is not sufficient information to process the appeal, You, Your representative or the prescriber, who filed the appeal on Your behalf, will be notified by written communication of the information required to process the appeal and directions on how to resubmit the appeal.
H. If any of the appeal reviews overturns the Adverse Determination, the benefit will beallowed.

Urgent Claims (Expedited) Appeal:

A. An expedited appeal may be filed by You, Your representative or a

prescriber, acting onYour behalf. Contact Express Scripts customer service at 877-817-1440 to initiate an appeal.

B. The clinical pharmacist or physician reviewer, in discussion with You and/or independent third-party review organization, will determine whether the appealconstitutes an expedited appeal.
C. Upon initially receiving an expedited appeal, a clinical pharmacist will review the expedited appeal and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, You and the prescriber, on Your behalf,will be notified of the outcome in writing.
D. If the clinical pharmacist upholds the Adverse Determination, Express Scripts will forward the appeal request to an external Independent Review Organization (IRO). The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the Appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician will each hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (Doctor of Medicine) or the Advisory Board of Osteopathic Specialists (Doctor of Osteopathic Medicine).
E. If within 24 hours after the filing date of the expedited appeal, there is not sufficient information to process the appeal, You, Your representative or the prescriber, who filed the appeal on Your behalf, will be notified verbally with a follow up in writing of the information required to process the appeal and directions on how to resubmit the appeal.
F. The decision on an expedited appeal will be rendered and communicated verballywithin 24 hours of receipt of the appeal request.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, You may call The Claims Administrator atthe number on Your ID card before requesting a formal appeal. If The Claims Administrator cannot resolve the issue to Your satisfaction over the phone, You have the right to file a formalappeal as described below.

How to Appeal a Denied Claim

If You wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, You or Your authorized representative must submitYour appeal in writing within 180 days of receiving the adverse benefit determination. You donot need to submit urgent care appeals in writing. This communication should include:

A. The patient’s name and ID number as shown on the ID card.
B. The provider’s name.

C. The date of medical service.
D. The reason You disagree with the denial.
E. Any documentation or other written information to support Your request.
F. You or Your authorized representative may send a written request for an appeal to:UnitedHealthcare – Appeals
P.O. Box 30432,
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, You or Your provider can call TheClaims Administrator at the number on Your ID card to request an appeal.

Types of Claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to Your health, or the ability to regain maximum function, or cause severe pain. If Your situation is urgent, Your review will be conducted as quickly as possible. If You believe Your situation is urgent, You may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on Your health plan ID card. Generally, an urgent situation is when Your life or health may be in serious jeopardy. Or when, in the opinion of Your doctor, You may be experiencing severe painthat cannot be adequately controlled while You wait for a decision on Your claim or appeal.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of Your appeal. The appeal maybe reviewed by:

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

Once the review is complete, if the Claims Administrator upholds the denial, You will receivea written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal from The Claims Administrator within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Federal External Review Program

If, after exhausting Your internal appeals, You are not satisfied with the determination made bythe Claims Administrator, or if the Claims Administrator fails to respond to Your appeal in accordance with applicable regulations regarding timing, You may be entitled to request an external review of the Claims Administrator's determination. The process is available at no charge to You.

If one of the above conditions is met, You may request an external review of adverse benefitdeterminations based upon any of the following:

A. Clinical reasons.
B. The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
C. Rescission of coverage (coverage that was cancelled or discontinued retroactively).
D. Consideration of whether the Plan complies with the surprise billing and cost-sharing protections under the No Surprises Act.
E. As otherwise required by applicable law.

You or Your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or Your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on Your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date You received The Claims Administrator's

decision.

An external review request should include all of the following:

A. A specific request for an external review.
B. The Covered Person's name, address, and insurance ID number.
C. Your designated representative's name and address, when applicable.
D. The service that was denied.
E. Any new, relevant information that was not provided during the internal appeal.
F. An external review will be performed by an Independent Review Organization (IRO).The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:
G. A standard external review.
H. An expedited external review.

