SUMMARY PLAN DESCRIPTION

Abbott Laboratories
Retiree Indemnity Plan with Medicare Primary

Effective: January 1, 2023

Group Number: 704077

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

- Member services and claim inquiries, Care Coordination℠ and Claims Administrator: 1-800-603-3813.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.
- If you have a question about Medicare, visit **www.medicare.gov** and select, "Find Out What Medicare Covers." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Abbott Laboratories is pleased to provide you with this Summary Plan Description (SPD), which describes the Retiree Indemnity Plan coverage option under the Abbott Laboratories Retiree Health Care Plan (the "Plan"). In general, this Plan is only available for Retirees, eligible Dependents who are eligible for Medicare and certain grandfathered non-Medicare eligible Dependents. Coverage options for Retirees and Dependents who are not Medicare-eligible are described in separate SPDs, available from the Abbott Benefits Center or at **www.abbottbenefits.com**.

This SPD includes information about:

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

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

Abbott Laboratories intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan or the Abbott Laboratories Retiree Health Care Plan at any time to the extent permitted by law. This SPD is not to be construed as a contract of or for employment or guarantee any particular benefits. The Abbott Laboratories Retiree Health Care Plan is governed by formal legal documents and contracts for administration and payment of all benefits. In case of a conflict between this summary and those legal documents, the Plan's legal documents will control.

The Plan is not a standardized Medicare Supplement Plan. UnitedHealthcare does not insure the benefits described in this booklet. UnitedHealthcare is a private healthcare claims

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

Please read this SPD thoroughly to learn how the Retiree Indemnity Plan works. If you have questions, call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments (Summaries of Material Modifications) at **www.abbottbenefits.com** or request printed copies by contacting the Abbott Benefits Center.
- Capitalized words in the SPD have special meanings and are defined in Section 13, *Glossary*.
- The words "you" and "your" used throughout this SPD refer to a Retiree who otherwise meets all eligibility and participation requirements under the Retiree Health care Plan and the Retiree Indemnity Plan coverage option (and, with respect to certain participant rights and obligations under the Plan, the Retiree's covered Dependents). Receipt of this SPD does not guarantee that the recipient is a Covered Person and/or is otherwise eligible for benefits under the Plan.
- Abbott Laboratories is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, the Plan's legal documents will control.

SECTION 2 – INTRODUCTION TO THE RETIREE MEDICAL PLAN

What this section includes:

- Who's eligible for retiree medical coverage under the Retiree Health Care Plan.
- Determining your available coverage options.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

Retiree Eligibility

This SPD describes Retiree Indemnity Plan coverage available to Retirees and eligible Dependents covered under the Abbott Laboratories Retiree Health Care Plan who are eligible for Medicare and grandfathered non-Medicare eligible Dependents of certain pre-2014 Retirees.

In general, you are an eligible Retiree if you are a former Abbott Employee who terminates employment with a participating Employer and who, at the time of such termination, has completed at least ten years of service with an Employer (while the Employer was an Abbott affiliate), or is age 65 or older and has completed at least three years of service with an Employer (while the Employer was an Abbott affiliate); and either

- Qualifies for retirement or early retirement and is eligible to begin pension benefit payments under the Abbott Laboratories Annuity Retirement Plan ("ARP"); or
- was a member of the Abbott Green Group who terminated employment on or after January 1, 2020 at age 55 or later.

Your "years of service" for any period of employment with an Abbott affiliate during which you were excluded from participation in the ARP as a member of the Green Group means service that would have been included as "benefit service" under the ARP if you had been employed by a participating division under the ARP during such period.

Special eligibility rules may apply to employees of businesses that were acquired, spun-off, or sold by Abbott. Contact the Abbott Benefits Center for more information or if you are not sure if you are eligible for the Retiree Health Care Plan.

A former Employee of Hospira, Inc. who was eligible to elect coverage under the Retiree Health Care Plan as of May 1, 2004, will be eligible upon retirement or termination of employment with both employers. A former Employee of Hospira, Inc. who was not eligible to elect coverage under the Retiree Health Care Plan as of May 1, 2004, and who returns to employment with an Employer will have any Hospira service earned prior to May 1, 2004 disregarded for purposes of determining Retiree eligibility.

A former Employee of TAP Pharmaceutical Products Inc. who was eligible to elect coverage under the Retiree Health Care Plan as of May 1, 2008, and who terminated employment from TAP Pharmaceutical Products Inc. or one of its subsidiaries on or before that date, is also eligible for coverage as a Retiree. A former Employee of TAP Pharmaceutical Products Inc. who was not eligible to elect coverage under the Retiree Health Care Plan as of May 1, 2008, and who terminated employment from TAP Pharmaceutical Products Inc. or one of its subsidiaries on or before that date, is not eligible for coverage as a Retiree.

If you terminated your employment with Abbott due to a total disability prior to January 1, 2014, and you are receiving disability benefits from the Abbott Laboratories Long-term Disability Plan (LTD), you may also be eligible to participate in the Retiree Health Care Plan. Survivors of eligible Employees who die while employed by an Employer, covered Retirees, or covered LTD recipients may also be eligible, as described below in this section.

Eligible Dependents

If you are an eligible Retiree and elect medical coverage under the Retiree Health Care Plan, you may also cover certain Dependents.

Eligible Dependents include:

- Your Spouse or eligible Domestic Partner, and
- Your biological and legally adopted children (including children of a Domestic Partner), children for whom you are the legal parent or legal guardian, foster children and stepchildren up to the end of the month of their 26th birthday).

Grandfathered Dependents

Prior to 2014, Medicare-eligible Retirees were permitted to enroll their non-Medicare-eligible Dependents either in this Plan or in a pre-65 retiree medical option under the Retiree Health Care Plan. Effective January 1, 2015, this Retiree Indemnity Plan option was closed to Dependents who were not Medicare-eligible. Non-Medicare-eligible Dependents who were enrolled in this Retiree Indemnity Plan option on December 31, 2014, were permitted to remain in this Plan. Any such grandfathered Dependents cannot be switched to a pre-65 retire medical option. However, no other non-Medicare-eligible Dependents have since been eligible for coverage under this Retiree Indemnity Plan.

Once a grandfathered Dependent becomes eligible for Medicare, the Plan will become the secondary payer and will coordinate with Medicare. Benefits received as a grandfathered Dependent will count toward the Plan's Lifetime Maximum Benefit.

If the grandfathered Dependent has other health benefits plan coverage, the COB rules described in Section 11, *Coordination of Benefits* will determine whether this Plan is the primary or secondary payer.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children to be dependents for benefits tax purposes. Therefore, the value of Abbott Laboratories cost in covering a Domestic Partner may be imputed to the Retiree as income.

Domestic Partner Coverage

To qualify for enrollment of a Domestic Partner, you and your partner must either be registered with any state or local governmental domestic partner registry, or meet all of the following criteria:

- Have shared a continuous committed relationship for no less than six months.
- Are not legally married to another person, and have no other such Domestic Partnership relationship with any other person.
- Reside in the same household and intend to do so indefinitely.
- Are not related by blood to a degree of kinship that would prevent marriage from being recognized under law.
- Are at least 18 years old and mentally competent to enter into contracts.

Legal Guardianship or Custody

If you have sole legal custody or guardianship (as evidenced by court documents) for any child, that child may be eligible for plan coverage. You must provide copies of sole legal guardianship or custody papers to the Abbott Benefits Center within the appropriate time frame before this coverage can be approved.

Disabled Dependents

An unmarried child who is not capable of self-support and is totally disabled due to a physical or mental condition that began before age 26 may be eligible for Dependent coverage after age 26. To enroll your disabled child in this extended coverage, you will be required to provide a physician's statement documenting the disabling condition prior to age 26 upon enrollment and periodically thereafter. The plan administrator determines eligibility for this coverage. To continue existing coverage for a disabled child beyond age 26, you must submit written proof of disability within 31 days after the day coverage for the dependent would normally end. Coverage for an adult disabled child may also be elected if you are enrolling yourself and your dependents within 31 days upon first becoming eligible for Abbott benefit coverage, within 31 days of a qualifying life event or during the annual open enrollment period for coverage effective January 1 of the following year. If coverage for your adult disabled child ends after age 26 under the Abbott Laboratories Health Care Plan or the Retiree Health Care Plan for any reason, this coverage will not become available at a later date.

Verification forms can be obtained from UnitedHealthcare by calling the number on the back of your ID card.

Qualified Medical Support Orders

Federal law requires the Retiree Health Care Plan, under certain circumstances, to provide coverage for your children after you and your spouse divorce, provided you pay the required premiums. The process begins when the Retiree Health Care Plan receives a qualified medical child support order (QMCSO).

This means any judgment, decree or order, including approval of a settlement agreement, which:

- Issues from a court of competent jurisdiction pursuant to state domestic relations law
- Requires you to provide group health coverage available under the plan for your children - even though you no longer have custody, and
- Clearly specifies your name and address, the names and addresses of each child covered by the order, a reasonable description of the coverage to be provided, the length of time the order applies and the plan(s) affected by the order.

The Retiree Health Care Plan will provide written notification to you and each identified child that it has received a court order requiring coverage. If the Retiree Health Care Plan receives a QMCSO, it must permit immediate enrollment. This means the children identified will be included for coverage as your eligible Dependents. The child's custodial parent, legal guardian or a state agency can apply for coverage, even if you don't apply for coverage.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Dependents who are not Eligible

Dependents who are not eligible for this coverage include children of a Domestic Partner if the Domestic Partner is not covered, grandchildren (unless you have legal custody or guardianship), dependent parents, or siblings.

If you become legally separated from or divorce your Spouse or terminate a Domestic Partnership arrangement, your Spouse or Domestic Partner is no longer an eligible Dependent and must be removed from coverage within 31 days after your legal separation, divorce, or termination of Domestic Partnership. If your former Spouse/Domestic Partner is not dropped from your coverage, you will be required to reimburse the Retiree Health Care Plan for any payments made for the ineligible Dependent, at the Plan Administrator's discretion. Coverage for a former Spouse may be continued for a limited period of time following your divorce or separation under the continuation of coverage provisions (COBRA) under *Continuing Coverage Through COBRA* in Section 12, *When Coverage Ends*.

A Spouse, Domestic Partner, or child covered under an Abbott health plan (as an Employee, Retiree or Dependent) may not be covered as the Dependent of another Employee or Retiree under an Abbott health plan.

Survivor Coverage

If you die while enrolled in retiree medical coverage under the Retiree Health Care Plan (either as a Retiree or as a covered LTD recipient), your covered surviving Dependents will be eligible to continue coverage under the terms in effect on that date.

In addition, if you die while an Employee of an Employer and, at the time of your death, you either (i) had 15 or more years of Abbott service or (ii) would have qualified as a Retiree if you had terminated employment with Abbott on the day before your death, your surviving eligible Dependents who had medical coverage under the Abbott Laboratories Health Care Plan on the date of your death will be eligible for survivor coverage under the Retiree Health Care Plan.

Your surviving Dependents may continue coverage until:

- Your surviving Spouse becomes covered by another employer-sponsored health plan.
- He or she no longer qualifies as a dependent child under the Plan (in the case of a child).
- The required contribution is not paid.
- The Plan ends.

Retiree Health Care Plan Coverage Options

If you are an eligible Retiree or Dependent (including a surviving Dependent eligible for retiree coverage), your available coverage options depend on whether you are eligible for Medicare:

- If you are a Retiree or Dependent who is eligible for Medicare due to age 65, disability, or end stage renal disease (ESRD), you will be covered under the Retiree Indemnity Plan option. This SPD applies to you.
- If you are a Retiree or Dependent who is not eligible for Medicare, you may enroll in one of the available pre-65 retiree medical options. Grandfathered non-Medicare eligible Dependents cannot be switched to a pre-65 retire medical option. Contact the Abbott Benefits Center for information about your retiree medical options and to request the applicable SPD.

If you are Medicare-eligible but your Dependents are not, your coverage will "split" – that is, you will be enrolled in the Retiree Indemnity Plan option, and your Dependents will continue coverage in one of the pre-65 retiree medical options under the Retiree Health Care Plan. Similarly, if you have a Medicare-eligible Dependent but you are not yet Medicare-eligible, only your Medicare-eligible Dependent will be enrolled in the Retiree Indemnity Plan.

