UNISYS

Unisys Medical Plan

Summary Plan Description and Plan Document for Unisys Medical, Dental and Vision Plans

Effective January 1, 2015

2015

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INTRODUCTION

This document is the Summary Plan Description (SPD) for the Unisys Medical Plan. It provides details on the medical benefits offered to you as an eligible associate of Unisys Corporation (Unisys) and its participating affiliates (the Company).

This document also serves as the plan document for the Unisys Medical Plan (the Plan, the Medical Plan or the Consumer Health Plan) and the Unisys Dental and Vision Plans. Complete details of the Dental and Vision Plans are found in the SPDs for those Plans, which are incorporated into this document by reference. Depending on the context, "Plan" refers to the Medical Plan or to the Medical, Dental and Vision Plans collectively.

Health Savings Accounts (HSAs) are briefly described in this SPD, even though they are available outside the Medical Plan and are not part of an employer-sponsored welfare benefit plan for purposes of the U.S. Employee Retirement Income Security Act of 1974, as amended (ERISA).

Throughout this SPD, "you" is used to refer to both an eligible covered associate and an eligible covered dependent.

This SPD contains Plan provisions as of January 1, 2015. It replaces and supersedes all previous SPDs and summaries of material modifications including, but not limited to, Plan changes described in Annual Enrollment materials issued prior to January 1, 2015.

If you have questions about this SPD or any of your benefits, you can call the Unisys Benefits Service Center (USBC) toll-free at **877-864-7972**, Monday through Friday (except holidays) from 9:00 AM to 5:00 PM Eastern Time or you can find information online at **http://resources.hewitt.com/unisys**.

Any materials about the Medical Plan distributed to new hires and during future post-2015 Annual Enrollments that say they are Summaries of Material Modifications (SMMs) of this SPD (including, but not limited to, required associate contributions for medical coverage and available discounts and surcharges) are incorporated by reference into this SPD.

The provision of benefits by the Company does not imply the creation of a contract of employment or an obligation to continue the present or future level of benefits.

Note: Because Unisys cannot give legal, financial or tax advice, you are strongly urged to consult your own personal legal, financial, and tax advisors before you take any action under the Plan.

You may request a hard copy of SPDs, free of charge, through any one of the following methods:

- Submit your request to "Ask HR"
- Email the HR Service Center at ~HRSC or **HRSC@unisys.com**
- Call the HR Service Center at 888-560-1782, Monday through Friday (except holidays), 9 a.m. to 6 p.m. Eastern Time
- Mail your request to: Unisys Corporation, 1133 College Drive, Bismarck, ND 58501

ELIGIBILITY AND ENROLLMENT

This chapter applies to the Medical Plan. Eligibility and enrollment information for the Dental and Vision Plans can be found in the SPDs for those Plans.

ELIGIBILITY

YOU

You may participate in the Medical Plan if you are a regular full-time or regular part-time associate of the Company. A regular full-time associate has a regular work schedule of 30 or more hours per week. A regular part-time associate has a regular work schedule of at least 20 but less than 30 hours per week.

WHO IS NOT ELIGIBLE

You are not eligible to participate in the Plan described in this SPD if any of the following apply:

- You are employed by a U.S. subsidiary of Unisys that does not participate in the Plan (separate documents describe your benefits).
- Your terms of employment are covered by a collective bargaining agreement or other contractual agreement that does not provide for participation in the Plan. To the extent your contract includes coverage under the Plan described in this SPD, you are eligible for the provisions described in this SPD.
- You are in a temporary employment status.
- You are an independent contractor or other person who is not treated by the Company as an associate for purposes of withholding Federal employment taxes, regardless of how you may be classified by the Internal Revenue Service, any government agency or court.
- You are a co-op or intern.
- You are a regular part-time associate and your normal work schedule is less than 20 hours per week.
- You are employed in Puerto Rico.

YOUR DEPENDENTS

If you enroll in the Medical Plan, you may choose to enroll your spouse or same-gender domestic partner and your dependent children.

For Medical Plan purposes, your spouse is your legal spouse (including a legal same-gender domestic partner), as determined under the state law or the law of a foreign jurisdiction that has the legal authority to sanction marriages where the marriage was performed. You must certify that your same-gender marriage is valid under the laws of the state in which the marriage first qualified. Certification can be done online from any computer with internet access on the *Your Benefits Resources* (YBR) website at **http://resources.hewitt.com/unisys** or by telephone through the UBSC.

A common-law spouse may be covered if the common-law marriage is recognized by such foreign jurisdiction or state in which the marriage first qualified. You must certify that your common-law marriage is valid under the laws of the state in which the marriage first qualified. Certification can be done online from any computer with internet access on the *Your Benefits*

Resources (YBR) website at **http://resources.hewitt.com/unisys** or by telephone through the UBSC. The Company recognizes the termination of a common-law marriage only through legal separation or divorce in accordance with applicable law. In these cases, you can drop coverage for your ex-spouse and your former stepchildren within 30 calendar days following the legal separation or divorce.

A same-gender domestic partner is defined on the following page.

Your dependent children include:

- Your biological or legally adopted children, including children who have been placed with you for legal adoption
- Biological or adopted children, or other children, who are named in a Qualified Medical Child Support Order (QMCSO)
- Your stepchildren who live with you in a regular parent/child relationship
- Your same-gender domestic partner's children if they reside with you
- Children for whom legal guardianship has been awarded to you or your spouse/same-gender domestic partner, if the child:
  - Is primarily supported by you
  - Lives with you in a regular parent/child relationship
  - Is claimed by you as a dependent for Federal income tax purposes
  - Has no other health care available through a biological parent

To be eligible for Medical Plan coverage, your dependent children must:

- Be under age 26 (coverage ends on the last day of the month of a child's 26th birthday), or
- Be any age and have become disabled and incapable of self-support because of a mental or physical impairment before age 19

If you have an unmarried child as described above who is incapable of self-support because of a mental or physical impairment, that child may continue to be covered under your Medical Plan option, regardless of age, if the following condition is satisfied:

- Proof of your child's disability is provided to the claims administrator for your Medical Plan option **within 30 calendar days following** the child's 26th birthday and periodically thereafter when requested.

If you would like to enroll a disabled dependent for Medical Plan coverage, you may contact your Medical Plan administrator (e.g., Aetna, HealthPartners, Kaiser). The administrator will provide a form for you to complete. Once you return the form, the administrator will make a determination about whether to approve or deny coverage. When a determination has been made, the administrator will notify you and the UBSC. The UBSC will process your request based on the administrator's determination.