Standard External Review
A standard external review is comprised of all of the following:

A. A preliminary review by the Claims Administrator of the request.
B. A referral of the request by the Claims Administrator to the IRO.
C. A decision by the IRO.
D. Within the applicable timeframe after receipt of the request, The Claims Administratorwill complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:
E. Is or was covered under the Plan at the time the health care service or procedure that isat issue in the request was provided.
F. Has exhausted the applicable internal appeals process.
G. Has provided all the information and forms required so that the Claims Administratormay process the request.

After the Claims Administrator completes the preliminary review, the Claims Administratorwill issue a notification in writing to You. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administratorwill assign requests by either rotating claims assignments among the *IRO*s or by using a random selection process.

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

The Claims Administrator will provide to the assigned *IRO* the documents and

informationconsidered in making the Claims Administrator's determination. The documents include:

A. All relevant medical records.
B. All other documents relied upon by the Claims Administrator.
C. All other information or evidence that You or Your Physician submitted. If there is anyinformation or evidence You or Your Physician wish to submit that was not previouslyprovided, You may include this information with Your external review request and TheClaims Administrator will include it with the documents forwarded to the *IRO*.

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

Upon receipt of a *Final External Review Decision* reversing the Claims Administrator's determination, the Plan will immediately provide coverage or payment for the benefit claim atissue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with the Claims Administrator's determination, the Plan will not be obligated to provide Benefits for the healthcare service or procedure.

Expedited External Review

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

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

A. An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion ofan expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function andYou have filed a request for an expedited internal appeal.
B. A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize thelife or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal

decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether theindividual meets both of the following:

A. Is or was covered under the Plan at the time the health care service or procedure that isat issue in the request was provided.
B. Has provided all the information and forms required so that The Claims Administratormay process the request.

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

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

You may contact the Claims Administrator at the number on Your ID card for more information regarding external review rights, or if making a verbal request for an expeditedexternal review.

Timing of Appeals Determinations

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

A. Urgent care request for Benefits- a request for Benefits provided in connection withurgent care services.
B. Pre-Service request for Benefits – a request for Benefits which the Plan

must approveor in which You must notify UnitedHealthcare before non-urgent care is provided.

C. Post-Service – a claim for reimbursement of the cost of non-urgent care that has alreadybeen provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefitsare available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, andhow to access those rights, will be provided in the Claims Administrator's decision letter to You.

The tables below describe the time frames which You and the Claims Administrator arerequired to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If Your request for Benefits is incomplete, the Claims Administrator must notify You within:	**24 hours**
You must then provide completed request for Benefits to TheClaims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify You of the benefit determination within:	**72 hours**
If The Claims Administrator denies Your request for Benefits, Youmust appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify You of the appeal decisionwithin:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call The Claims Administrator as soon aspossible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If Your request for Benefits is filed improperly, the ClaimsAdministrator must notify You within:	**5 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If Your request for Benefits is incomplete, the Claims Administrator must notify You within:	**15 days**
You must then provide completed request for Benefits informationto the Claims Administrator within:	**45 days**
The Claims Administrator must notify You of the benefit determination:	
If the initial request for Benefits is complete, within:	**15 days**
After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify You of the first level appealdecision within:	**15 days** after receivingthe first level appeal
You must appeal the first level appeal (file a second level appeal)within:	**60 days** after receiving the first level appeal decision
Must notify You of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days,only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If Your claim is incomplete, The Claims Administrator must notify You within:	**30 days**
You must then provide completed claim information to TheClaims Administrator within:	**45 days**
The Claims Administrator must notify You of the benefit determination:	
If the initial claim is complete, within:	**30 days**
After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal an adverse benefit determination no laterthan:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify You of the first levelappeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second levelappeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify You of the secondlevel appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend the treatment is an urgent care request for Benefits as defined above, Your request will be decided within 24 hours, provided Your requestis made at least 24 hours prior to the end of the approved treatment. The Claims Administratorwill make a determination on Your request for the extended treatment within 24 hours from receipt of Your request.