Split coverage is not allowed with the Kaiser HMO plan. If you or your Dependents are enrolled in the Kaiser HMO as a pre-65 Retiree and you or your Dependents become eligible for Medicare, the non-Medicare eligible Retiree or Dependent will need to choose a different pre-65 retiree medical option. If no choice is made the non-Medicare eligible Retiree or Dependent will be defaulted to the UnitedHealthcare Health Investment Plan option. Call the Abbott Benefits Center at (844) 30-MY-ABC or (844-306-9222) for more details and to find out your options.

How to Enroll

You may enroll in Retiree Health Plan coverage for yourself and your eligible Dependents 31 days before your retirement date, and you will have up to 31 days after your retirement date to complete your enrollment to ensure no lapse in coverage. Complete your election by logging on to the Abbott Benefits Center at www.abbottbenefits.com.

If you are eligible for Medicare at the time of your retirement, you must contact the Abbott Benefits Center to provide your Medicare number (MBI) in order to complete your enrollment in the Retiree Health Care Plan. If you are Medicare-eligible and you do not timely provide your MBI, neither you nor your Dependents will begin coverage under the Retiree Health Care Plan.

If you do not enroll in Retiree Health Care Plan medical coverage when you retire, you may enroll at a later time by contacting the Abbot Benefits Center.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Abbott Benefits Center within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan. These Benefits are subject to any prior plan's or carrier's obligations under state law or contract.

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

When You Become Medicare Eligible

If you are enrolled in a pre-65 Retiree Health Care Plan coverage option when you become eligible for Medicare, your coverage will automatically change over to the Retiree Indemnity Plan option. Several months before turning age 65, you will be sent information regarding enrollment in this Retiree Indemnity Plan option. Your covered Dependents who are not Medicare-eligible will remain in their current pre-65 retiree medical option.

Similarly, your covered Spouse or Domestic Partner will be sent information regarding enrollment in this Retiree Indemnity Plan option as he or she approaches age 65.

IMPORTANT: Medicare Eligibility Due to Disability

If you or your Dependent becomes eligible for Medicare due to disability, you must contact the Abbott Benefits Center by calling: (844) 30-MY-ABC or (844) 306-9222. Failure to provide this notice could result in loss of benefits to you or your Dependent(s).

The Plan automatically pays benefits on a secondary basis **if you are eligible for Medicare**. This means your claims are processed as if you received a Medicare payment for each Eligible Expense (Parts A and B) **even if you did not enroll for Part B benefits**. **Therefore, it is important that you enroll in Medicare as soon as you are eligible and contact the Abbott Benefits Center as soon as you or your covered Dependents become eligible for Medicare**.

Contributions

If you elect to participate in the Retiree Medical Plan, you are required to contribute toward the cost of this coverage. The Company determines Retiree contributions annually. You can find current cost information on the Benefits Web site at www.abbottbenefits.com, or by calling the Abbott Benefits Center (844) 30-MY-ABC or (844)306-9222. Contact the Abbott Benefits Center to learn more about your payment options.

Your contributions are based on the coverage option (pre-65 medical option or Retiree Indemnity Plan Medicare option) and the level of coverage you choose. The coverage levels are:

- Retiree only.
- Retiree plus Spouse/Domestic Partner.
- Retiree plus child(ren).
- Retiree plus Spouse/Domestic Partner and child(ren).

If you elect medical coverage for your Domestic Partner, the Company's contribution for your Domestic Partner and your Domestic Partner's dependents will be reported as taxable income to you. Details on this imputed income are available from the Abbott Benefits Center.

Changing Your Covered Dependents

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

- Your marriage.
- The birth, adoption, placement for adoption or legal guardianship of a child.
- Registering a Domestic Partner.
- Becoming the legal guardian of a child.
- A court or administrative order requiring coverage of a child (QMCSO).

- Your Dependent gains or loses coverage under Medicare or Medicaid.

If you wish to change your Dependent coverage elections, you must contact the Abbott Benefits Center within 31 days of the change in family status event. If you request coverage for your Dependent(s) within 31 days of the family status change, coverage for your Dependent will begin on the date of the event. If you do not notify the Abbott Benefits Center within 31 days of the change in family status, you will need to wait until the next annual Open Enrollment.

You must notify the Abbott Benefits Center within 31 days if you become legally separated from or divorce your Spouse or terminate a Domestic Partnership arrangement. Coverage will automatically end for individuals who lose Dependent eligibility, subject to COBRA continuation coverage rights.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. In this case, you must notify the Abbott Benefits Center within 31 days of the placement ending. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

SECTION 3 – MEDICARE AND YOUR ABBOTT RETIREE INDEMNITY PLAN COVERAGE

What this section includes:

- Retiree Indemnity Plan enrollment – Must provide your MBI number
- Basic information about Medicare benefits.
- How this Retiree Indemnity Plan coordinates with Medicare.

Enrollment in the Retiree Indemnity Plan Option

All Retirees and Dependents who are eligible for Medicare receive retiree medical coverage under the Retiree Indemnity Plan option (the "Plan"). To complete enrollment in the Plan, your Medicare Beneficiary Identifier (MBI) number must be on file with the Abbott Benefits Center the month prior to coverage eligibility to ensure that coverage is not interrupted for you and/or your Medicare-eligible covered Dependents. A Medicare-eligible Retiree or Dependent cannot be enrolled without an MBI on file with UnitedHealthcare.

If you are Medicare-eligible and your MBI is not on file on the date you become Medicare-eligible, you will not be enrolled in the Plan, and your Retiree Medical Plan coverage will be suspended until you provide your MBI. If you have covered Dependents, coverage for your Dependents will also be suspended (even if they are covered under a pre-65 retiree medical option). Once you provide your MBI, your coverage and coverage for your covered Dependents can be prospectively reinstated from the date you provide your MBI – in other words, if you do not provide your MBI, you and your covered Dependents may have a gap in medical coverage.

About Medicare

Medicare is a health insurance program for people age 65 or older and people under age 65 with certain disabilities. The program has several parts –A thru D. Medicare Parts A and B are also called "Original Medicare". For more information about your Medicare benefits, please call the Social Security Administration at 1-800-772-1213, or visit the Medicare Website at **www.medicare.gov.**

Enrolling in Medicare

Call the Social Security Administration at 1-800-772-1213 regarding Medicare Benefits and enrollment procedures. Be sure to enroll for both Part A and Part B benefits. You will generally get both Medicare Part A and Part B on the first day of the month in which you turn 65. Your Medicare card will come with your name and Medicare Beneficiary Identifier (MBI) printed on it about three months before your birthday.

If you have a disability and have been receiving Social Security Disability Insurance (SSDI) based on total disability, you should get your Medicare card three months before you become eligible for Medicare. (You become eligible for Medicare on the 25th month you get disability benefits.) Be sure to enroll for both Part A and Part B Benefits.

If you have kidney disease or ALS, your eligibility for Medicare may begin sooner.

You should enroll through your local Social Security office. Be sure to enroll for both Part A and Part B Benefits.

Medicare Parts A and B

When you, your spouse or Domestic Partner becomes eligible for Medicare it is important to sign up for both Part A (Hospital) and Part B (Supplementary Medical Insurance) coverage. The Plan automatically pays benefits on a secondary basis **if you are eligible for Medicare**. This means your claims are processed as if you received a Medicare payment for each Eligible Expense (Parts A and B) **even if you did not enroll for Part B Benefits**.

Medicare Part D

The prescription drug coverage provided through Abbott's Retiree Indemnity Option for Medicare-eligible Retirees meets the government's requirements for "creditable coverage", meaning our coverage is as good as, or better than, the standard Medicare Part D plan.

Abbott Retiree drug benefits for all enrolled participants who are eligible for Medicare and living in the U.S. are provided through a combination of a Medicare Part D plan plus supplementary coverage. The Plan's prescription drug coverage is administered by Express Scripts.

You cannot receive prescription drug coverage through another Medicare Part D plan and the Abbott Plan at the same time. **To keep your Abbott prescription drug coverage, you should not enroll in another Medicare Part D plan.** Since you are enrolled in a Medicare Part D plan through the Abbott Retiree Indemnity Plan option, you will not pay any late enrollment fees if you choose to elect another Medicare Part D plan at some point in the future.

Medicare Crossover

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

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

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

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

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

Primary Coverage through Medicare

When you or your Dependent become eligible for Medicare, medical benefits under Medicare generally becomes primary for that individual. (This Plan may be the primary payer for a period of time for a Covered Person who is eligible for Medicare due to end-stage renal disease (kidney failure).) The Retiree Indemnity Plan is a non-duplication plan – a plan that considers Medicare's coverage first (unless this Plan is the primary payer due to end-stage renal disease) and pays the difference between Medicare's payment and the Abbott plan's standard payment for covered services. So, when you use health care services:

- Medicare pays their covered charges.
- The Plan calculates its standard payment for covered charges, then pays the difference between Medicare's payment and the Abbott Plan's standard benefits, if there is any.
- You pay any remaining balance.

Because Medicare pays 80% for many expenses and your Plan coverage is 80% after your Annual Deductible, in many cases you will not receive a secondary payment on your claims from this Plan until you have met your Out-of-Pocket Maximum limit.

The Plan tracks the amount you pay out-of-pocket on all charges and applies it to your Out-of-Pocket Maximum (currently $2,000). Once you've paid $2,000 out of your pocket for approved claims, the Plan pays the remaining balance of approved claims for the rest of the calendar year. Here is an example of this:[1]

Type Of Claim	Total Charges (Medicare Approved Amount/ Allowable Expense)	**Total Paid by Medicare**	**Abbott Plan Covered Charges** (80% of Medicare Approved Amount/Allowable Expense)	**Total Paid By Retiree Indemnity Plan**	**You Pay**	**Your Total Payment (Cumulative for the Year)**
Doctor Charges	$1,600	$1,280	$1,280	$0 – Plan and Medicare cover the same amount so Plan pays nothing.	$320	$320
X-ray	$5,000	$4,000	$4,000	$0 - Plan and Medicare cover the same amount so Plan pays nothing	$1,000	$1,320

Type Of Claim	Total Charges (Medicare Approved Amount/ Allowable Expense)	**Total Paid by Medicare**	**Abbott Plan Covered Charges** (80% of Medicare Approved Amount/Allowable Expense)	**Total Paid By Retiree Indemnity Plan**	**You Pay**	**Your Total Payment (Cumulative for the Year)**
Lab	$500	$400	$400	$0 – Plan and Medicare cover the same amount so Plan pays nothing.	$100	$1,420
Outpatient Surgery	$4,000	$3,200	$3,420[2]	$220 - Plan paid difference because you reached $2,000 Out-of-Pocket Maximum.	$580	$2,000
Doctor charges	$500	$400	$500[2]	$100 - Plan pays amount because you reached $2,000 Out-of-Pocket Maximum.	$0	$2,000

[1] This example is provided to help illustrate how your benefits are coordinated with Medicare and is not intended to be regarded as a legal document or contract. Examples assume providers accept Medicare assignment. This example assumes that both the Part B and Abbott Plan deductibles were met, but none of the out-of-pocket maximum has been satisfied.

[2] Once the Out-of-Pocket Maximum is reached, the Abbott Plan Covered Charges becomes 100% of the Medicare Approved Amount/Allowable Expense.

SECTION 4 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

The Benefits of the Plan described in this SPD are based on the assumption that you are enrolled in Medicare Part A and Part B or are a grandfathered non-Medicare eligible Dependent. The Plan was designed to provide secondary coverage to Medicare eligible Covered Persons and primary coverage for grandfathered non-Medicare eligible Dependents. For Medicare eligible Covered Persons, the Plan will pay Benefits up to the Eligible Expenses (*i.e.*, the Allowable Expense), only to the extent that the Eligible Expense has not been paid by Medicare, and subject to all other limitations and exclusions set forth in Section 9, *Exclusions and Limitations*.

Please be aware that when this Plan is secondary, Plan payments are based on expenses approved by Medicare but not paid by Medicare. If your provider does not accept Medicare assignment, you are responsible for any charges exceeding Medicare's allowable amounts. It is to your advantage to use Medicare participating providers, approved facilities and approved Hospice agencies in order to avoid additional out-of-pocket expenses.

As a Covered Person in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay.

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Plan does not provide a Network Benefit level or a non-Network Benefit level.