DEPENDENT VERIFICATION

You are required to provide documentation verifying the eligibility of your dependents through a Dependent Verification process when you first enroll your dependents. Dependent verification may also occur after enrollment, at the Company's discretion. Documents to verify dependents may include:

- Birth certificates

- Government-issued marriage certificates
- Proof of ongoing relationship or tax dependency
- Same-gender domestic partner affidavits
- Documentation proving legal guardianship

New hires or associates adding dependents during Annual Enrollment or due to a qualifying life event will receive a dependent verification package within seven to ten business days after enrolling, which will need to be completed and returned with the required documentation within 45 calendar days of receipt.

If satisfactory documentation is not received by the applicable deadline, your dependent's coverage will be cancelled and your dependent will not be eligible for continuation coverage under the U.S. Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). If you later provide the required documentation, coverage will be reinstated back to the date of cancellation and you will be responsible for any missed associate contributions.

The Company reserves the right to require proof of eligibility as part of periodic audits.

Providing false information about your dependents may result in loss of coverage for the ineligible dependent and possible disciplinary action against you, up to and including termination of employment. Benefits paid in error for ineligible dependents must be reimbursed to the Medical Plan.

SAME-GENDER DOMESTIC PARTNERS

To cover your same-gender domestic partner, all of the following must be satisfied:

- You are both each other's sole same-gender domestic partner and intend to remain so indefinitely.
- You are of the same gender and neither of you is married to, or the same-gender domestic partner of, another person.
- You are at least 18 years of age and mentally competent to consent to a contract.
- You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- You reside in the same household and are engaged in a committed relationship of mutual caring and support.
- You are jointly responsible for each other's common welfare and share financial obligations (including food and housing) or one of you is financially dependent on the other (regardless of whether you contribute equally or jointly for these costs, as long as you are both responsible for these costs).
- In the last 12 months, you have not enrolled anyone else as a same-gender domestic partner for benefits through the Company.

Opposite-gender domestic partners are not eligible.

If your same-gender domestic partner meets the requirements above and has dependent children and they reside with you, the children also may be covered, so long as they are less than 26 years old.

The provisions of the Medical Plan that apply to a spouse generally apply to your qualifying same-gender domestic partner. Your qualifying partner's eligible dependent children are generally treated as if they are your eligible stepchildren.

The provisions that apply include, but are not limited to:

- Options available when a qualifying same-gender domestic partnership begins or ends (see page 12) — subject to the 12-month limitation between domestic partnerships noted earlier)
- Options available if your qualifying same-gender domestic partner gains employment, loses employment, or dies (see pages 13 – 14)
- Health care continuation coverage that generally parallels COBRA health care continuation coverage provisions (see page 80)

EFFECT OF STATE LAWS

There are some states that prohibit coverage for same-gender domestic partners in fully-insured Health Maintenance Organizations (HMOs) in the state. If you are enrolled in an HMO, check with the UBSC to determine if state law prohibits you from enrolling your same-gender domestic partner. The limitations **do not apply** to the Consumer Health Plan offered through Aetna or HealthPartners.

TAX IMPLICATIONS

Depending on the Federal income tax status of your qualifying same-gender domestic partner and your qualifying domestic partner's dependent children:

- You may not be able to make contributions for their coverage on a pre-tax basis.
- You may have to pay Federal income taxes on the imputed income attributed to the value of their coverage that is paid by the Company.

SURCHARGE FOR SPOUSE/SAME-GENDER DOMESTIC PARTNER

If your spouse/same-gender domestic partner has access to subsidized health care coverage elsewhere (e.g., from his or her current or former employer, etc.), you will be charged an additional $325 per month if you choose to enroll him or her in the Consumer Health Plan. The spousal surcharge does not apply if your spouse/same-gender domestic partner:

- Is not eligible for subsidized coverage
- Lost coverage as an active associate but was offered unsubsidized continued health care under COBRA or COBRA-like coverage
- Is covered by Medicare
- Is employed by Unisys

If your spouse/same-gender domestic partner loses employer coverage during the calendar year (e.g., during 2015) due to a Qualifying Life Event (loss of job or eligibility), he or she can be added to your Unisys Medical Plan coverage with no surcharge within 30 days of the Qualifying Life Event if you give timely notice.

Note: The Company reserves the right to verify if your spouse/same-gender domestic partner has subsidized coverage elsewhere. Misrepresenting whether your spouse/same-gender domestic partner has access to subsidized medical coverage outside of Unisys may result in disciplinary action up to and including termination of employment, in accordance with Unisys policies.

MEDICAL PLAN ELIGIBILITY FOR FOREIGN NATIONALS

You and your eligible dependents may enroll in the Medical Plan if you are a foreign national — a non-U.S. associate of the Company placed on international assignment in the U.S. for a two-

or three-year period — and you are paid by your home country and a U.S. Company payroll in U.S. dollars, and your home country medical benefits are not portable (services provided in the U.S. are not covered by your home country medical plan). No associate contributions are required for the Medical Plan, but you must maintain your home country medical plan and pay any applicable contributions for it.

GLOBAL PLAN ELIGIBILITY OUTSIDE THE U.S.

You and your eligible dependents may participate in the Open choice® Preferred Provider Organization PPO offered through Aetna Global Benefits (AGB) Program if you are:

- An expatriate — a U.S. associate of the Company placed on temporary international assignment to a non-U.S. country, paid from a U.S. Company payroll in U.S. dollars by Unisys or by a participating U.S. affiliate. Associate contributions are required, if applicable. Coverage is effective on the effective date of your temporary international assignment outside the U.S. The period of time you remain eligible as an international assignee is determined by the Company's policies on international assignment.
- Third-country national — a non-U.S. associate of the Company placed on temporary international assignment in a non-U.S. country for a period greater than 12 months and your home country medical plan is not portable (services provided in the host country are not covered by your home country medical plan) and the host country medical coverage is not available to you. You must maintain your home country benefits plans and pay any applicable contributions.
- A short-term international assignee — a non-U.S. associate of the Company placed on temporary international assignment of four to 12 months, working in any location other than your home country (including the U.S.). You must maintain your home country benefit plans and applicable contributions, if any.

Information about the AGB Program can be found in the Appendix to this SPD.

PARTICIPATION

WHEN COVERAGE BEGINS

To participate, an eligible associate must elect coverage, either when hired or during Annual Enrollment. If elected when hired, coverage for eligible full-time associates and their dependents begins on the first day of regular full-time employment, and coverage for eligible part-time associates and their dependents begins on the 61st day after the first date of employment.