If Your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment waspreviously approved for a specific period of time or number of treatments, and You request toextend treatment in a non-urgent circumstance, Your request will be considered a new requestand decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against NTESS or the Claims Administrator to recover reimbursement until 90 days after You have properly submitted a request for reimbursement asdescribed in this section and all required reviews of Your claim have been completed. If You want to bring a legal action against NTESS or the Claims Administrator, You must do so within three years from the expiration of the time period in which a request for reimbursementmust be submitted or You lose any rights to bring such an action against NTESS or the ClaimsAdministrator.

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

- If You would rather track claims for Yourself and Your covered Dependents online, Youmay do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Section 11. Medical Plan Administrative Services

Claims Administrators

The Claims Administrators are the third parties designated by Sandia to receive, process, andpay claims according to the provisions of the Programs. For medical, behavioral health, and EAP claims, this is UHC, and for Outpatient prescription drugs this isExpress Scripts.

UHC Member Identification Cards

IMPORTANT: Always present Your Program's member identificationcard when obtaining healthcare.

If You have elected single coverage, You will receive one Program ID card. If You have elected any other coverage, You will receive two Program ID cards. You may obtain additional ID cards through myuhc.com or by calling UHC Customer Service at 877-835-9855. The Program ID Card identifies You to providers as an eligible member. This card contains:

- Your name and the names of any covered Dependents
- A unique subscriber ID number that has been assigned to You by UHC and is linked tothe primary subscriber's Social Security number in the UHC system
- The group number
- The claims filing address
- Customer Service phone number
- Applicable plan deductibles
- Applicable Out-of-Pocket Limits

Express Scripts Member Identification Cards

If You are a new enrollee in the Programs, You will receive new ExpressScripts ID cards. If You need additional identification cards, You may call Express Scripts Customer Service at 877-817-1440 and request them.

IMPORTANT: Always present Your Express Scripts member ID card when obtaining prescriptions at a retail pharmacy. If You do not use Your card, You are not eligible to receivereimbursement for the prescription.

My UHC Website

The UHC member website, www.myuhc.com, provides information at Your fingertips anywhere and anytime You have access to the Internet. Myuhc.com offers practical and personalized tools and information so You can get the most out of Your benefits. Once Youhave registered at www.myuhc.com, You can:

- Learn about health conditions, treatments, and procedures
- Search for in-network providers
- Complete a health risk assessment to identify health habits You can improve, learnabout healthy lifestyle techniques, and access health improvement resources
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in Your geographical area
- Use the hospital comparison tool to compare hospitals in Your area on various patientsafety and quality measures
- Make real-time inquiries into the status and history of Your claims
- View eligibility and benefit information
- View and print EOB statements online
- Print a temporary ID card or request a replacement ID card
- Update Dependent coordination of benefits status
- Organize Your health information in one place with Your online Personal HealthManager and Personal Health Summary

Note: If You have not already registered as a www.myuhc.com subscriber, go to www.myuhc.com and click on Register Now. Have Your UHC ID card ready.

www.myuhc.com

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

With www.myuhc.com You can:

- Research a health condition and treatment options to getready for a discussion with Your Physician.
- Search for Network providers available in Your Planthrough the online provider directory.
- Complete a health survey to help You identify health habits You may improve, learn about healthy lifestyle techniques, and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of

the costs of various procedures in Your area.
- Use the Hospital comparison tool to compare Hospitals inYour area on various patient safety and quality measures.

Registering on www.myuhc.com

If You have not already registered on www.myuhc.com, simply go to www.myuhc.com and click on "Register Now." Have YourID card handy. The enrollment process is quick and easy.
Visit www.myuhc.com and:

- Make real-time inquiries into the status and history ofYour claims.
- View eligibility and Plan Benefit information, includingCopays and Annual Deductibles.
- View and print all of Your Explanation of Benefits (EOBs)online.
- Order a new or replacement ID card or print a temporaryID card.

Want to learn more about a condition or treatment?