UnitedHealthcare arranges for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under the Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of Abbott or UnitedHealthcare. It is your responsibility to select your provider.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

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

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

Designated Providers

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

Medicare Participating Provider

A Medicare participating provider is a provider that signs an agreement with Medicare to always "accept assignment." This means that the provider agrees to use Medicare's fee schedule for services and supplies they provide to you that are covered by Medicare. When you choose a Medicare participating provider, you are assured that the provider will always accept assignment and that the provider will never bill you for the difference between their charges and the amount Medicare allows based on the fee schedule.

Medicare Non-Participating Provider

A provider that is not a Medicare participating provider can choose to either "accept assignment" or not "accept assignment." If the non-participating provider accepts

assignment, they are treated the same way as a Medicare participating provider described in the preceding paragraph.

If the non-participating provider chooses not to accept assignment, by law this provider cannot bill in excess of the "limiting charge" of 115% of the Medicare allowable amount for the services and supplies they provide to you.

Opt-Out Provider

An opt-out provider is a provider that signed an opt-out affidavit agreeing to never be a Medicare participating provider. You should expect to pay significantly more with this type of provider arrangement. See Section 11, *Coordination of Benefits*, for details. If you choose an opt-out provider, the provider will not bill Medicare and Medicare will not pay for any health services you receive. If the provider is contracted with UnitedHealthcare (a Network provider) they will bill UnitedHealthcare directly. If the provider is not a UnitedHealthcare Network provider, you may be required to submit the claim to UnitedHealthcare.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 15, *Glossary*. Abbott Laboratories has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan. Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. Providers may request that you pay all charges when services are rendered. You must file a claim with UnitedHealthcare for reimbursement of Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in this SPD.

For Covered Persons eligible for Medicare, Eligible Expenses are the Medicare approved amount.

For grandfathered non-Medicare eligible Dependents, Eligible Expenses are based on the following:

- When Covered Health Services are received from a provider that has agreed to participate in a Plan that does not offer a network of participating providers, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law.
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - When Covered Health Care Services are Pharmaceutical Products, Eligible Expenses are the average wholesale price of such Pharmaceutical Products as set

forth in the *Red Book* drug pricing resource. The Pharmaceutical Product pricing information is updated annually.

- When *Red Book* does not have a price for the product, an alternative pricing source such as *RJ Health* or an internally developed pharmaceutical pricing resource to determine the average wholesale price for the covered Pharmaceutical Product will be used.

In the event that a rate is not available for the services because there is no CPT code, the Eligible Expense is based on 20% of the billed charge.

IMPORTANT NOTICE: Providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

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

Medicare Eligible Payment and Coordination of Benefits Summary

As a Medicare eligible Covered Person, Medicare will be your primary coverage plan paying benefits. This means that Medicare will consider charges for health services first, regardless of the type of provider you choose or whether the health services are covered by Medicare. After Medicare pays available benefits, this Plan will coordinate with Medicare by paying additional Benefits, if available, as the secondary coverage plan. The Plan will pay Benefits only to the extent that an Eligible Expense has not been paid by Medicare and subject to all other coverage conditions, limitations and exclusions shown in this SPD.

See *Types of Providers* in Section 4, *How the Plan Works* for details on types of providers and Section 11, *Coordination of Benefits* for details on how this Plan coordinates with Medicare.

Medicare Reimbursement

When you or your provider bill Medicare for health services or supplies, Medicare will determine whether all or a portion of the services and supplies are covered by Medicare. Medicare will then pay any available benefits to your provider, based on Medicare's coverage and fee schedule. Medicare will advise you of any patient responsibility for each claim; this can include a Copay or Coinsurance that Medicare assigns or amounts you owe the provider when the provider's charges exceed Eligible Expenses, as described under *When This Plan is Secondary to Medicare* in Section 11, *Coordination of Benefits*.

Plan Reimbursement

After Medicare pays any available benefits, claims are forwarded to UnitedHealthcare for processing. When a service or supply is covered by Medicare, the Plan will coordinate with Medicare by paying additional Benefits, if available, as the secondary coverage plan as described in Section 11, *Coordination of Benefits*. When a service or supply is not covered by Medicare but is a Covered Health Service under the Plan, the Plan will pay Benefits as though it were the primary plan.

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to receive Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

You must pay a $400 Annual Deductible per person each calendar year before the Plan begins to pay benefits for certain expenses. This Annual Deductible applies to you and each of your covered Dependents enrolled in the Retiree Indemnity Plan. There is a maximum family Deductible of $800 per calendar year.

A separate Deductible of $100 per person/$200 per family applies to prescription drugs.

If you are covering grandfathered Dependents who are not eligible for Medicare, separate individual and family prescription drug Deductibles will apply for Medicare-eligible family members and family members who are not eligible for Medicare. For example, if you and your covered Spouse are Medicare-eligible, and you also have a grandfathered Dependent child who is not eligible for Medicare, you and your Spouse will be subject to a $200 family Deductible and your Dependent child will be subject to a separate $100 individual Deductible.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible. (In other words, even if the Covered Person pays the full cost for a Covered Health Service with a visit or day limit because the Covered Person has not satisfied the Annual Deductible, that service still counts against the applicable visit or day limit.)

The Annual Deductible applies only to this Retiree Indemnity Plan coverage. If you switched from a separate pre-65 retiree medical option to this Retiree Indemnity Plan in the middle of the year, your Annual Deductible starts at $0 – in other words, any out-of-pocket expenses incurred while you were covered under the pre-65 retiree medical option or enrolled in Abbott's active medical plan as an Employee will not count toward the Annual Deductible for this Plan. Similarly, if you are enrolled in this Retiree Indemnity Plan because you are eligible for Medicare but you have a covered Dependent under a different Abbott pre-65 retiree medical plan option who is not Medicare-eligible (*i.e.*, not a grandfathered Dependent under this Retiree Indemnity Plan), only your out-of-pocket expenses will count toward the Annual Deductible for this Plan; your Dependent's benefits will be subject to a separate annual deductible under the Dependent's pre-65 retiree medical plan option.

Coinsurance

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

meet the Annual Deductible. For example, if your Coinsurance is 20% of Eligible Expenses, the Plan pays the remaining 80%.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services, including amounts applied to the Annual Deductible. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year. Your share of covered medical expenses is limited to $2,000 per person/$4,000 for all covered family members each calendar year.

A separate Out-of-Pocket Maximum limit of $1,500 per person and $3,000 per family applies to prescription drug expenses.

The Out-of-Pocket Maximum limit applies only to this Retiree Indemnity Plan coverage. If you switched from a separate pre-65 retiree medical option to this Retiree Indemnity Plan in the middle of the year, your out-of-pocket expenses for the year resets to $0 – in other words, any out-of-pocket expenses incurred while you were covered under the pre-65 retiree medical option or enrolled in Abbott's active medical plan as an Employee will not count toward the Out-of-Pocket Maximum limit for this Plan. Similarly, if you are enrolled in this Retiree Indemnity Plan because you are eligible for Medicare but you have a covered Dependent under a different Abbott pre-65 retiree medical plan option who is not Medicare-eligible (*i.e.*, not a grandfathered Dependent under this Retiree Indemnity Plan), only your out-of-pocket expenses will count toward the Out-of-Pocket Maximum limit for this Plan; your Dependent's benefits will be subject to a separate annual out-of-pocket limit under the Dependent's pre-65 retiree medical plan option.

If you are covering grandfathered Dependents who are not eligible for Medicare, separate individual and family drug Out-of-Pocket Maximum limits will apply for Medicare-eligible family members and family members who are not eligible for Medicare. For example, if you and your covered Spouse are Medicare-eligible, and you also have a grandfathered Dependent child who is not eligible for Medicare, you and your Spouse will be subject to a $3,000 family Out-of-Pocket Maximum limit and your Dependent child will be subject to a separate $1,500 individual Out-of-Pocket Maximum limit.

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

Plan Features	Applies to the Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes
Coinsurance Payments, except those for covered services provided under the separate prescription drug program administered by Express Scripts.	Yes
Charges for non-Covered Health Services	No

Plan Features	Applies to the Out-of-Pocket Maximum?
Charges that exceed Eligible Expenses	No

Lifetime Maximum Benefit

There is a $500,000 per person Lifetime Maximum Benefit for this Plan. This maximum applies to each Covered Person's lifetime: The Lifetime Maximum Benefit is the most that the Plan will pay for the combined total of medical and prescription drug Benefits during the entire period that an individual is enrolled in this Plan. Any claims you and your family members incurred while under your active or pre-65 Retiree coverage do not count against individual lifetime maximums under your Retiree coverage under this Plan. Additional lifetime limits may apply to specific services.

SECTION 5 - CARE COORDINATION[SM]

What this section includes:

- An overview of the Care Coordination[SM] program.
- Covered Health Services for which you need to contact Care Coordination[SM].
- Care Coordination[SM] is not available for Medicare-eligible Retirees and Dependents.

UnitedHealthcare provides a program called Care Coordination[SM] designed to encourage personalized, efficient care for any covered grandfathered non-Medicare eligible Dependents.

Care Coordination[SM] nurses center their efforts on prevention, education, and closing any gaps in the Covered Person's care. The goal of the program is to ensure your covered Dependent receives the most appropriate and cost-effective services available.

Care Coordination[SM] nurses will provide a variety of different services to help your covered non-Medicare eligible Dependent 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 the Covered Person to implement the Care Coordination[SM] process and to provide information about additional services that are available to the Covered Person, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Care Coordination[SM] program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help the Covered Person prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If your grandfathered non-Medicare eligible Dependent is hospitalized, a Care Coordination[SM] nurse will work with your Dependent's Physician to make sure your Dependent is getting the care your Dependent needs and that your Dependent's Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and the Covered Person's home if the Covered Person is at high risk of being readmitted. After leaving the Hospital, if your covered grandfathered non-Medicare eligible Dependent has a certain chronic or complex condition, your Dependent may receive a phone call from a Care Coordination[SM] nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care Coordination[SM] nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for Covered Persons 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. Covered Persons may receive a phone call from a Care Coordination[SM] nurse to discuss and share important health care information related to the Covered Person's specific chronic or complex condition.

If your covered grandfathered non-Medicare eligible Dependent does not receive a call from a Care Coordination[SM] nurse but feels he or she could benefit from any of these programs, please call the number on your ID card.

Contacting UnitedHealthcare or Care Coordination[SM] is easy.
Simply call the number on your ID card.

Requirements for Notifying Care Coordination[SM]

For covered grandfathered non-Medicare eligible Dependents, the Plan requires notification for certain Covered Health Services. (These notification rules do not apply to Medicare-eligible Retirees and Dependents.)

When your covered grandfathered non-Medicare eligible Dependent chooses to receive certain Covered Health Services, your Dependent is responsible for providing notification before the Dependent receive these services. Note that this obligation to provide notification is also applicable when a non-Network provider intends to admit your covered grandfathered non-Medicare eligible Dependent to a Network facility or refers such a Dependent to other Network providers. Once your Dependent has provided notification, your Dependent should review the authorization from UnitedHealthcare carefully so that your Dependent understand what services have been authorized and what providers are authorized to deliver the services that are subject to the notification.

Services for which your grandfathered non-Medicare eligible Dependents are required to provide notification are identified below. Please note that notification timelines apply.

The services that require notification are:

- Ambulance - Non-emergency air ambulance. The Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-emergency air ambulance transport), you must provide pre-service notification to the Claims Administrator as soon as possible before transport.
- Clinical Trials. You must notify the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises.
- Durable Medical Equipment for items that will cost more than $1,000 d, including diabetes equipment for the management and treatment of diabetes.
- Home health care including nutrition and Private Duty Nursing. You must provide pre-service notification five business days before receiving services, including nutritional foods and Private Duty Nursing, or as soon as reasonably possible.
- Hospice care - inpatient. You must provide pre-service notification five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.

- Hospital Inpatient Stay - all scheduled admissions. For Benefits for a scheduled admission, you must provide pre-service notification five business days before admission, or as soon as reasonably possible for a non-scheduled admission (including Emergency admissions).
- Lab, X-Ray and Diagnostics - Outpatient – Genetic Testing and sleep studies.
- Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility). For a scheduled admission (including an admission for services at a Residential Treatment facility), you must provide pre-service notification five business days before admission or as soon as is reasonably possible for a non-scheduled admission (including Emergency admissions).
- Maternity care that exceeds the following delivery timeframes: You must provide notification as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.
- Obesity surgery. You must notify the Claims Administrator as soon as the possibility of obesity surgery arises.
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy. You must provide pre-service notification five business days before undergoing a Reconstructive Procedure. When you provide notification, the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services. You must provide pre-service notification five business days before admission, or as soon as is reasonably possible for non-scheduled admissions.
- Therapeutics - dialysis, IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound. You must provide pre-service notification for these outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible.
- Transplantation services. You must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Notification is required within 24 hours of admission or on the same day of admission if reasonably possible after you are admitted to a Hospital as a result of an Emergency.