If elected during Annual Enrollment, coverage begins on the next following January 1 for full-time associates and for part-time associates, on the later of:

- The next following January 1, or
- The 61st day after the first date of employment.

ENROLLMENT

Benefit enrollment is managed by the UBSC. When you first become eligible to participate in Unisys benefits, you will receive enrollment information with instructions on how to enroll in the Medical Plan and other benefits. If you do not enroll when you first become eligible, you must

generally wait until the next Annual Enrollment period, which usually begins during the fall for coverage that will be effective the following January 1. Enrollment elections and default coverages are irrevocable.

PAYING FOR YOUR BENEFITS

You are required to pay contributions by payroll deduction for the medical benefits you elect during enrollment. Your contributions will be deducted from your paycheck before Federal taxes. In the event you leave Unisys or drop coverage during a pay period, you will not receive a refund of your contributions. Your last day of coverage will be the last day worked.

Your Medical Plan contributions for the 2015 Consumer Health Plan (including the Prescription Drug Program) will be deducted from your paycheck on a pre-tax basis for Federal income tax purposes.

The amount of your required contributions for Medical Plan coverage may be adjusted annually and will be communicated in your enrollment materials. Your contributions may be reduced by discounts for participating in a biometric screening and non-tobacco use (see page 76 for more details). A surcharge will be applied if you cover a spouse or same-gender domestic partner who has subsidized coverage available elsewhere (e.g., through their own current or former employer).

If it is unreasonably difficult for you or a family member to meet the requirements for the non-tobacco use discount due to a health factor, or if it is medically inadvisable for you, please contact the Unisys Benefits Service Center (UBSC) toll-free at **877-864-7972** to see if you may be otherwise eligible for the discount.

Discounts and the surcharge apply only to your Medical Plan coverage through the Company and only while you are making contributions through payroll deductions or during periods of Company-subsidized COBRA or COBRA-like coverage.

Pre-tax contributions reduce your taxable income for purposes of Federal income, Social Security and Medicare taxes, as well as state and local income taxes in many jurisdictions. Since the amount you pay in Social Security taxes is reduced, your future Social Security benefits may be slightly less.

IRS DEFINITION OF DEPENDENT

The Internal Revenue Service (IRS) defines dependents for Federal income tax purposes. More details are in IRS Publication 501, Exemptions, Standard Deduction, and Filing Information and IRS Publication 502, Medical and Dental Expenses, available from any regional IRS office or the IRS website at **http://www.irs.gov/**. The IRS definition may include or exclude individuals that the Company allows you to include as eligible dependents under the Unisys Medical Plan. If they do not meet the IRS definition of dependent, they are not entitled to favorable Federal income tax treatment, even if the Plan allows them to be covered. Depending on the Federal income tax status of the dependents you cover through the Company:

- You may not be able to make pre-tax contributions for their coverage.
- You may have to pay Federal income taxes on the imputed income attributed to the value of their coverage that is paid by the Company.

WHEN COVERAGE ENDS

Your, your spouse's or same-gender domestic partner's, and your dependents' coverage under Unisys benefits will terminate effective at 11:59 p.m. on the date that any one of the following

events occurs:

- Your employment with the Company terminates
- You stop paying required contributions
- You are no longer in a benefits-eligible position
- The Medical Plan is terminated

Your, your spouse's or same-gender domestic partner's, or your dependents' coverage will also terminate effective at 11:59 p.m. on the date that they are no longer eligible and/or on the date they are no longer enrolled as dependents in the Medical Plan.

If you, your spouse or same-gender domestic partner, or any of your dependents loses Plan coverage, you, your spouse/same-gender domestic partner or your dependents may be entitled to continue coverage as provided by the Federal law known as COBRA, and as extended by Unisys through COBRA-like coverage for dependents not eligible for COBRA. See the COBRA section for more information.

MAKING CHANGES DURING THE YEAR

This chapter applies to the Medical, Dental and Vision Plans.

After the Annual Enrollment deadline passes, your elections remain in effect for the next calendar year. You may not change your elections until the next Annual Enrollment period, unless you have a Qualifying Life Event during the year and act in a timely manner. After a Qualifying Life Event, you have 30 days to notify the Unisys Benefits Service Center at **877-864-7972** and request a change to your coverage. Some Qualifying Life Events may also be registered online at the Your Benefits Resources website at **http://resources.hewitt.com/unisys**. Your change in coverage must be consistent with your life event.

Changes in contributions and coverages are effective retroactive to the date of the Qualifying Life Event.

The following are Qualifying Life Events that allow you to change your coverage elections mid-year (as determined by the applicable claims administrator in its sole discretion):

Marriage or entering a qualifying same-gender domestic partnership: Changes must be registered within 30 calendar days following the event. If you had previously elected coverage, you can add coverage for any newly eligible dependents, but cannot add coverage for any dependents who were eligible prior to the life event. You can drop coverage for yourself and/or any dependents who gain coverage under the employer plan of your new spouse or same-gender domestic partner. If you had not previously elected coverage, you can add coverage for yourself and any newly eligible dependents, but cannot add coverage for any dependents who were eligible prior to the life event.

End of marriage or same-gender domestic partnership due to divorce, termination of qualifying same-gender domestic partnership, annulment, legal separation or death. If you had previously elected coverage, you must drop coverage for your former spouse and stepchildren or former same-gender domestic partner and your partner's children (COBRA or COBRA-like coverage will be available to dropped dependents). You cannot drop coverage for yourself or your biological or adopted children (unless they will be covered under your former spouse's or former same-gender domestic partner's coverage, or through a Qualified Medical Child Support Order (QMCSO)). If you had not previously elected coverage, you can add coverage for yourself and any eligible dependents who were covered under the plan of your former spouse or former same-gender domestic partner.

New dependent child. You may add coverage for new dependent children gained through birth, adoption, placement in your home for adoption, a stepchild joining your household, court assignment of legal guardian status, or a court-ordered QMCSO.

If you fail to register your new child **within 30 calendar days following** the event, the child will not have medical coverage for the plan year. You must wait until the following Annual Enrollment to add the dependent to coverage.

If you had previously elected coverage, you can add coverage for the new dependent. You cannot drop coverage for yourself or any dependent(s) covered under the Plan prior to the life event. If you had not previously elected coverage, you can add coverage for yourself and the

new dependent, but cannot add coverage for just yourself. You can add coverage for yourself and any eligible dependents if the new dependent is a newborn or newly adopted, provided you add coverage for the new dependent in a timely manner.