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

Express Scripts Website

The Express Scripts member website, www.express-scripts.com, provides information at Yourfingertips anywhere and anytime You have access to the Internet. Express Scripts.com offers practical and personalized tools and information so You can get the most out of Your benefits. Log on to:

- Locate retail network pharmacies
- Price prescription drugs at retail network pharmacies and mail service
- Refill prescriptions through mail service
- Find out what drugs are covered under the Programs

You can also access the above information on the Express Scripts Rx phone app from any smartphone. Simply enter "Express-scripts.com" into Your smartphone browser or downloadthe app by going to the Apple App Store, Google Play Store, or Blackberry World.

Contact Telephone Numbers and Hours of Operation

Function	Telephone Numbers
UnitedHealthcare – www.myuhc.com	
Customer Service • Claims questions • Check eligibility • Benefit information • Participating providers • Case management	**877-835-9855** 6:00 a.m. – 8:00 p.m. MT Monday – Friday
Prior Authorization to Personal Health Support℠	**877-835-9855** 6:00 a.m. – 8:00 p.m. MT, Monday – Friday
Precertification for certain behavioral health services	**877-835-9855** 6:00 a.m. – 8:00 p.m. MT, Monday – Friday
Precertification for Employee Assistance Program(EAP)	**800-622-7276**24 hours a day, 7 days a week
Advocate4Me	**800-563-0416** 24 hours a day, 7 days a week
Virtual Visits for diagnoses & treatment of low acuity conditions	www.myuhc.com or UnitedHealthcare mobile app 24 hours a day, 7 days a week
UHC Dedicated Advocate	Please see Get to Know your Providers page for contact information by going to HR.Sandia.gov, Resources, Get to Know Our Benefit Providers, Meet Unitedhealthcare-Medical.
Maternity Support Program	**888-246-7389** 8:00 a.m. – 10:00 p.m. MT, Monday – Friday
Centers of Excellence (COE) Programs • Transplant Resource Services Program • Cancer Resources Services Program • Congenital Heart Disease Resource Services Program	**877-835-9855**
Express Scripts Prescription Drug Program– www.express-scripts.com	
Customer Service • Refill a mail order prescription • Determine if a pharmacy is in the pharmacy network • Obtain information about Your benefits • Speak with a pharmacist about a prescription • Request additional ID cards	**877-817-1440** 24 hours a day seven days a week

Sandia National Laboratories – hr.sandia.gov	
Function	**Telephone Numbers**
HR Solutions Enrollment/disenrollment in benefit programs, forms, and general questions.	**505-284-4700** Fax: 505-844-7535 8:00 a.m. – 4:30 p.m. MT

When You Change Your Address

When You move, You must change Your address with Sandia. Active Employees can change their address through Sandia's HR Self-Service. Retirees must change their address with ViaBenefits and Sandia National Laboratories.

If You move to California and wish to enroll in the Total Health PPO Plan administered by Kaiser Permanente for Active Employees, You may enroll in this plan during Open Enrollment. If You are a retiree, refer to the Post-Employment H&W Plan SPD for more details.

Section 12. Definitions

Please note that certain capitalized words in this Benefit Summary have special meanings.These words have been defined in this section. You can refer to this section as You read thisdocument to have a clearer understanding of Your benefits.