Special Note Regarding Medicare

Covered Retirees and non-grandfathered Dependents are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits). Therefore, the above notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as

secondary payer as described in Section 11, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 6 - PLAN HIGHLIGHTS

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

Payment Terms and Features

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

See the *Addendum – Prescription Drug Benefits* section of this SPD for information about the separate Annual Deductible and Out-of-Pocket Maximum applicable to your prescription drug benefits program, administered by Express Scripts.

Plan Features	Indemnity
Annual Deductible (except Prescription Drug)	
■ Individual.	$400
■ Family (not to exceed the applicable Individual amount per Covered Person).	$800
Annual Out-of-Pocket Maximum (except Prescription Drug)	
■ Individual.	$2,000
■ Family (cumulative Out-of-Pocket Maximum).	$4,000
The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.	
Annual Deductible (Prescription Drug Benefits)	
■ Individual.	$100
■ Family	$200

Plan Features	Indemnity
Annual Out-of-Pocket Maximum (Prescription Drug Benefits)	
■ Individual.	$1,500
■ Family	$3,000
The Prescription Drug Annual Deductible applies toward the Prescription Drug Out-of-Pocket Maximum.	
Lifetime Maximum Benefit	$500,000

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 7, *Additional Coverage Details*.

This Plan will not duplicate benefits paid by Medicare. If Medicare reimburses at the same level, no additional payment will be made by this Plan.

Covered Health Services	Benefit *(The Amount the Plan Pays based on the Eligible Expense)*
Acupuncture Services See Section 7, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible
Ambulance Services - Emergency Only Ground or air ambulance, as UnitedHealthcare determines appropriate.	*Ground and/or Air Ambulance* 80% after you meet the Annual Deductible
Ambulance Services – Non-Emergency Ground or air ambulance, as UnitedHealthcare determines appropriate.	*Ground and/or Air Ambulance* 80% after you meet the Annual Deductible
Ambulatory Surgical	80% after you meet the Annual Deductible
Anesthesia Services	80% after you meet the Annual Deductible
Audiology	80% after you meet the Annual Deductible
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section
Dental Services - Accident Only	80% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.

Covered Health Services	Benefit *(The Amount the Plan Pays based on the Eligible Expense)*
Diabetes Self-Management Items ■ Diabetes equipment. ■ Diabetes supplies.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section. Abbott-produced diabetic equipment covered at 100%. *Coverage for Abbott Diabetes Supplies provided under the Express Scripts Prescription Drug Plan*
Durable Medical Equipment (DME), Orthotics and Supplies	80% after you meet the Annual Deductible
Emergency Health Services – Outpatient	80% after you meet the Annual Deductible
Hearing Aids See Section 7, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible
Home Health Care See Section 7, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible
Injections in a Physician's Office	80% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient ■ Lab Testing - Outpatient. ■ X-Ray and Other Diagnostic Testing - Outpatient.	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible
Mental Health Services ■ Inpatient. ■ Outpatient.	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible

Covered Health Services	Benefit *(The Amount the Plan Pays based on the Eligible Expense)*
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient.	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Nutritional Counseling	80% after you meet the Annual Deductible
Obesity Surgery	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Oral Surgery	80% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible
Pregnancy - Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	 100% 100% 100%
Private Duty Nursing - Outpatient See Section 7, *Additional Coverage Details* for limits.	80% after you meet the Annual Deductible

Covered Health Services	Benefit *(The Amount the Plan Pays based on the Eligible Expense)*
Prosthetic Devices	80% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 7, *Additional Coverage Details*, for visit limits.	80% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	80% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient.	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	Depending upon where the Covered Health Services is provided, Benefits will be the same as those stated under each Covered Health Services category in this section.
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible
Transplantation Services	Depending upon where the Covered Health Services is provided, Benefits will be the same as those stated under each Covered Health Services category in this section.
Urinary Catheters	80% after you meet the Annual Deductible

Covered Health Services	Benefit *(The Amount the Plan Pays based on the Eligible Expense)*
Urgent Care Center Services	80% after you meet the Annual Deductible
Vision Examinations See Section 7, *Additional Coverage Details*, for visit limits.	80% after you meet the Annual Deductible
Wigs See Section 7, *Additional Coverage Details*, for visit limits.	80% after you meet the Annual Deductible

SECTION 7 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Plan pays Benefits.

This section supplements the second table in Section 6, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply. Please note that for non-Medicare eligible grandfathered Dependents, certain Covered Health Services require notification to *Care Coordination*SM – see Section 5, *Care Coordination*SM for information. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 9, *Exclusions and Limitations*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

Acupuncture Services

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

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

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Ambulance Services - Emergency Only

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 15, *Glossary* for the definition of Emergency.

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

Ambulance Services - Non-Emergency

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

- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.
- Facility to home.

Anesthesia Services

Benefits are available for anesthesia services if administered at the same time as a covered surgical procedure in a hospital or ambulatory surgical facility or by a physician other than the operating surgeon or by a CRNA. Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a hospital or ambulatory surgical facility if a medical condition requiring hospitalization for dental care is present, or if required for a child age 6 or under.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.

- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services*

to meet both of the following criteria:

- ♦ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
- ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Dental Services - Accident Only

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

- Treatment is necessary because of accidental damage to sound, natural teeth.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

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

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

Benefits are available only for treatment of a sound, natural tooth. Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, or that it:

- Has no decay.
- Has no filling on more than two surfaces.
- Has no gum disease associated with bone loss.
- Has no root canal therapy.
- Is not a dental implant.
- Functions normally in chewing and speech.

Dental services to repair the damage caused by accidental Injury must conform to the following time-frames: Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan. Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Oral Surgery

Benefits are available for services provided by a licensed dentist or oral surgeon for treatment of fractures or dislocations of the jaw, removal of cysts or tumors in the mouth, surgical incisions to remove foreign bodies from mucosa, skin or subcutaneous alveolar tissue. Covered surgical expenses include surgeons' fees, consultation fees, anesthesia expenses and surgical dressings for outpatient use.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps, subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.

The following diabetes supplies are covered under the prescription drug program administered by Express Scripts (see the *Addendum – Prescription Drug Benefits* section of this SPD for more information about your prescription drug benefit).

- Blood glucose meters, including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Durable Medical Equipment (DME), Orthotics and Supplies

The Plan pays for Durable Medical Equipment (DME), Orthotics and Supplies that are:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.
- Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Bath chairs and portable commodes.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits available for unilateral and bilateral cochlear implementation for

severe to profound hearing loss. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.

- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets) without review for plagiocephaly diagnosis, shoe inserts, arch supports, shoes (standard or custom), lifts and wedges and shoe orthotics.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

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

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Service.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this *SPD*.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.
- Powered exoskeleton devices.

UnitedHealthcare will decide if the equipment should be purchased or rented.

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

Benefits for dedicated speech-generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are covered when medically appropriate for the condition.

You must obtain the Durable Medical Equipment or orthotics from the vendor UnitedHealthcare identifies or purchase it directly from the prescribing Physician.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment or orthotic covered when medically appropriate for the condition or due to normal growth process.

Disposable Medical Supplies

Disposable Medical Supplies are only covered when billed by Home Health Care agency (including any disposable supplies needed for use in conjunction with items of DME such as feeding machines or respiratory machines) or hospital.

Benefits for disposable medical supplies include:

- Durable Medical Equipment and supplies that are necessary for the effective use of the item/device (e.g., tubings, nasal cannulas, connectors and masks used in connection with DME).
- Surgical stockings or support hose if prescribed and require purchase through a medical supply company. limited to 6 pairs per calendar year.

Emergency Health Services - Outpatient

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

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

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

Hearing Aids

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

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

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

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

Benefits are limited to $5,000 every 36 months. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 15, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 15, *Glossary* for the definition of Skilled Care.

Benefits are limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services.

Hospice Care

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

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

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

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Benefits for an Inpatient Stay in a Hospital do not include Physician Services delivered at a facility operating as an adventure-based therapy program, boot camp program, outward bound program, wilderness therapy program, outdoor therapy program, alternative schooling/therapeutic boarding school program, or other similar program.

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

Injections in a Physician's Office

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections and growth hormone injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Lab, X-Ray and Diagnostics - Outpatient

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

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Limited to 18 Presumptive Drug Tests per calendar year.

Limited to 18 Definitive Drug Tests per calendar year.

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

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

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

Cholesterol check, PSA, pap smear, occult covered regardless of diagnosis.

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

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.

- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.

You are encouraged to contact the Claims Administrator/Care Coordination[SM] for assistance in locating a provider and coordination of care.

Neurobiological Disorders - Autism Spectrum Disorder Services

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

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

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

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

You are encouraged to contact the Claims Administrator/Care Coordination[SM] for assistance in locating a provider and coordination of care.

Nutritional Counseling

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

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

Some examples of such medical conditions include, but are not limited to:

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

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

Obesity Surgery

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

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

Lap Band surgery and follow-up adjustments are covered if the procedure meets the severe and morbid obesity guidelines.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 15, *Glossary* and are not Experimental or Investigational or Unproven Services.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

Covered Health Services include Genetic Counseling. Benefits are available for Genetic Testing following genetic counseling when ordered by the Physician and not part of any course of Assisted Reproductive Technology. Benefits for preventive services are described under *Preventive Care Services* in this section.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

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

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

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

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

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care benefits include:

- Adult immunizations based upon the recommendations of the CDC's Advisory Committee on Immunization Practices (ACIP), when performed in your doctor's office.
- Annual prostate cancer check for men age 40 and older.
- Annual well-woman exam and related testing.
- Annual mammogram for women age 35 and older.
- Bone density testing (age 65+).
- Colorectal cancer screening, including but not limited to fecal occult blood testing and flexible sigmoidoscopy, colonoscopy for members age 40 and older.
- Influenza virus vaccine, including FluMist nasal vaccine is covered.

- Services excluded from this 100% preventive care benefit, but covered under regular plan provisions if ordered by your doctor include but are not limited to: EKGs, chest x-rays, stress tests and bone density screenings under age 65.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 6, *Plan Highlights*, under *Covered Health Services*.

Please Note
Preventive care benefits must be billed by your health care provider using appropriate "v" codes and preventive codes. Covered services for preventive care that exceed the recommended limits or intervals will not be paid at 100%.

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

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

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

Please visit the preventive care website for a current list of covered preventive services **www.uhc.com/health-and-wellness/preventive-care**. For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Podiatrist Care

Covered services include treatment for illnesses and injuries of the foot, including appropriate surgeries, by a licensed podiatrist. Routine foot care provided in a podiatrist's office may be covered when necessary for severe systemic disease.

A 15 visit per calendar year limit applies to non-surgical podiatry care including orthotic services. The maximum does not apply to podiatry services related to surgery in a facility.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Benefits are limited to 60 visits per calendar year.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost. Replacements are covered when medically appropriate for the condition or due to normal growth process. Lost or stolen prosthetics and those less than 5 years old are not covered when replaced.

Benefits are available for repairs and replacement, except as described in Section 9, *Exclusions and Limitations,* under *Medical Supplies and Appliances*.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same

manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Breast reduction surgery for diagnosis of gynecomastia in men is a covered expense. Services are only covered in the presence of functional/physiological impairment.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedures. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 15, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedures.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment and massage therapy if rendered by physical therapist or Chiropractor.
- Naprapath (D.N.) therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Vision therapy – Only covered following diagnosis of cross-eyed or convergence insufficiency.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative

services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Covered Health Services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

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

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

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Benefits are limited to:

- Unlimited visits per calendar year for physical therapy.
- Unlimited visits per calendar year for occupational therapy.
- Unlimited visits per calendar year for speech therapy.
- Unlimited visits per calendar year for pulmonary rehabilitation therapy.
- 72 visits per calendar year for cardiac rehabilitation therapy.
- Unlimited visits per calendar year for cognitive rehabilitation therapy.
- Unlimited visits per calendar year for Manipulative Treatment.
- Unlimited visits per calendar year for vision therapy.
- Unlimited visits per calendar year for post-cochlear implant aural therapy.
- 15 visits per calendar year for Naprapath therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are

described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits that apply to certain preventive screenings are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

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

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

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

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

You are expected to improve to a predictable level of recovery.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 15, *Glossary*.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.