Dependent child loses coverage eligibility. A loss of eligibility can be the result of reaching age 26, a QMCSO, a stepchild leaving your household, a change in legal guardianship, abandoned adoption proceedings, or death. If you had previously elected coverage, you can drop coverage for the dependent who is no longer eligible (COBRA or COBRA-like coverage will be available to dropped dependents). You cannot drop coverage for yourself or any other dependents. If you had not previously elected coverage, you cannot add coverage for yourself or any other dependents.

Dependent gains coverage eligibility through own employer. A dependent's gaining coverage from their own employer may result from new employment, fulfillment of a benefits waiting period, or newly qualifying for eligibility due to a change in status or work arrangement. If you had previously elected coverage, you can drop coverage for yourself and/or any dependents gaining coverage through the other employer plan. If you had not previously elected coverage, you cannot add coverage for yourself or any other eligible dependents.

Dependent loses coverage eligibility or coverage subsidy through own employer. A dependent's loss of coverage eligibility or coverage subsidy from their own employer may result from loss of employment, newly disqualifying for eligibility due to a change in status or work arrangement, a coverage level reduction for a condition that you or your dependent(s) are treated for, or a significant reduction in the provider network. If the employer continues to subsidize benefits following one of these events, then the date that the subsidy ends is considered the Qualifying Life Event. If you had previously elected coverage, you cannot drop coverage for yourself or any dependents covered prior to the life event. If you had not previously elected coverage, you can add coverage for yourself and any eligible dependents if previous coverage was through the plan of your dependent's employer.

Eligible dependent makes benefit changes during own employer's open enrollment period that differs from the Unisys Annual Enrollment period. If you had previously elected coverage, you can drop coverage for yourself and/or any dependents only if being added to the other employer's plan. If you had not previously elected coverage, you can add coverage for yourself and any eligible dependents only if being dropped from the other employer's plan.

Note: You can change your Annual Enrollment elections with Unisys after the Annual Enrollment period closes (but before January 31) and retain the January 1 effective date if the other employer's annual enrollment period (for the following plan year) ends after the close of Annual Enrollment through Unisys.

Significant change in benefits through spouse's or same-gender domestic partner's employer. If you had previously elected coverage, you can drop coverage for yourself and any dependents only if being added to the spouse's or same-gender domestic partner's employer's plan that is significantly decreasing in cost. If you had not previously elected coverage, you can add coverage for yourself and eligible dependents only if being dropped from the spouse's or same-gender domestic partner's employer's plan that is significantly increasing in cost.

FALSE INFORMATION

Providing false information may result in loss of coverage for dependents and disciplinary action against you, including termination of employment. If applicable, the changes you request must be consistent with the elections made by your spouse or same-gender domestic partner through their employer. Unisys reserves the right to conduct audits to verify the information you provide.

Benefit Option Added by Spouse's or Qualifying Same-Gender Domestic Partner's Employer. If you had previously elected coverage, you can drop coverage for yourself and/or any dependents only if enrolling in the related new benefit option added through the spouse's or same-gender domestic partner's employer. If you had not previously elected coverage, you cannot add coverage for yourself and any eligible dependents.

Benefit Option Dropped by Spouse's or Qualifying Same-Gender Domestic Partner's Employer. If you had previously elected coverage, you cannot drop coverage for yourself and/or any dependents. If you had not previously elected coverage, you can add coverage for yourself and any eligible dependents only if losing coverage through the spouse's or same-gender domestic partner's employer.

Dependents lose other coverage. You can add Unisys coverage for these dependents.

Gain or loss of Medicare, Medicaid, Federal or state medical program, or coverage through an educational institution. If you gain such other coverage, you can drop Unisys coverage. If you lose such other coverage, you can add Unisys coverage for yourself and any eligible dependents. If your dependents gain such other coverage, you can drop Unisys coverage for those dependents.

Note: Federal law requires that Medicare is secondary to coverage through Unisys for an active associate or the covered dependent of an active associate (with the exception of Medicare eligibility due to end stage renal disease after 30 months). This means that no benefit may be payable from Medicare in addition to benefits paid under the Medical Plan.

Participation in Medicare Part B can be deferred without financial penalty (by way of higher contributions) if you are enrolled for medical coverage through Unisys as an active associate or dependent of an active associate. A "Special Enrollment Period," or SEP, for Medicare Part B applies when active employment ends.

To learn more about Medicare benefits, contact your local Social Security Administration office or review the information available online at **www.medicare.gov**.

Qualification for a public health insurance exchange. If you qualify for a special enrollment event as defined by the public health insurance exchange, you may enroll in a public health insurance exchange within 60 days of your qualified life event. You can find more information at **healthcare.gov**.

Household move. If you are participating in the Medical Plan, you can change from one Medical Plan option to another if a household move results in loss of eligibility for your current Medical Plan option, availability of a new Medical Plan option that was not available at your prior address that you wish to elect, a different network of providers in your national HMO option or Consumer Health Plan option, or you move to or from a non-network area. If you are in an active

employment status, the UBSC must be notified of your move within one week after you update your address in Employee Self Service (ESS). Since allowable changes are contingent upon a change in your address, it is imperative that you update your address in ESS as soon as you move. If you are not in an active employment status, contact the UBSC to notify them of your move **within 30 calendar days following** the date of your move. The effective date of the event is measured from the date reflected in ESS if you are an active associate, or the date you tell the UBSC that you moved, if you are not an active associate. If you fail to register an allowable change **within 30 calendar days following** your move, you remain in your current Medical Plan option, even if network providers are not available in your new location. If you change your Medical Plan option, services you receive after the date of your move are subject to the terms and provisions of your new Medical Plan option, not your prior Medical Plan option.

COBRA continuation coverage from another employer expires or is lost early or you lose subsidized coverage from another employer. If you had previously elected coverage, you cannot drop coverage for yourself and/or any dependents. If you had not previously elected coverage, you can add coverage for yourself and any eligible dependents losing COBRA or subsidized coverage from another employer.

You work for another employer in addition to Unisys and have a change in coverage through that employer (includes military service). If you had previously elected coverage, you can drop coverage for yourself and any dependents only if gaining coverage under the other employer's plan. If you had not previously elected coverage, you can add coverage for yourself and any eligible dependent(s) only if losing coverage under the other employer's plan.

Regular part-time status to regular full-time status change. If you had previously elected coverage, you cannot drop coverage for yourself and/or any dependents. If you had not previously elected coverage, you can add coverage for yourself and any eligible dependents.