Adverse Benefit Determination or Adverse Determination	A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes a decision to deny benefits based on: • An individual being ineligible to participate in the Programs; • Utilization review; • A service being characterized as Investigational, Experimental, or Unproven or not medically necessary or appropriate; • A concurrent care decision; and • For medical claims, certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.
Coinsurance	The percentage of a covered health service which the plan pays after You've met the Deductible.
Congenital Anomaly	A physical developmental defect that is present at birth.
Cost-effective	Least expensive equipment that performs the necessary function. Applies to Durable Medical Equipment and prosthetic appliances/devices.
Cosmetic Procedures	Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is an example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function, such as in breathing.
Covered Member	An enrolled participant or enrolled Dependent. This term refers to a person only while enrolled under the Programs. References to "You" and"Your" throughout this document are references to a Covered Member.
Covered Health Services	Covered Health Services are those health services and supplies that are: • Provided for preventing, diagnosing, or treating Sickness, Injury, mental illness, Substance Abuse, or their symptoms • Included in Section 6 of this Benefit Summary (subject to limitations and conditions and exclusions as stated in this Benefit Summary) • Provided to You, if You meet the applicable eligibility requirements as described in the Employee H&W Plan Summary Plan Description or Post-Employment Health and Welfare Plan Summary Plan Description • Medically Necessary
Custodial Care	Services or supplies, regardless of where or by whom they are provided, that • A person without medical skills or background could provide or could be trained to provide or • Are provided mainly to help You with daily living activities, including (but not limited to): ▪ Walking, getting in and/or out of bed, exercising and moving ▪ Bathing, toileting, administering enemas, dressing, and assisting with any other physical or oral hygiene needs

Custodial Care, cont.	▪ Assistance with eating by utensil, tube, or gastrostomy ▪ Homemaking, such as preparation of meals or special diets, and house cleaning ▪ Acting as a companion or sitter ▪ Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications • Provide a protective environment • Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve Your Sickness, Injury, or functional ability, or • Are provided for the convenience of You or the caregiver or are provided because Your own home arrangements are not appropriate or adequate.
Deductible	Covered charges incurred during a calendar year that You must pay in full before the Programs pay benefits. Does not apply to Outpatient prescription drugs purchased through Express Scripts.
Developmental Care	Services or supplies, regardless of where or by whom they are provided, that: • Are provided to You if You have not previously reached the level of development expected for Your age in the following areas of major life activity: ▪ Intellectual ▪ Physical ▪ Receptive and expressive language ▪ Learning ▪ Mobility ▪ Self-direction ▪ Capacity for independent living ▪ Economic self-sufficiency • Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness) or are educational in nature
Eligible Expenses	For Covered Health Services, incurred while the Plan is in effect, Eligible Expensesare determined by UHC as stated below: Eligible Expenses are determined solely in accordance with UHCs reimbursement policy guidelines. UHC develops the reimbursement policy guidelines, in UHC's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies: • As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*. • As reported by generally recognized professionals or publications. • As used for Medicare. • As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.
Emergency	See Medical Emergency
Emergency Services	1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate an Emergency Medical Condition; 2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient

Emergency Services, cont.	(regardless of the department of the hospital in which such further examination or treatment is furnished); and 3. Post stabilization services which are additional services covered under the Plan that are furnished by a Non-Participating Provider or Non-Participating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after a patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay, with respect to the visit in which the services described in subsections 1 and 2, above, are provided, until: • The provider or facility determines that the participant or dependent is (i) stable; (ii) able to travel using nonmedical transportation or nonemergency medical transportation to an available Participating Provider or Participating Facility within a reasonable travel distance, taking into account the individual's medical condition; and (iii) in a condition to receive the information and provide informed consent, as described herein; • The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Participating Provider with respect to the Plan, of the estimated charges for the treatment and any advance limitations that the Plan may put on such treatment, of the names of any Participating Providers at the facility who are able to provide such treatment, and that the participant or dependent may elect to be referred to one of the Participating Providers listed; and • The participant or dependent gives informed consent to continued treatment by the Non-Participating Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or dependent.
Experimental or Investigational	Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other healthcare services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UHC makes a determination regarding coverage in a particular case, are determined to be any of the following: • Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.) Exceptions: • Clinical Trials for which Benefits are available as described under *Clinical Trials*. • If You are not a participant in a qualifying Clinical Trial and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the UHC may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UHC must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition. Refer to Section 7: Prescription Drug Program, for Experimental or Investigational language for Express Scripts
Genetic Testing	Examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Assessment	A confidential online questionnaire that asks You about Your health history, lifestyle behaviors (such as smoking and exercise habits) and Your willingness to make changes.
Health Care Facility	The term "Health Care Facility" (for non-Emergency Services) means each of the following: • A hospital (as defined in section 1861(e) of the Social Security Act); • A hospital outpatient department; • A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and • An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act
Hospice	A program provided by a licensed facility or agency that provides home healthcare, homemaker services, emotional support services, and other service provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician
Independent Freestanding Emergency Department	A health care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct and licensed separately from a hospital under applicable State law and provides Emergency Services.
Injury	Bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms
Inpatient Stay	An uninterrupted confinement of at least 24 hours following formal admission to a hospital, Skilled Nursing Facility or inpatient rehabilitation facility
Intensive Outpatient Program	A structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.
Maintenance Care	Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as Nonsurgical Spinal Treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.
Medical Emergency	An accidental Injury or a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to his/her health (or, if pregnant, to the unborn child); 2) serious impairment to the bodily functions; or 3) serious dysfunction of any bodily organ or part.