You are encouraged to contact the Claims Administrator/Care Coordination[SM] for assistance in locating a provider and coordination of care.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Temporomandibular Joint Dysfunction (TMJ)

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

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

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

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

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

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.

- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received by a Designated Provider or Network facility that is not a Designated Provider.

Benefits are also available for cornea transplants.

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

Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

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

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 15, *Glossary*. When Urgent Care services are

provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services*.

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility every calendar year.

The medical plan pays for the first pair of glasses or contacts after cataract surgery. Otherwise, no hardware coverage is available.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting following chemotherapy or a serious medical condition.

Benefits are limited to $1,000 lifetime maximum and one wig per calendar year.

SECTION 8 - CLINICAL PROGRAMS AND RESOURCES

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

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

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

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

Consumer Solutions and Self-Service Tools

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that Abbott Laboratories has available that may help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take prescription drug products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

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

NurseLine℠ is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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

SECTION 9 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 7, *Additional Coverage Details*.

For Medicare-eligible Covered Persons, payment for the following is specifically excluded from this plan:

- Any expense that is
  - Not a Eligible Expense; or
  - Beyond the limits imposed by Medicare for such expense; or
  - Excluded by name or specific description by Medicare; except as specifically provided under the "Covered Expenses" section or any other portion of this SPD.
- Any portion of a Covered Expense to the extent paid or payable by Medicare;
- Any benefits payable under one benefit of this Plan to the extent payable under another benefit of this Plan;

In addition, for all Covered Persons, the Plan does not pay Benefits for the below services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 7, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 6, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 6, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy, unless performed by a covered provider.
5. Rolfing.

6. Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 7, *Additional Coverage Details*.

7. Adventure-based therapy, boot camp programs, outward bound programs, wilderness therapy, outdoor therapy, alternative schooling, or similar programs.

Comfort and Convenience

Supplies, equipment and similar incidentals for personal comfort. Examples include:

1. Television.

2. Telephone.

3. Air conditioners.

4. Beauty/barber service.

5. Guest service.

6. Air purifiers and filters.

7. Batteries and battery chargers.

8. Dehumidifiers and humidifiers.

9. Ergonomically correct chairs.

10. Electric scooters.

11. Non-Hospital beds and comfort beds.

12. Devices and computers to assist in communication and speech except when covered as DME based on Care Coordination guidelines. This exclusion does not apply to dedicated speech-generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 7, *Additional Coverage Details*.

13. Home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia except as described under *Dental Services - Accident Only* in Section 7, *Additional Coverage Details*).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 7, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 7, *Additional Coverage Details*.

2. Preventive care, diagnosis, treatment of the teeth or gums. Examples include:

   - Extractions (wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 7, *Additional Coverage Details*.

3. Dental implants and braces.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 7, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Outpatient prescription drug coverage is excluded under the medical portion of the Plan because it is a separate benefit. Coverage of prescription drugs for outpatient use may be available under the prescription drug portion of the Plan which is administered by Express Scripts, not UnitedHealthcare. See *Addendum -- Prescription Drugs Benefits* for coverage details and exclusions.

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by the UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion that are contracted with a

specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Certain new Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 7, *Additional Coverage Details*.

6. Compounded drugs that contain certain bulk chemicals including compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 15, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 7, *Additional Coverage Details*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

2. Treatment of flat feet.

Medical Supplies and Appliances

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

2. Tubings, nasal cannulas, connectors and masks that are not used in connection with DME.

3. Orthotic appliances that straighten or re-shape a body part (including some types of braces) when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 7, *Additional Coverage Details*. Examples of excluded orthotic appliances and devices include, but are not limited to any orthotic braces available over-the-counter. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

4. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 7, *Additional Coverage Details*.

5. Powered and non-powered exoskeleton devices.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 9, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services in Section 7, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services.

8. Adventure-based therapy, boot camp programs, outward bound programs, wilderness therapy, outdoor therapy, alternative schooling, or similar programs.

9. Non-Medical 24-Hour Withdrawal Management.

10. High intensity residential care for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment, based on *American Society of Addiction Medicine (ASAM)* criteria.

Nutrition and Health Education

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to medical or behavioral/mental health related education services as described in *Physician Office Services – Sickness and Injury*, in Section 7, *Additional Coverage Details*.

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to medical education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

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

3. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.

4. Foods that are not covered include:

   - Enteral feedings and other nutritional and electrolyte formulas, including when administered using a pump, infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. This means medical foods taken orally or by nasal or abdominal tube, including Ensure and other over the counter nutritional supplements, are also covered if prescribed by a Physician due to diagnosed injury or disease and if the patient is unable to meet nutritional

requirements with a normal diet. Infant formula available over the counter is always excluded.
- Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
- Oral vitamins and minerals.
- Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
- Other dietary and electrolyte supplements.

5. Health club memberships and programs, and spa treatments.

6. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, tobacco cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 15, *Glossary*. Examples include:

   Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 7, *Additional Coverage Details*.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 7, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

2. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

3. Therapies for the purpose of general well-being or conditioning in the absence of a disabling condition.

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

5. Rehabilitation services for speech therapy, except when required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 7, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

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

8. Chelation therapy, except to treat heavy metal poisoning.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

10. Sex transformation operations and related services.

11. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 7, *Additional Coverage Details*.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis).

13. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, oral appliances (orthotic splints), Doppler

analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

14. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 7, *Additional Coverage Details*.

15. Helicobacter pylori (H. pylori) serologic testing.

16. Intracellular micronutrient testing

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

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

5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. The following services related to a Gestational Carrier or Surrogate:

    - Fees for the use of a Gestational Carrier or Surrogate.
    - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
    - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

5. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 11, *Coordination of Benefits (COB).*

2. Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.

3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

4. While on active military duty.

5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants,

   - except as identified under *Transplantation Services* in Section 7*, Additional Coverage Details*.
   - not consistent with the diagnosis of the condition.

2. Health services for transplants involving animal organs.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Travel or transportation expenses. For grandfathered non-Medicare eligible Dependents, travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 7, *Additional Coverage Details*.

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses (except for the first pair of either glasses or contact lenses after cataract surgery and contact lens and related charges for the diagnosis of Aphakia).

3. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing
   - Services, supplies or equipment that are advertised by the Provider as free.

3. Charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency.

4. Charges prohibited by federal anti-kickback or self-referral statutes.

5. Chelation therapy, except to treat heavy metal poisoning.

6. Custodial Care as defined in Section 15, *Glossary*, or services provided by a personal care assistant.

7. Diagnostic tests that are:

- Delivered in other than a Physician's office or health care facility.
- Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

8. Domiciliary Care, as defined in Section 15, *Glossary*.

9. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 15, *Glossary*.
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.

10. In the event a provider waives, does not pursue, or fails to collect the Coinsurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the Coinsurance and/or deductible are waived.

11. Foreign language and sign language interpretation services offered by or required to be provided by a Network or non-Network provider.

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

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

13. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded.

14. Private duty nursing received on an inpatient basis.

15. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 7, *Additional Coverage Details*.

16. Rest cures.

17. Speech therapy to treat stuttering, stammering, or other articulation disorders.

18. Speech therapy, except when required for treatment of a speech impairment or speech dysfunction that results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorder or a Congenital Anomaly, or is needed following the placement of a cochlear implant as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 7, *Additional Coverage Details*.

19. Manipulative Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies.

20. Long term (more than 30 days) storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery.

21. The following treatments for obesity:

    - Non-surgical treatment, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*.

22. Treatment of hyperhidrosis (excessive sweating).

23. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

SECTION 10 - CLAIMS PROCEDURES

What this section includes:

- How claims work.
- What to do if your claim is denied, in whole or in part.

Reasonable and Consistent Claims Procedures

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. The Plan Administrator has delegated to the Claims Administrators the final, discretionary authority to determine if an initial Benefits claim or appeal is payable under the terms of the Plan. The Plan Administrator retains the discretionary authority to determine whether a Retiree or Dependent is eligible for initial or continued enrollment in the Plan.

Any interpretation, determination, or other action of the Plan Administrator (or a Claims Administrator, as the delegate of the Plan Administrator) will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or its delegate will be based only on such evidence presented to or considered by the Plan Administrator or its delegate at the time they made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under the Plan constitutes agreement with and consent to any decisions that the Plan Administrator or its delegate make, in its sole discretion, and, further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

The Claims Administrator for medical Benefits is UnitedHealthcare. The Claims Administrator for outpatient prescription drug benefits (described in the *Addendum – Prescription Drug Benefits* section of this SPD) is Express Scripts.

Authorized Representatives

An authorized representative is someone who is designated by a Covered Person to act on his or her behalf on a benefit claim filed under the Plan. A Covered Person's authorized representative will be required by the Plan Administrator or Claims Administrator, as applicable, to produce evidence of his or her authority to act on behalf of the Covered Person that is acceptable to the Plan Administrator or Claims Administrator, as applicable, prior to the authorized representative taking any action on behalf of the Covered Person's claim. The Plan Administrator or Claims Administrator, as applicable, reserves the right to require a Covered Person to execute a form approved by the Plan Administrator or Claims Administrator, as applicable, appointing an individual as his or her authorized representative for purposes of filing claims and appeals under the Plan. If a party is not properly designated as an authorized representative under the Plan, as determined by the Plan Administrator or Claims Administrator in its discretion, the Plan Administrator and Claims Administrator generally will not communicate with that party with respect to any benefit claim or other attempted exercise of a Covered Person's rights under the Plan. With respect to any urgent

pre-service or concurrent care Plan Claim, a Covered Person's treating Physician or health care professional with knowledge of the Covered Person's medical condition may act as an authorized representative in exercising a Covered Person's claims and appeals rights under the Plan. An assignment of benefits by a Covered Person to a health care provider does not constitute a designation of an authorized representative for purposes of the Plan. In addition, the Covered Person must agree to grant his or her authorized representative access to his or her protected health information. The Covered Person should contact the Plan Administrator or applicable Claims Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

When to Submit a Claim

You should present your UnitedHealthcare identification card along with Your Social Security Medicare identification (if Medicare-eligible) on your first visit to the Physician or Hospital. Most providers will submit a claim with Medicare and UnitedHealthcare for you.

If your provider does not file your claim and if you receive a bill for Covered Health Services from a provider, you must send the bill to the Claims Administrator for processing, as described below. To make sure the claim is processed promptly and accurately, a completed claim form should be attached and mailed to the appropriate Claims Administrator.

A claim means any challenge, demand, allegation, assertion, dispute, or request that, in the Plan Administrator's or Claims Administrator's discretion, relates to any past, current, or future benefit, right, duty, or benefit amount potentially due to or possessed by (i) any Covered Person under the Plan, or (ii) any party that challenges or disputes his or her eligibility as a Covered Person under the Plan. A claim must include all information requested by the Plan Administrator or Claims Administrator, including information to be provided by the Covered Person's health care provider. A claim will be considered filed if a properly completed claim form or other written request is submitted to the Plan Administrator or Claims Administrator, as applicable, as described below. All information and medical records subsequently requested by the Plan Administrator or a Claims Administrator in connection with any claim shall be furnished as requested. Should the Plan Administrator or Claims Administrator contact the Covered Person for additional information, the Covered Person must respond with the required information in order for the claim to be processed by the Plan Administrator or Claims Administrator. Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered benefit claims that require processing under ERISA. If you wish to make a claim for Plan Benefits in accordance with ERISA, you must do so in writing to the Plan Administrator or Claims Administrator, as applicable.

How to File Your Claim

You can obtain a claim form for medical services by visiting **www.myuhc.com** or by calling the toll-free number on your ID card.

If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your (Retiree's) name and address.
- The patient's name, age and relationship to the Retiree.
- 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 any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

After the Claims Administrator has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

For prescription drug claims, see the *Addendum – Prescription Drug Benefits* section of this SPD.

International Claims

Medicare does not reimburse for foreign claims. This Plan will act as the primary payer for eligible services rendered outside of the U.S. for Medicare-eligible Covered Persons. To receive reimbursement for eligible foreign expenses, an international claim form must be completed and submitted, along with all appropriate documentation, to the International Claims unit. Contact UHC member services at 1-800-603-3813 for more information or to obtain an international claim form.