Regular full-time status to regular part-time status change. If you had previously elected coverage, you can drop coverage for yourself and/or any dependents. If you had not previously elected coverage, you cannot add coverage for yourself and any eligible dependents.

Workforce reduction or layoff. A workforce reduction or layoff is also considered a COBRA continuation coverage qualifying event. Changes can be registered within 30 calendar days following either the effective date of the workforce reduction/layoff or end of Unisys-subsidized COBRA coverage. If you had previously elected coverage, you can drop coverage for any enrolled dependents and cannot add coverage for any other eligible dependents. If you had not previously elected coverage, you cannot add coverage for yourself and any eligible dependents.

Return from an unpaid leave of absence (LOA). An unpaid LOA is considered a COBRA continuation coverage qualifying event. An unpaid LOA, which is covered by FMLA, is not a COBRA continuation coverage qualifying event. Please note that the start or end of a paid LOA is not considered a Qualifying Life Event.

During an unpaid LOA through which you are offered COBRA, you are able to drop coverage. If you return from an unpaid LOA within 30 days and within the plan year the leave started, your medical coverage will be reinstated. If you return from an unpaid LOA after more than 30 calendar days after the start of your leave, your enrollments are reinstated, however you have the option to make an enrollment change. If you return from an unpaid LOA in a new plan year, most of your enrollments will be reinstated, except FSA and HSA elections; however, you will have the option to make new enrollments. Upon returning from an unpaid LOA, you have 30 days to make changes to your elections by calling the Unisys Benefits Service Center.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in the Medical Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes, but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the Medical Plan's eligibility requirements (that is, legal separation, divorce, cessation of dependent status, death of an associate, termination of employment, reduction in the number of hours of employment)
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor
- Elimination of the coverage option a person was enrolled in and another option is not offered in its place
- Failing to return from a U.S. Family and Medical Leave Act of 1993 (FMLA) leave of absence
- Loss of coverage under Medicaid or the U.S. Children's Health Insurance Program (CHIP)

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under the Medical Plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted contribution subsidy towards the Medical Plan, you may request enrollment under the Medical Plan within 60 days after the date Medicaid or CHIP determines that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain additional information, call the UBSC at **877-864-7972**.

CONSUMER HEALTH PLAN

INTRODUCTION

The benefits offered under the Medical Plan are called the Consumer Health Plan. Medical benefits are administered in 2015 by Aetna (nationwide) and HealthPartners (in select markets). If you live in an area where HealthPartners is available, you may choose either Aetna or HealthPartners.

Depending on where you live, you may have other options available:

- Residents of Hawaii: Your only option is Kaiser Permanente Hawaii. See the Appendix to the SPD for information about Kaiser Permanente Hawaii.
- Residents of Puerto Rico: The Medical Plan options described in this SPD are not available to you. Instead, your medical benefits are based on any local offerings in Puerto Rico. Contact your local Human Resources representative for information.
- Expatriates, third-country nationals and short-term international assignees: You are eligible for the Open choice® Preferred Provider Organization PPO offered through Aetna Global Benefits (AGB) Program, which is described in the Appendix to this SPD.
- Foreign nationals: You are eligible for the Consumer Health Plan at no cost to you. You must maintain your home country benefit plans and pay any applicable contributions.

This section will refer to Aetna, HealthPartners, and any other third-party administrators of Unisys medical options as the “claims administrator.” The prescription drug benefits are administered by Express Scripts.

The Consumer Health Plan satisfies the Internal Revenue Service (IRS) requirements to enable you to open a Health Savings Account (HSA). If you attest that you are eligible to contribute to an HSA during the enrollment process, Unisys will make an annual contribution to your HSA that can be used to pay part of your annual deductible.

	2015 CONSUMER HEALTH PLAN	
ANNUAL DEDUCTIBLE	**IN-NETWORK**	**OUT-OF-NETWORK** *Subject to Recognized Charge*
You Only	$1,500	$1,500
You + Dependent(s)	$3,000	$3,750
Coinsurance (Plan Pays/ You Pay)	80% / 20%*	50% / 50%*
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)		
You Only	$3,500	None
You + Dependent(s)	$7,000	None
Lifetime Maximum	Unlimited	
COINSURANCE		
Most Covered Medical Services (You Pay)	20%*	50%*
Preventive Care (You Pay)	No Charge	50%* [1]
Urgent Care (You Pay)	20%*	50%*
Emergency Room (You Pay)	20%*	20%*

*After annual deductible

[1] Prior to 7/1/2015 Preventive Care not covered out of network

Your share of the cost of your coverage is deducted from your paycheck before taxes for Federal income tax purposes. The amount of your contribution will be determined annually and communicated in your Annual Enrollment materials. Your contribution may be discounted if: (i) you and your household are non-tobacco users, or (ii) you and/or your spouse/same-gender domestic partner participate in a biometric screening (see page 76 for more details).

HOW THE PLAN WORKS

The Consumer Health Plan gives you the option to use in-network or out-of-network providers. If you need to see a specialist, you do not need a referral from your family doctor. The Plan provides a higher level of benefits when you use network hospitals, physicians, and specialists.

By choosing a provider within the network, you will take advantage of discounted service rates negotiated with network doctors and hospitals.

You do not have to use network providers. You can go to any provider you want and still be covered under the Plan for covered expenses. If you choose an out-of-network provider, you will pay more for the care than if you use a network provider.

With the exception of covered preventive services, you pay the cost of all services (including, but not limited to, prescription drugs copays (see page 67 for more information about prescription drug costs)) until you meet your annual deductible. Then you pay 20% of covered network charges and the Consumer Health Plan pays 80%, called coinsurance. For out-of-network covered services, you pay 50% and the Plan pays 50% of the recognized charge. You also pay any amount in excess of the recognized charge. The recognized charge for covered services is determined by the claims administrator.

NETWORK PROVIDERS

You can learn if a provider is in the network by:

- Aetna: go to **www.aetna.com** and select a provider from the "Aetna Choice POS II (Open Access)" network. If you do not have internet access, call Aetna Customer Care toll-free at **800-223-3580** for assistance. Representatives are available Monday – Friday, 8:00 a.m. – 6:00 p.m. Eastern Time. Hearing impaired: **800-628-3323**.
- HealthPartners: go to **www.healthpartners.com** and select a provider from the Open Access network. If you do not have internet access, call HealthPartners toll-free at **800-883-2177** for assistance. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. Eastern Time. Hearing impaired: **952-883-6060**.
- HealthAdvocate™ can also assist you in finding a provider. They can review your network options and even call the doctor's office to schedule an appointment for you. (See page 77 for more details.) They can be reached toll-free at **866-695-8622**.