Medically Necessary	Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by UHC or its designee, within UHC's sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice*. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms. • Not mainly for Your convenience or that of Your doctor or other healthcare provider. • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Sickness, Injury, disease or symptoms. *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UHC reserves the right to consult expert opinion in determining whether healthcare services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UHC's sole discretion. UHC develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UHC and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on Your ID card, and to Physicians and other healthcare professionals on www.unitedhealthcareonline.com.
Network	When used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries. A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.
Nonsurgical Spinal Treatment	Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including • Distortion • Misalignment • Subluxation

Nonsurgical Spinal Treatment, cont.	to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column
No Surprises Act	The federal No Surprises Act (Public Law 116-260, Division BB).
Out-of-Pocket Limit	Your financial responsibility for covered medical expenses before the Programs reimburse additional covered charges at 100%, with no Deductible, for the remaining portion of that calendar year.
Outpatient	A person who visits a clinic, Emergency room, or health facility and receives healthcare without being admitted as an overnight patient (under 24-hour stay).
Outpatient Surgery	Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours.
Partial (or day) Hospitalization	A program that provides covered services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.
Primary Covered Member	The person for whom the coverage is issued; that is, the NTEES Employee, Retiree, Surviving Spouse, Long Term Disability Terminee or the individual who is purchasing temporary continued coverage.
Prior Authorization	The process whereby You call UHC/UBH to obtain prior approval for certain services.
Residential Treatment Facility	Provides acute overnight services for the care of a Substance Abuse disorder or overnight mental health services for those who do not require acute care.
Sickness	Physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Summary includes Mental Illness, or substance-related and addictive disorders, regardless ofthe cause or origin of the Mental Illness, or substance-related and addictive disorder.
Skilled Nursing Facility	A nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a hospital is considered a Skilled Nursing Facility for purposes of the Programs.
Sound Natural Teeth	Teeth that: • Are whole or properly restored • Are without impairment or periodontal disease • Are not in need of the treatment provided for reasons other than dental injury
Specialist Physician	A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.
Substance Use Disorder Services	Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.
Unproven Services	Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. Well-conducted randomized controlled trials are two or more treatments compared

Unproven Services cont.	to each other, with the patient not being allowed to choose which treatment is received. Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group. UHC has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UHC issues medical and drug policies that describe the clinical evidence available with respect to specific healthcare services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com. **Note:** If You have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UHC may, at their discretion, consider an otherwise Unproven service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UHC must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health. UHC may, in their discretion, consider an otherwise Unproven service to be a Covered Health Service for a covered person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met: • If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved • It must be performed by a physician and in a facility with demonstrated experience and expertise • You must consent to the procedure acknowledging that UHC does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective • At least two studies must be available in published peer-reviewed medical literature that would allow UHC to conclude that the service is promising but unproven • The service must be available from a network physician and/or network facility • The decision about whether such a service can be deemed a Covered Health Service is solely at UHC's discretion. Other apparently similar promising but Unproven Services may not qualify
Urgent Care	Treatment of an unexpected Sickness or Injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary sufferingsuch as high fever, a skin rash, or an ear infection.
Urgent Care Facility	Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing healthcare services.