Payment of Benefits

Except as required by applicable law, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 11*, Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

Interests Not Transferable

No benefit, right, or interest of any Covered Person or beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person, except as permitted under the terms of a group insurance policy or as required (i) under a QMCSO, (ii) by a state plan for medical assistance approved under Title XIX of the Social Security Act; or (iii) by the tax withholding provisions of any applicable law. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, garnish, execute, or levy upon, or otherwise dispose of, any right to benefits payable hereunder shall be void. A Covered Person shall be permitted to direct the payment of Plan Benefits to a health care provider in accordance with procedures established by the Claims Administrator (see "Payment of Benefits" above); provided, however, that a direction to pay a health care provider shall not cause such health care provider to become a beneficiary under the Plan and shall not constitute an assignment of any right under the Plan or of any legal or equitable right to institute any court proceeding or to request or receive Plan documents under ERISA. The

Plan prohibits any Covered Person or beneficiary from assigning his or her right to bring suit under ERISA to a Physician or other health care provider who accepts assignments of claims. Nothing contained in this Summary Plan Description or the official Plan document shall be construed to make the Plan, the Plan Administrator, or any Employer liable to any third party to whom a Covered Person may be liable for medical care, treatment, or services.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms. (Prescription drug claims are not included in your Health Statement.)

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 15, *Glossary*, for the definition of Explanation of Benefits.

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:

- Provide information sufficient to identify the claim (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning).
- Explain the specific reasons for the denial (including the denial code and its corresponding meaning, as well as a description of the standard if any, that was used in denying the claim).
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review), including a statement of your rights to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal.
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental or Investigational Services or Unproven Services exclusions, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service for purposes of the 12-month deadline is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

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

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

For medical services, Mental Health Services, Autism Spectrum Disorder services, or Substance-Related and Addictive Disorders Services, 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 for medical services, Mental Health Services, Autism Spectrum Disorder services, or Substance-Related and Addictive Disorders Services that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

For prescription drug appeals, see the *Addendum – Prescription Drug Benefits* section of this SPD.

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.

(More details below)

Review of an Appeal

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

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

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation that will:

- Provide information sufficient to identify the claim (including the denial code and its corresponding meaning and a description of the standard, if any, that was used in denying the Claim).
- Explain the specific reasons for the appeal denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information.
- Provide a statement describing any second level appeal procedures offered by the Plan and your right to bring an action under ERISA Section 502(a).
- Provide a statement that, upon request and free of charge, the Plan will provide a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity or Experimental or Investigational Services or Unproven Services exclusion or other similar exclusion or limit.
- Information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process.

Filing a Second Appeal

Your Plan offers two mandatory levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare

within 60 days from receipt of the first level appeal determination. You will receive a written explanation of the decision on second level appeal that includes the types of information described above and a discussion of the decision.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Timing of Claim and Appeals Determinations

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

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

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 or is filed improperly, UnitedHealthcare must notify you within:	**24 hours**
If your request is incomplete, 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 benefit determination within:	**72 hours**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

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

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare 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:	**Original 15 days, or within 15 days if an extension is requested**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the 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

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare 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 pre-service claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan. You will be notified if an extension is necessary within the initial 15-day period.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare 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:	**Original 30 days, or within 15 days if an extension is requested**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the 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
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial post-service claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan. You will be notified if an extension is necessary within the initial 30-day period.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

If an on-going course of treatment was previously approved for a specific period of time or number of treatments and UnitedHealthcare decides to reduce or end the course of treatment early, UnitedHealthcare will notify you of its decision in time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

Eligibility, Enrollment, and Premium Payment Claims and Appeals Procedures

Eligibility, Enrollment, and Premium Payment Claims

Claims involving eligibility for coverage under the Plan, enrollment in the Plan, or your premium payment obligations under the Plan, are decided by the Abbott Laboratories Corporate Benefits Department. Either you or your authorized representative may file a claim in writing by contacting the Abbott Benefits Center at (844) 30-MY-ABC (844-306-9222) and requesting a claim form. You may submit the claim form to the mailing address or e-mail address below:

Abbott Laboratories
Attn: Abbott Benefits Practice Center – AB6B D-589
100 Abbott Park Road
Abbott Park Il 60064

Authorized representative authorization forms are available from the Corporate Benefits Department.

If your eligibility, enrollment, or premium payment claim is denied, you will receive a written notice from the Corporate Benefits Department within 30 days after the claim was received, as long as all needed information was provided with the claim.

Sometimes, additional time is necessary to process a claim because of circumstances beyond the Plan's control. If an extension is necessary, the Corporate Benefits Department representative will notify you in writing within the initial 30-day period of the reasons for the

extension and the date by which it expects to make a decision. The extension will be no longer than 15 days.

If the extension is necessary because you failed to provide all needed information, the notice of extension will describe the additional information required. You will have 45 days to provide the needed additional information. If all additional information is received within 45 days, the Corporate Benefits Department will notify you of its claim decision within 15 days after the information is received. If you do not provide all needed information within the 45-day period, the Corporate Benefits Department will deny the claim.

Any notification of denial will include the information described above in *Explanation of Benefits (EOB)*, to the extent applicable.

Appeals of Eligibility, Enrollment, and Premium Payment Claims

The Divisional Vice President, Compensation, Benefits of Abbott is the head of the Corporate Benefits Department and has discretionary authority to decide appeals of denied claims involving eligibility for coverage under the Plan, enrollment in the Plan, or premium payment obligations under the Plan. If your eligibility, enrollment, or premium payment claim is denied, you have the right to appeal this denial by writing to the Divisional Vice President at:

Divisional Vice President, Compensation and Benefits
Abbott Laboratories
Attn: Abbott Benefits Practice Center - AB6B D-589
100 Abbott Park Road
Abbott Park Il 60064

There is only one level of appeal for denied eligibility, enrollment, or premium payment claims.

You have 180 days from receipt of the denial notice to file an appeal. All appeals must be in writing and should include a copy of the claim denial letter. You may also submit written comments, documents, records, and any other information you possess that supports the position(s) taken in your appeal. You should provide any additional relevant information within two (2) weeks of the date on which you file your appeal to ensure that it is received by the Divisional Vice President in time to be considered in the review of your appeal.

The Divisional Vice President will provide a full and fair review of your claim and any supporting documentation you timely submit, including all comments, documents, records, and other information either not previously submitted or not considered in the initial decision. The Divisional Vice President will conduct an independent review of your claim; no deference will be afforded to the initial claim decision. Upon request and free of charge, you will also be provided reasonable access to and copies of all documents, records, and information relevant to your claim.

The Divisional Vice President will provide you with any new or additional evidence considered, relied on, or generated in connection with your appeal sufficiently in advance of the date on which the decision is due to give you a reasonable opportunity to respond. In

addition, the Divisional Vice President will provide you with any new or additional rationale for denying your appeal before issuing a final decision, and will allow you a reasonable opportunity to respond.

You will be notified of the Divisional Vice President's decision on appeal within 60 days after receipt of your appeal request. If your appeal is denied, the notification of denial will include the information described above in *Claim Denials and Appeals*, to the extent applicable.

Limitation of Action

You cannot bring any legal action against Abbott Laboratories, the Plan or its fiduciaries, or the Claims Administrator for benefits, to recover reimbursement, or for any other reason until all required reviews of your claim have been completed. Any further legal action taken against Abbott Laboratories, the Plan or its fiduciaries, or the Claims Administrator must be filed in a court of law by the earliest of: (i) 180 days after the final decision on the benefit claim under the Plan's claims and appeals procedures; (ii) three years after the date that the medical or dental treatment or service at issue in the legal action was provided by a Physician or other medical provider; or (iii) the statutory deadline for filing a claim or lawsuit with respect to the Plan benefits at issue in the judicial proceeding as determined by applying the most analogous statute of limitations for the State of Illinois. Otherwise, you will lose any rights to bring such an action against Abbott Laboratories, the Plan or its fiduciaries, or the Claims Administrator. In no case may a suit or legal action be brought if the claim for benefits was not made within the time period specified in the above claims and appeals procedures. This limitation on suits for benefits applies in any forum where a Covered Person (or his or her authorized representative) initiates a suit or legal action. If you decide to pursue any legal action relating to your claim, the evidence that you may present in your case will be strictly limited to the documents, information, and other evidence timely presented to the applicable Plan fiduciary in connection with the Plan's claims and appeal procedures, as described above.

SECTION 11 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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

- Medicare.
- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Other governmental health benefit.
- The California Unemployment Insurance Code or the Self-Insured Voluntary Plan for employees of an employer effective under the provisions of California Unemployment Insurance Code if such benefits are payable during hospital confinement.
- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See the order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

For Covered Persons Who 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. However, for Medicare-eligible individuals with end-stage renal disease (ESRD), the Plan pays Benefits first and Medicare pays benefits second for a limited period of time:

- If you are eligible for Medicare on the basis of ESRD, then for the first 30 months of your eligibility, this Plan will pay Benefits first.
- After the first 30 months that you are eligible for Medicare on the basis of ESRD, this Plan will pay Benefits secondary to Medicare.
- This switch in the primary and secondary payer will occur regardless of whether you actually apply for or enroll in Medicare.

Determining the Allowable Expense When this Plan is Secondary to Medicare

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

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

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

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

What Are the Rules for Determining the Order of Benefit Payments for Plans Other Than Medicare?

Order of Benefit Determination Rules

The order of benefit determination rules determine 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 do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each 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 so that payments from all plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person who is not Medicare-eligible is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When a Covered Person has coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. 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 a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One 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 or are 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, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
   (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.

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

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under 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 a health benefits plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Services by following the steps below.

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

The Covered Person will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment a Covered Person can receive from all plans may be less than 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the

reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two plans' reasonable and customary charges. If this Plan is secondary to Medicare, please also refer to the discussion in the section above, titled "Determining the Allowable Expense When this Plan is Secondary to 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 other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Does This Plan Have the Right of Recovery?

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 Eligible Expenses.

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

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on your account, 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 expenses incurred 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 refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for 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, future Benefits that are payable in connection with services provided to other Covered Persons under the Plan. 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.

SECTION 12 - SUBROGATION AND REIMBURSEMENT

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

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

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

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your Employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you, and you will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your Dependents or the Retiree, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery

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

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

SECTION 13 - WHEN COVERAGE ENDS

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

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

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

Your coverage under the Plan will end on the earliest of:

- The date the Plan ends.
- The date you stop making the required contributions.
- The date you are no longer eligible.
- The date UnitedHealthcare receives written notice from Abbott Laboratories to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends (other than due to your death).
- The date you stop making the required contributions.
- The date UnitedHealthcare receives written notice from Abbott Laboratories to end your coverage, or the date requested in the notice, if later.
- The date your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan reserves the right to retroactively cancel your coverage due to fraud or intentional misrepresentation of material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Fraud

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an

event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's fraudulent claim. These actions may result in termination of the Covered Person's coverage under the Plan and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate Claims. If someone else - such as your spouse or another family member – files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-866-242-7727. All calls are strictly confidential.

Note: If UnitedHealthcare and Abbott Laboratories find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Abbott Laboratories has the right to demand that you pay back all Benefits Abbott Laboratories paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Continuing Coverage Through COBRA

Under certain conditions you, your Spouse or other covered Dependents may elect to continue medical plan coverage for a limited period beyond the date it would otherwise stop - with the cost of coverage paid by you or your Dependent. This continuation coverage, which is offered in compliance with the Consolidated Omnibus Budget Reconciliation Act, is commonly called COBRA.

This COBRA coverage is available to:

- Your Spouse, upon divorce or separation.
- Your children, when they no longer qualify as eligible Dependents under the Abbott Laboratories Retiree Health Care Plan
- You and your eligible Dependents, if coverage stops due to Abbott's commencement of a bankruptcy proceeding.

If you or your Dependent becomes eligible for coverage under this provision, the COBRA Administrator will send you a notice of the right to continue coverage, information on the cost of continuing coverage and a form for electing coverage.