When you use a network provider, you are charged the rates negotiated by the claims administrator, even before you meet your deductible. Network providers will complete your claim forms and request precertification for you.

Participation in the network can change. You should verify with your provider's staff that your provider continues to participate each time you make an appointment for services.

INDIVIDUAL AND FAMILY ANNUAL DEDUCTIBLE

The annual deductible is the amount of covered medical expenses you pay each calendar year before the cost of covered expenses is shared between you and the Consumer Health Plan. The annual deductible does not apply to covered preventive services from network providers, which are covered at 100% of the negotiated fees. The annual deductible applies to all other covered services, including covered prescription drugs. A list of identified preventive prescription drugs that do not apply to the deductible is maintained by the prescription provider.

Your annual deductible is based on whether you elect coverage for just yourself (You Only coverage) or whether you cover at least one other family member (You + Dependent(s) coverage). For Aetna's Plan, network and out-of-network deductibles are combined; therefore they cross-apply. For HealthPartner's Plan, separate annual deductibles apply to network and out-of-network charges; therefore, they do not apply.

If you have family coverage, there are no individual annual deductibles. The family annual

deductible can be met by one of your covered family members or by all of your covered family members as a group. When the family annual deductible reaches the maximum amount, no further annual deductible is applied to the covered medical expenses for any covered family member for the balance of that calendar year.

Annual deductibles apply each calendar year based on when the expenses are provided, not when you are billed. There is no carry-over from one calendar year to another.

The following expenses do not count toward the annual deductible:

- Amounts exceeding the recognized charge for covered services from out-of-network providers
- Charges for services that are not medically necessary
- Charges for services that are not covered
- The difference in cost between a generic and a brand-name prescription drug when a brand-name prescription drug is not medically necessary
- The added cost for failure to use a network pharmacy or use your prescription identification card at a network pharmacy

COINSURANCE

After your annual deductible is met, the Consumer Health Plan pays a percentage of your covered charges, called coinsurance. The Plan pays 80% of covered network charges and 50% of the recognized charge for covered out-of-network services.

INDIVIDUAL AND FAMILY ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the amount of network covered medical expenses that you must pay before the Plan pays 100% of the network charges for the remainder of the calendar year. Out-of-network charges do not have an out-of-pocket maximum.

The annual out-of-pocket maximum applies to the sum of your annual deductible and coinsurance amounts.

Like the annual deductible, your annual out-of-pocket maximum depends on whether you have associate-only or family coverage.

The family annual out-of-pocket maximum can be met by one of your covered family members or by all of your covered family members as a group. When the family annual out-of-pocket maximum is reached, 100% of charges are paid by the Consumer Health Plan for covered services for any covered family member.

Annual maximum out-of-pocket expenses apply to each calendar year based on when the services are provided, not when you are billed. There is no carry-over from one calendar year to another.

The following expenses do not apply to the out-of-pocket maximum:

- Charges for services that are not medically necessary
- Charges for services that are not covered
- The difference in cost between a generic and a brand-name prescription drug when a brand-name prescription drug is not medically necessary
- Out-of-network charges over the recognized charge
- Expenses for non-emergency use of the emergency room

- Expenses incurred for non-urgent use of an urgent care provider
- Expenses that are not paid, or precertification benefit reductions because a required precertification for the service(s) or supply was not obtained from the claims administrator

PRECERTIFICATION

Precertification means obtaining approval from the claims administrator within a required time period before a claim will be covered. Certain services require precertification (see page 22 for services that require precertification). You do not need to precertify services provided by a network provider, because they will obtain necessary precertification for you. Since precertification is a network provider's responsibility, there is no additional out-of-pocket cost to you if a network provider fails to precertify services.

When you go to an out-of-network provider, it is your responsibility to obtain precertification from the claims administrator for any services or supplies on the precertification list below. If you do not precertify, your benefits may be reduced, or the Plan may not pay any benefits.

THE PRECERTIFICATION PROCESS

Precertification should be secured within the timeframes specified below. To obtain precertification, call the claims administrator at the telephone number listed on your ID card.

FOR THIS SERVICE	PRECERTIFICATION DEADLINE
Non-emergency admissions	You, your physician, or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
Emergency outpatient medical condition	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
Emergency admission	You, your physician, or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency medical services requiring precertification	You or your physician must call at least 14 days before the outpatient care is provided or the treatment or procedure is scheduled.

The claims administrator will provide a written notification to you and your physician of the precertification decision. If your precertified expenses are approved, the approval is good for 60 days as long as you remain enrolled in the Plan.

When you have an inpatient admission to a facility, the claims administrator will notify you, your physician, and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be precertified. You, your physician, or the facility will need to call the claims administrator at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. The claims administrator will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

You or your provider may request a review of the precertification decision by filing an appeal as provided in the Claims and Appeals section.

COVERED SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION

Precertification is required for the following types of inpatient and outpatient covered medical expenses:

COVERED SERVICES REQUIRING PRECERTIFICATION
▪ Stays in a hospital
▪ Stays in a skilled nursing facility
▪ Stays in a rehabilitation facility
▪ Stays in a hospice facility
▪ Outpatient hospice care
▪ Stays in a residential treatment facility for treatment of mental disorders and substance abuse
▪ Partial hospitalization programs for mental disorders and substance abuse
▪ Home health care
▪ Private duty nursing care
▪ Intensive outpatient programs for mental disorders and substance abuse
▪ Amytal interview (interview under the influence of sodium amytal used for psychiatric treatment)
▪ Applied behavioral analysis
▪ Biofeedback
▪ Electroconvulsive therapy
▪ Neuropsychological testing
▪ Outpatient detoxification
▪ Psychiatric home care services
▪ Psychological testing

HOW YOUR BENEFITS ARE AFFECTED

The chart below illustrates the effect on your covered expenses if necessary precertification is not obtained.

IF PRECERTIFICATION IS	THEN THE COVERED EXPENSES ARE
Requested and approved	Covered expense, according to provisions of the Plan
Requested and denied	Not covered, may be appealed
Not requested, but would have been covered if requested	Covered expense, according to provisions of Plan, after a precertification benefit reduction of $400 is applied
Not requested, would not have been covered if requested	Not covered, may be appealed

FAILURE TO PRECERTIFY

Any additional out-of-pocket expenses incurred because your precertification requirement was not met (including the $400 benefit reduction) will not count toward your annual deductible or maximum out-of-pocket limit.