The COBRA Administrator is:

Abbott Benefits Center
P.O. Box 564110
Charlotte, NC 28256-4110

(844) 30-MY-ABC (844-306-9222)

Continuation of Coverage for Domestic Partners

The Plan Sponsor voluntarily provides continuation of coverage benefits to Domestic Partners (and their eligible children). The Domestic Partner of a covered Retiree (and any eligible Dependent child) who was covered under the Plan on the day before a qualifying event and who lost coverage under the Plan as a result of a qualifying event will have the same options as a similarly-situated legal Spouse or Dependent stepchild, as applicable, of a covered Retiree to continue coverage under the federal COBRA rules. For this purpose, a termination of a Domestic Partnership is considered equivalent to a divorce or legal separation.

If You Are the Covered Spouse of an Abbott Retiree

If you are the Spouse of a Retiree covered by the Plan, you have the right to choose continuation coverage under the Plan for any of the following reasons:

- A change in your Spouse's employment status with Abbott that makes your Spouse ineligible for coverage (for example, termination of eligibility for Long-Term Disability Plan benefits).
- Divorce or legal separation from your Spouse.

- If your coverage is dropped during an annual open enrollment in anticipation of a divorce or legal separation.

You or your Spouse must notify the Abbott Benefits Center (the COBRA Administrator), in writing, within 60 days after the loss of eligibility due to divorce, legal separation to preserve your rights under COBRA.

If You Are the Covered Child of an Abbott Retiree

If you are the Dependent child of a Retiree covered by the Plan, you have the right to choose continuation coverage under the Plan for any of the following reasons:

- A change in your parent's employment status with Abbott that makes your parent ineligible for coverage (for example, termination of eligibility for Long-Term Disability Plan benefits).
- Your parents' divorce or legal separation.
- You cease to be a "Dependent child" under the terms of the Plan.

A child born to or placed for adoption with a COBRA participant who is a Retiree or a Retiree's Spouse during the period of continuation coverage is also eligible for coverage for the remainder of the continuation period as long as the COBRA Administrator is properly notified.

You or your parent must notify the Abbott Benefits Center, in writing, within 60 days after the loss of eligibility due to divorce, legal separation, or loss of Dependent child status to preserve your rights under COBRA.

What You Need to Do

You, your Spouse/Domestic Partner or your child must notify the Abbott Benefits Center within 60 days after the loss of eligibility (that is, within 60 days after the divorce date or the date a child's eligibility ends) to preserve your rights under COBRA. Upon notification, the COBRA Administrator designated by the company will send a notice of the right to continue coverage, information on the cost of continuing coverage and a form for electing coverage.

You or your former Dependent(s) must elect to continue coverage within 60 days after the notice of the right to continue coverage is received (or after the date the coverage terminated, if later). You will have an additional 45 days to pay the back premium necessary to avoid a break in coverage. If coverage is not elected during this 45-day grace period, it will not be offered again.

Your costs for this coverage will be on an after-tax basis. As long as premiums are paid, coverage can continue up to:

- 36 months if dependent coverage stops for any reason other than Abbott's bankruptcy.
- Your death if coverage ends due to Abbott's bankruptcy.
- 36 months for your Dependents following your death, if coverage ends due to Abbott's bankruptcy. An 18-month period of continuation coverage may be extended for up to 11

months (for a total of up to 29 months of continuation coverage) if you or your covered dependent is determined to be disabled for Social Security disability purposes at the time of the loss of coverage or within 60 days after that date. The Plan Administrator must be notified before the end of the 18-month period.

COBRA coverage will stop earlier if:

- The required premiums are not paid in time.
- You or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends (whichever comes first).
- You or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA.
- During a 29-month extension due to disability, there is a final determination that you are no longer disabled. The Plan Administrator must be notified within 30 days of any such determination.
- The Abbott Laboratories Retiree Health Care Plan and all other Abbott health plans end.

Coverage Provided Under COBRA

If you choose continuation coverage, you are entitled to be provided with coverage that is identical to the coverage provided under the Plan to similarly situated Retirees or their family members. Individuals with COBRA coverage receive annual open enrollment information each fall and have the same opportunities to change coverage for the following calendar year as eligible Retirees.

COBRA Coverage and Medicare

If you or your dependent becomes entitled to Medicare prior to electing COBRA coverage, you or your Dependent may still elect COBRA coverage. Medicare is treated as the primary coverage and COBRA is treated as the secondary coverage, regardless of whether you or your Dependent has enrolled in Medicare coverage. Because of this, it is important to enroll in Medicare Benefits when the COBRA qualifying event occurs, if you or your Dependent had not enrolled when first eligible.

If you or your Dependent becomes entitled to Medicare after COBRA was elected, COBRA coverage ends.

SECTION 14 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with UnitedHealthcare and Abbott Laboratories.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Your Relationship with UnitedHealthcare and Abbott Laboratories

In order to make choices about your health care coverage and treatment, Abbott Laboratories believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

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

UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Abbott Laboratories and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and the Plan and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

Neither the Plan nor UnitedHealthcare provide health care services or supplies, nor do they practice medicine. Instead, The Plan and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare credentialing process confirms public information about the providers' licenses and other

credentials, but does not assure the quality of the services provided. They are not Abbott Laboratories or Plan employees, nor are they employees of UnitedHealthcare. None of Abbott Laboratories, the Plan, or UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan or of Abbott Laboratories for any purpose with respect to the administration or provision of benefits under this Plan.

Abbott Laboratories, as the Plan Sponsor and Plan Administrator, is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

The Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Abbott Laboratories is that of employer and retiree/former employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

Abbott Laboratories and UnitedHealthcare have the exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.

- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Abbott Laboratories and UnitedHealthcare may delegate this discretionary authority to other persons or entities including UnitedHealthcare's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and UnitedHealthcare's discretion. In order to receive Benefits, you must cooperate with those service providers.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

Information and Records

Abbott Laboratories and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, and as otherwise permitted or required by law. UnitedHealthcare may use your individually identifiable health information to identify procedures, products, or services that you may find valuable, Abbott Laboratories and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Abbott Laboratories and UnitedHealthcare will keep this information confidential. UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Abbott Laboratories and UnitedHealthcare with all information or copies of records relating to the services provided to you. Abbott Laboratories and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Retiree's enrollment form. Abbott Laboratories and UnitedHealthcare agree that such information and records will be considered confidential.

Abbott Laboratories and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Abbott Laboratories or the Plan is required to do by law or regulation. UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Abbott Laboratories recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, Abbott Laboratories and UnitedHealthcare will designate other persons or entities to request records or information on its behalf from or related to you, and to release those records as necessary.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various UnitedHealthcare wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 8, *Clinical Programs and Resources*.

Rebates and Other Payments

Abbott Laboratories and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This

includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Abbott Laboratories and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan and the Retiree Health Care Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan or the Retiree Health Care Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A Plan change may transfer Plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

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

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

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 15 - GLOSSARY

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

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

Abbott - Abbott Laboratories and its participating subsidiaries and affiliates.

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

Allowable Expense - the amount of a health care expense for a Covered Health Service under this Plan that is used to determine Plan Benefits for coordination of benefits purposes. See Section 11, *Coordination of Benefits (COB)*.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility). A facility operating as an adventure-based therapy program, boot camp program, outward bound program, wilderness therapy program, outdoor therapy program, alternative schooling/therapeutic boarding school program, or other similar program is not considered an Alternate Facility.

Annual Deductible (or Deductible) - the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 6, *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums.

BMI - see Body Mass Index (BMI).

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare) and its affiliates, who provide certain claim administration services for the Plan. Mental Health/Substance-Related and Addictive Disorders Services under the Plan are generally administered by Optum Behavioral Health, an affiliate of UnitedHealthcare.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 4, *How the Plan Works and* the *Addendum – Prescription Drug Benefits* section.

Company - Abbott Laboratories.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees/retirees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services or supplies, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services or their symptoms.

- Included in Section 6, Plan Highlights and Section 7, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction to the Retiree Medical Plan*.
- Not identified in Section 9, *Exclusions and Limitations*.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Retiree or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction to the Retiree Medical Plan*. A Dependent does not include anyone who is also enrolled as a Retiree or an Employee who is enrolled in the Abbott Laboratories Health Care Plan. No one can be a Dependent of more than one Retiree.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Retiree has established a Domestic Partnership.

Domestic Partnership - a relationship between a Retiree and one other person of the same or opposite sex that meets the requirements described under *Eligibility* in Section 2, *Introduction to the Retiree Medical Plan.*

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses –

For non-Medicare Covered Persons: Eligible Expenses shall mean charges for Covered Health Services incurred while the Plan is in effect. Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 4, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

For Medicare-eligible Covered Persons: Eligible Expenses shall mean the allowable amount in the Medicare plan that a Physician or supplier can be paid, including what Medicare pays and any Deductible, Coinsurance or Copayment that you pay (*i.e.*, the Medicare approved amount). It may be less than the actual amount charged by a Physician or supplier. Eligible Expenses for Medicare-eligible Covered Persons are determined by UnitedHealthcare as stated above and as detailed in Section 4, *How the Plan Works*.

For purposes of clarity, Eligible Expenses for Medicare-eligible Covered Persons only apply to expenses of the kind covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare. Payment of benefits under the Plan for Eligible Expenses for Medicare-eligible Covered Persons will be based on the same payment conditions and determinations of medical necessity as are applicable under Medicare.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Employee - an employee of an Employer who is eligible to participate in the Abbott Laboratories Health Care Plan. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer - Abbott Laboratories and its participating affiliates that adopt the Abbott Laboratories Retiree Health Care Plan. To determine whether your employer participates in the Abbott Laboratories Retiree Health Care Plan, contact the Abbott Benefits Center.

ERISA - see *Employee Retirement Income Security Act of 1974 (ERISA).*

Experimental or Investigational Service(s) – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 7, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 7*, Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.

- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Green Group - The Abbott "Green Group" consists of Employees of (i) Tendyne Holdings, Inc., Tendyne Medical, Inc., Topera, Inc., and the Abbott Electroyphysiology division, Abbott Medical Devices division (with the exception of Abbott Diabetes Care), including the Vascular division, Abbott Structural Heart division, Cardiac Arrhythmias and Heart Failure division, Cardiac Rhythm Management division, Heart Failure division and Neuromodulation division (and any successor groups, entities, divisions or businesses) hired or rehired on or after March 1, 2017, (ii) employees of the Rapid and Molecular Diagnostics business other than employees of the Abbott Molecular, Point of Care or Informatics divisions hired or rehired on or after January 1, 2021 (or January 1, 2018, in the case of Rapid Diagnostic division employees other than employees of Alere Inc. or any of its subsidiaries), and (iii) employees of St. Jude Medical, LLC, Alere Inc. or Cephea Valve Technologies, Inc. or any of their respective subsidiaries (and any successor entities) who were either employed as of the date of acquisition by Abbott or hired or rehired afterwards (even if the employee later transfers to a non-"Green Group" employer).

Green Group employees also generally include employees who transfer from a foreign affiliate after previously working for a Green Group employer in the U.S.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital does not include a facility operating as an adventure-based therapy program, boot camp program, outward bound program, wilderness therapy program, outdoor therapy program, alternative schooling/therapeutic boarding school program, or other similar program.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital. A Hospital-based Facility does not include a facility operating as an adventure-based therapy program, boot camp program, outward bound program, wilderness therapy program, outdoor therapy program, alternative schooling/therapeutic boarding school program, or other similar program.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law. An Inpatient Rehabilitation Facility does not include a facility operating as an adventure-based therapy program, boot camp program, outward bound program, wilderness therapy program, outdoor therapy program, alternative schooling/therapeutic boarding school program, or other similar program.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related issues and mental health.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Lifetime Maximum Benefit – The maximum amount the Plan will pay for Covered Health Services (including prescription drugs) during a Covered Person's lifetime, as described in *Lifetime Maximum Benefit* under Section 4, *How the Plan Works*.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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.

While it may be beneficial for Covered Persons to use Network providers to take advantage of discounted charges, this Plan does not have a Network versus non-Network Benefit level.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment - the period of time, determined by Abbott Laboratories, during which eligible Retirees may enroll themselves and their Dependents under the Plan. Abbott Laboratories determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - this is the maximum amount you pay for Covered Health Services every calendar year. Your payments toward the Annual Deductibles, Copayments, and Coinsurance are used to satisfy your Out-of-Pocket Maximum. If a Covered Person reaches the applicable Out-of-Pocket Maximum during a calendar year, the Plan will pay 100 percent of remaining Eligible Expenses for that Covered Person (and, if applicable, for the Covered Person's covered family members) during the rest of the calendar year. The combined Eligible Expenses of all family members is applied in determining when a per-family Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum and will not be paid at 100 percent after the Out-of-Pocket Maximum is reached:

- Charges for non-covered services
- Charges that exceed Eligible Expenses

Separate Out-of-Pocket Maximum may apply to specific expenses, such as outpatient prescription drugs.

Refer to Section 6, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 4, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Retiree Indemnity Plan coverage option under the Abbott Laboratories Retiree Health Care Plan. The Retiree Indemnity Plan is the retiree medical coverage option available to Retirees and Dependents who are Medicare-eligible.

Plan Administrator – The Corporate Benefits Department of Abbott Laboratories or its designee as that term is defined under ERISA.

Plan Sponsor - Abbott Laboratories.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or in a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.
- Non-skilled services when skilled nursing resources are available in the facility.
- The Skilled Care can be provided in the home by a Home Health Agency on a per visit basis for a specific purpose.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which

are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The treatment plan will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment approved by the Claims Administrator under the active participation and direction of a Physician and approved by the Claims Administrator.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital. Residential Treatment does not include adventure-based therapy, boot camp programs, outward bound programs, wilderness therapy, outdoor therapy, alternative schooling/therapeutic boarding school programs, or similar programs.

Retiree - a former Abbott Employee who is eligible to participate in the Abbott Laboratories Retiree Health Care Plan, as described under *Eligibility* in Section 2, *Introduction to the Retiree Medical Plan*. This SPD describes benefits available to Retirees who are eligible for Medicare.

Retiree Health Care Plan – the Abbott Laboratories Retiree Health Care Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan. A Skilled Nursing Facility does not include a facility operating as an adventure-based therapy program, boot camp program, outward bound program, wilderness therapy program, outdoor therapy program, alternative schooling/therapeutic boarding school program, or other similar program

Spouse – The Retiree's legal spouse as defined by the state in which the Retiree marries, provided he or she is not covered as a Retiree under the Abbott Laboratories Retiree Health Care Plan. A Spouse does not include an individual from whom the Retiree has obtained a legal separation or divorce.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised

apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services – health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. An Urgent Care Center does not include a facility operating as an adventure-based therapy program, boot camp program, outward bound program, wilderness therapy program, outdoor therapy program, alternative schooling/therapeutic boarding school program, or other similar program.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under *ERISA*.

This section includes information on the administration of the Plan and the Abbott Laboratories Retiree Health Care Plan, as well as information required of all Summary Plan Descriptions by *ERISA* as defined in Section 15, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Abbott Laboratories is the Plan Sponsor and Plan Administrator of the Abbott Laboratories Retiree Health Care Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Corporate Benefits Department
ATTN: Divisional Vice President, Compensation and Benefits
Abbott Laboratories
100 Abbott Park Road, DEPT 0589 AP6B-2
Abbott Park, IL 60064-6222
224-667-6100

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent For Service Of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Divisional Vice President, Compensation and Benefits
Abbott Laboratories
100 Abbott Park Road
Abbott Park, IL 60064-6222

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party Claims Administrators.

Plan Name:	Abbott Retiree Indemnity Plan The Retiree Indemnity Plan is a coverage option offered under the Abbott Laboratories Retiree Health Care Plan
Plan Number:	571
Employer Tax ID Number:	36-0698440
Plan Type:	Welfare benefits plan
Plan Year:	January 1 - December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Retiree and Company
Source of Benefits:	Assets of the Company and Internal Revenue Code Section 401(h) trust account

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided under *How to Appeal a Denied Claim* in Section 10, *Claims Procedures*.
- Receive a summary of the Abbott Laboratories Retiree Health Care Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 10, *Claims Procedures*, for details.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. You may not initiate any legal action to recover benefits under the Plan until you have followed the Plan's internal claims and appeal process (described in Section 10, *Claims Procedures*) and the requested Plan benefits have been denied in whole or in part. You must start legal action to recover benefits under the Plan no later than 180 days after the date you have completed the Plan's claims and appeals process and have received a final decision regarding your claim or, if earlier, the date that is three years after the medical or dental treatment or service at issue was provided or the statutory deadline for filing suit with respect to the Plan benefits at issue under the most analogous statute of limitations for the State of Illinois. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

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

Benefits Security Administration, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the *Employee Benefits Security Administration* at 1-866-444-3272.

The Plan's Benefits are administered by Abbott Laboratories, the Plan Administrator. The Claims Administrators processes claims for the Plan and provide appeal services; however, the Claims Administrators and Abbott Laboratories are not responsible for any decision you or your Dependents make to receive treatment, services or supplies from a provider The Claims Administrators and Abbott Laboratories are neither liable nor responsible for the treatment, services or supplies you receive from providers.

ATTACHMENT I - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT II – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT III – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏇ ᎨᏢ ᏗᏟᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᎣᏏ ᏩᏙᏢ ᏙᎯ ᎨᏒ ᏗᎫᎪᏙᏗ ᎪᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏧᏐᏅᏍᏓ 0. TTY 711

Language	Translated Taglines
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.

Language	Translated Taglines
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါခွဲးတါယာ်လၢနကဉ်းန့ါဘဉ်တါမၤစၢးဒီးတါဂ့ါတါကျိုလၢနကျိုဉ်ဒဉ်နဲ့ဝဲလၢတလိဉ်ဟုဉ်အ ပူၤဘဉ်နှဉ်လီၤ.လၢတါကယွန့ါပှၤကတီၤကျိုးထံတါတဂၤအဂီၢ်ကီးဘဉ်လီတဲစီအကျိုလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတါအိဉ်ဆူဉ်အိဉ်ချုအတါရဲဉ်တါကဲ့ အကးအလီၤဒီးဆီဉ်လီၤနိ်ါဂ့ါ 0 တကွံ.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711

Language	Translated Taglines
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yínikeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíilchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**

Language	Translated Taglines
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711

Language	Translated Taglines
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܝܬܠܘܟ ܐܒܬܠܡܘܟ ܝܗܘܒܬܐ ܕܡܥܠܝܬܘܢ ܫܝܢܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܟܪܬܐܝܬ ܠܡܫܡܥܝܐ ܡܢ ܝܢ ܡܠܦܢ ܠܡܠܦܢܐ، ܡܢܘܢ ܥܠ ܡܢܝܢܐ ܬܠܝܦܘܢ ܕܐܝܠܗ ܟܠܝܒܬܐ ܥܠ ܦܬܩܐ ܕܣܘܠܚܢܐ ܘܡܚܝ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711

Language	Translated Taglines
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM – PRESCRIPTION DRUG BENEFITS

Express Scripts Medicare administers prescription drug benefits and is the prescription drug Claims Administrator for the Plan. Express Scripts is not affiliated with UnitedHealthcare.

Express Scripts Medicare (PDP) Pharmacy Network

You can purchase a prescription at a non-network pharmacy without a reduction in your benefit level. If you purchase a prescription at a non-network pharmacy, you must pay the total cost of your prescription at the time of purchase and must file a claim for reimbursement from the Claims Administrator as described below:

Express Scripts

Attn: Medicare Part D

P.O. Box 14718

Lexington, KY 40512-4718

Appeals on Prescription Drug Claims (Express Scripts)
Express Scripts
Attn: Medicare Appeals
P.O. Box 66588
St. Louis, MO 63166-6588

Call: 1.844.374.7377 (1.844.ESI.PDPS)
TTY: 1.800.716.3231
Fax: 1.877.852.4070
Hours: 24 hours a day, 7 days a week

Appeals on Prescription Drug Claims (Express Scripts Medicare (PDP_)		
Type of Claim	**Level One Appeal**	**Level Two Appeal**
Urgent care or Concurrent	Express Scripts Final Decision within 72 hours	Abbott Laboratories* Final Decision within 72 hours
Pre-service	Express Scripts Response within 30 days	Abbott Laboratories* Final decision within 15 days
Post-service	Express Scripts Response within 30 days	Abbott Laboratories* Final decision within 30 days

*** Direct Level Two appeals to:**
Abbott Laboratories, D589, AP6B, 100 Abbott Park Road, Abbott Park, IL 60064-6214

To view a list of Network providers, go to Express Scripts' member web site at **www.express-scripts.com/medd/abbott**. You may also request information about pharmacy providers in your geographic area from Express Scripts Customer Service by calling (800) 935-7197.

Express Scripts ID Card

A separate prescription drug card will be provided to you from Express Scripts. You should use this prescription drug card each time you make a retail purchase from a participating pharmacy. Participating pharmacies provide Covered Persons with preferred pricing. When you use network providers, you pay only your deductible and/or coinsurance amount. There is no need to file a claim form.

Pharmacy Benefits

Annual Deductible

You must pay a prescription drug deductible of $100 per person or $200 per family each calendar year before the Plan begins to pay benefits for retail and/or mail service and specialty prescription drugs. This deductible is separate from and cannot be used to satisfy annual deductibles for other (non-prescription drug) covered health care expenses.[4]

Prescription Drug Out-of-Pocket Limit

There are annual out-of-pocket limits of $1,500 per person and $3,000 per family for prescription drugs.[5] Once your out-of-pocket limit is met, the Plan will pay 100 percent of charges for eligible prescription drugs for the remainder of the calendar year. Copayments, deductibles and coinsurance for other covered health services do not apply toward your prescription drug out-of-pocket limit.

Retail Purchases

Retail pharmacy purchases are limited to a 90-day supply. Once your annual deductible has been satisfied, you pay:

Retail (30 days)	You pay 25%, minimum $5 generic, $15 brand, maximum payment of $150 per prescription
Retail (90 days)	You pay 25%, minimum $15 generic, $45 brand, maximum payment of $150 per prescription

Express Scripts Pharmacy Home Delivery

Mail Service delivery is available for maintenance or long-term prescriptions. You may order up to a 90-day supply of your medications. When you use mail service you pay:

Mail (90 days)	You pay 20%, minimum $15 generic, $35 brand, maximum payment of $150 per prescription

[4]If you are covering family members who are not eligible for Medicare, separate individual and family drug deductibles will apply for Medicare-eligible family members and family members who are not eligible for Medicare.

[5]If you are covering family members who are not eligible for Medicare, separate individual and family drug out-of- pocket limits will apply for Medicare-eligible family members and family members who are not eligible for Medicare.

Filling Prescriptions

At a network pharmacy

To fill your prescription at a network retail pharmacy, you must show your member ID card. If you do not have your member ID card with you when you are at the pharmacy, you should ask the pharmacist to use Medicare's inquiry system to check your eligibility and membership status with your plan. If the pharmacy is unable to confirm your eligibility, you will have to pay the full cost of the prescription (rather than just paying your copayment or coinsurance). You can request reimbursement of the plan's share of the cost by submitting a paper claim to Express Scripts Medicare. You can get a paper claim form by visiting our website or by calling Customer Service.

Through our Pharmacy Home Delivery

You can use our home delivery pharmacy service, to fill prescriptions for most drugs on the Drug List. Home delivery is most appropriate for drugs that you take on a regular basis for a chronic or long-term medical condition. Usually, a home delivery pharmacy order from Express Scripts will get to you within 10 days. Some drugs that cannot be purchased through our home delivery service include medications with limited distribution and compound medications. It's also more appropriate to use a network retail pharmacy for drugs used for a short period of time (1 month or less) and drugs needed immediately for the treatment of a severe medical condition. Other home delivery pharmacies are available in our network and

they may have their own policies regarding prescriptions by mail. We suggest that you contact those pharmacies directly for any requirements they may have.

This plan may also provide coverage for specialty medications. If you require specialty medications to treat complex conditions, such as cancer, hepatitis C, hemophilia and multiple sclerosis, and want to use home delivery, consider asking your prescriber to send those prescriptions directly to Accredo, the Express Scripts specialty pharmacy. For more information, please have your prescriber visit www.accredo.com for referral forms, contact information by therapy and e-prescribing instructions.

See below for instructions for filling a prescription using our home delivery service by mail, electronically and fax. To get order forms and information, please visit our website or call Customer Service. Please note that you must use an in-network home delivery pharmacy. Prescription drugs that you get through any out-of-network home delivery. Express Scripts Medicare Resources

You may register at **www.express-scripts.com/medd/abbott** for access to Express Scripts' online self- service tools and health information, including a directory of network providers. Or, if you prefer, contact Express Scripts Patient Customer Service at (800) 935-7197.