HEALTH SAVINGS ACCOUNT

ELIGIBILITY

If you enroll in the Consumer Health Plan, you may open a Health Savings Account (HSA) if you:

- Do not have any other health care coverage that reimburses expenses for covered services (other than preventive services) before reaching an annual deductible (as defined by Federal rules).
- Are not covered by your spouse's/same-gender domestic partner's health plan or reimbursement account. Reimbursement accounts include health care reimbursement accounts or health care flexible spending accounts that reimburse expenses for covered services before meeting the Medical Plan's annual deductible (other than a limited scope health care flexible spending account).
- Are not eligible to be claimed as a dependent on someone else's Federal income tax return.
- Are not enrolled in Medicare, Medicaid or TRICARE. This includes Medicare Part A, which is typically provided at no cost to people who are Medicare eligible.
- Do not receive Veterans Administration Benefits, have not used a Veterans Administration hospital and have not received Veterans Administration Benefits for three months prior to opening an HSA.

You may enroll in the Consumer Health Plan without opening an HSA, but you will not receive the employer contribution.

OPENING AN HSA

The Medical Plan offers HSAs managed by PayFlex. If you qualify for an HSA, you may open your HSA with any financial institution, but if you choose PayFlex, Unisys may make employer contributions to your HSA to help offset the cost of your annual deductible and other qualifying medical expenses.

You open an HSA when you first enroll in the Consumer Health Plan. After that, Unisys may make employer contributions to your HSA if you attested that you were eligible to participate in an HSA.

Unisys' contributions for 2015 are $500 if you have You Only coverage or $1,000 if you have You + Dependent(s) coverage.

INDIVIDUALLY-OWNED HSA

You own and administer your HSA. You determine how much you will contribute to the account, subject to IRS annual limits, and when and for what to use the money.

You keep your HSA and any money in it, even if you are no longer enrolled in the Consumer Health Plan or change jobs. The account grows tax-free for Federal income tax purposes, including any interest. There are individual investment options for you if your account reaches $1,000 or above.

Because this is an individual bank account, you must take action when you first open the HSA. Due to the USA Patriot Act, additional information may be requested from the in-force HSA

administrator before your HSA is opened.

When your Unisys employment terminates, you may keep your HSA with the in-force HSA Administrator or transfer it to another financial institution.

CONTRIBUTIONS

COMPANY CONTRIBUTIONS

If you enroll in the Consumer Health Plan, Unisys will make a Company contribution to your HSA, provided you have opened an HSA with the HSA Administrator. Unisys' contribution amount for the calendar year will be announced in the Annual Enrollment guide. The contribution will be made during the first week of January. Unisys' contribution amounts are prorated for mid-year enrollments.

If you have not opened an HSA with the HSA Administrator, you are not entitled to any Company contributions until the first of the month after or concurrent with the date your HSA is approved and opened. There are no retroactive Company contributions unless Federal banking requirements delay approval and the timely establishment of your account.

Company contributions end on the later of the date your medical coverage as an active associate ends or, if you have a Qualifying Life Event and stop participating in the Consumer Health Plan, the last day of the month in which you participate in the Consumer Health Plan.

If you are eligible for Company contributions while working, the Company contribution will continue if you are not working due to:

- **Approved paid leave of absence**: Company contributions continue during your paid leave, provided you continue participating in the Consumer Health Plan. Company contributions end at the end of your paid leave, unless you return to work and continue participating in the Consumer Health Plan.
- **Approved unpaid leave of absence**: Company contributions while you are eligible for Company-subsidized COBRA coverage for your medical benefits.
- **Workforce reduction or layoff**: If your employment is affected by a workforce reduction or layoff, Company contributions continue while you are eligible for Company-subsidized COBRA coverage for your medical benefits.

Except as described above, Unisys does not make employer contributions to HSAs for COBRA participants.

ASSOCIATE CONTRIBUTIONS

You may elect to contribute to your HSA through Federal pre-tax payroll deductions. You may start or stop your payroll deductions at any time. You may also make lump-sum contributions by check. Lump-sum contributions that meet IRS rules are deductible on your Federal income tax return. Lump-sum contributions cannot be made by payroll deduction, but must be made directly to the HSA Administrator.

The amount you choose to contribute by payroll deduction is expressed as an annual figure and is withheld in equal amounts from each of your future paychecks for the balance of the year. Elections to begin, decrease or increase payroll deductions are effective as of the first of the month following the date the change is requested, except that changes requested on the first day of a month are effective on that day. If you stop contributions, they will end on the last day of the month in which the change is requested.

If you become ineligible to contribute to your HSA because you enroll in Medicare or TRICARE, you receive VA benefits, or you become covered by a non-high-deductible medical plan or full scope Flexible Spending Account or Health Reimbursement Account, you must call the Unisys Benefits Service Center immediately to cease your payroll deduction Health Savings Account contributions.

CONTRIBUTION LIMITS

Your contribution (including the Unisys HSA contribution) cannot exceed the annual IRS maximum as shown below for 2015.

HSA FUNDING LIMITS	
You Only	$3,350
You + Dependent(s)	$6,650

If you change between "You Only" and "You + Dependent(s)" coverage during the year due to a Qualifying Life Event, the new limit will become effective for you on the first of the month following the effective date of the Qualifying Life Event, unless the effective date is the first of a month, in which case the new limit will become effective on that day.

CATCH-UP CONTRIBUTIONS

If you are age 55 or older during 2015, you may contribute an additional "catch-up contribution" of up to $1,000 during 2015. Your eligibility to make additional contributions ends when you enroll in Medicare, typically at age 65. These additional contributions can be made to your account by you or anyone else, provided the contributions do not exceed the Federal maximums. Catch-up contributions cannot be made by payroll deduction, but must be made directly to the HSA Administrator. The IRS limits may be adjusted each year.

If you become ineligible to contribute to an HSA during the year, the amount of contributions you can make to the HSA during that year will be reduced. Any excess contributions will be subject to ordinary Federal income tax plus an additional 6% Federal excise tax.

HOW THE HSA WORKS

You can use your debit card to pay for qualified medical expenses. You must have a balance to use your debit card. There are no receipts for reimbursement, but it is recommended you retain the receipts in case the IRS ever requires substantiation.

HSA FEES

The Company pays the monthly maintenance fee while you are an active associate and participating in the Unisys Consumer Health Plan. All other fees are your responsibility and will be deducted from your HSA. You receive a schedule of fees from the HSA Administrator when you enroll in the Consumer Health Plan.

It is important for you to know the amount in your HSA prior to withdrawing funds. If you withdraw funds that exceed the available balance, you will be responsible for overdraft plus bank fees.

ELIGIBLE EXPENSES

If you use your HSA for qualified medical expenses, the money will not be taxable for Federal tax purposes when withdrawn. Qualified medical expenses include those of your spouse and dependents you can claim on your Federal income tax return (including a tax-dependent same-gender domestic partner), even if they are not covered by the Consumer Health Plan. Note that expenses for adult children **age 19** or older cannot be reimbursed from your HSA unless they are your tax dependents, even if they are enrolled in the Consumer Health Plan. An adult child age 19 or older is considered your Federal income tax dependent if he or she is a full-time student under age 24, or a "qualifying relative" as provided in Internal Revenue Code Section 152 (basically, a relative for whom you provide more than half the support).

Qualified medical expenses include any expense considered a deductible medical expense for Federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended. A complete list of these expenses is found in IRS Publication 502. In addition to medical, dental and vision expenses, qualified expenses include premiums for long-term care insurance, COBRA continuation coverage and Medicare (but not Medigap policies).

HSA funds used for expenses that are not qualified medical expenses are generally subject to:

- Federal income tax, and
- A 20% additional Federal tax (unless an exception applies, such as your death or disability, or your attainment of age 65)

VERIFICATION

The HSA Administrator may confirm upon request from a health care provider that your HSA contains sufficient funds to cover a bill owed to that provider. The actual dollar amount in your account will not be disclosed. If you do not want this information disclosed, notify the HSA Administrator in writing.

HSA FEDERAL TAX ADVANTAGES

Contributions to an HSA are tax-free for Federal tax purposes (they will be made through payroll deductions on a pre-tax basis if you elect to contribute). The money in this account (including interest and investment earning options) grows tax-free. As long as the funds are used to pay for qualified medical expenses, they are reimbursed tax-free. If you use your HSA funds for an expense that is not a qualified medical expense, the money is taxable and subject to a 20% tax penalty if you are under age 65. Discuss any state or local tax issues with your personal tax advisor before taking any action under the Plan.

TAX REPORTING

Each year that you have money in your HSA, you must file a Form 8889 with your Federal income tax return. This assures the pre-tax treatment of money (for Federal income tax purposes) withdrawn from your HSA and calculates the deduction for contributions you make by check. If you spend HSA money for non-qualified medical purposes, taxes due on the non-medical payments are calculated on the Form 8889. All tax documents for your HSA will be provided by your HSA Administrator.

This SPD discusses Federal tax treatment but does not address any state or local tax issues. You should discuss all those issues (Federal, state, and local) with your personal tax advisor before taking any action under the Plan.

COVERED MEDICAL SERVICES

WHAT IS COVERED

Services and supplies that you or a covered dependent receives are eligible expenses for the Medical Plan if they are listed below and they are determined by the claims administrator to be medically necessary.

Other than for preventive services, you pay your annual deductible before the Medical Plan pays any covered expenses. For all covered services other than preventive services and hospital emergency room care, after you meet your annual deductible, the Medical Plan pays 80% of network charges and 50% of the recognized charge for out-of-network services, until you reach your annual out-of-pocket maximum.

To learn if a medical service or supply is covered by the Medical Pan, you may:

- Call Aetna at **800-223-3580** or HealthPartners at **800-883-2177**
- Go online to **www.aetna.com** or **www.healthpartners.com**

COVERED PREVENTIVE CARE

This section on preventive care describes the covered expenses for services and supplies provided when you are well.

HOW PREVENTIVE SERVICES ARE COVERED

Certain preventive services are covered 100% in network with no annual deductible, and 50% out-of-network subject to the annual deductible. Note that Preventive services were not covered out-of-network prior to July 1, 2015.

The following preventive services are covered 100% in network with no annual deductible, and 50% out of network, subject to the annual deductible. Some limitations apply, as described in the following section.

PREVENTIVE SERVICES: 100% IN NETWORK AND 50% OUT OF NETWORK
▪ Routine preventive physical exams, including, but not limited to, well woman preventive visits
▪ Preventive care immunizations (example: flu shot)
▪ Routine cancer screening
▪ Screening and counseling for obesity, misuse of alcohol or drugs, and use of tobacco products
▪ Contraceptive counseling services
▪ Routine eye exams, including refraction
▪ Prenatal care office visit
▪ Lactation support and counseling
▪ Breast pumps and supplies
▪ Female contraceptive counseling services, office visit

- Female voluntary sterilization
- Female contraceptive generic prescription drugs and prescription contraceptive devices

ROUTINE PHYSICAL EXAMS

Covered expenses include charges made by your physician, for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the U.S. Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as for:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- X-rays, lab and other tests given in connection with the exam
- For covered newborns, an initial hospital check up

Limitations

Unless specified above, not covered under this preventive care benefit are charges for:

- Services that are covered to any extent under any other part of this Plan
- Services that are for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by a physician or under his or her direction
- Psychiatric, psychological, personality, or emotional testing or exams

PREVENTIVE CARE IMMUNIZATIONS

Covered expenses include charges made by your physician or a facility for immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the U.S. Centers for Disease Control and Prevention.

Limitations

Not covered under this preventive care benefit are charges incurred for immunizations that are not considered preventive care such as those required due to your employment or travel.

WELL-WOMAN PREVENTIVE VISITS

Covered expenses include charges made by your physician for a routine well-woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the U.S. Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

Limitations

Well-woman preventive visits are limited to one per calendar year.

Unless specified above, not covered under this preventive care benefit are charges for:

- Services that are covered to any extent under any other part of this Plan
- Services that are for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by a physician or under his or her direction
- Psychiatric, psychological, personality or emotional testing or exams

ROUTINE CANCER SCREENINGS

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms
- Fecal occult blood tests
- Digital rectal exams
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the U.S. Health Resources and Services Administration

FREQUENCY AND AGE LIMITS

For details on the frequency and age limits that apply to routine physical exams and routine cancer screenings, contact your physician, or check with your claims administrator as follows:

- Log onto the Aetna website **www.aetna.com**, or call member services at the number on the back of your ID card.
- Call HealthPartners at **800-883-2177** or log on to the HealthPartners website **www.healthpartners.com**.

Limitations

Unless specified above, not covered under this benefit are:

- Charges incurred for services that are covered to any extent under any other part of this Plan

SCREENING AND COUNSELING SERVICES

Covered expenses include charges made by your primary care physician in an individual or group setting for the following:

Obesity

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention
- Medical nutrition therapy
- Nutrition counseling
- Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

Benefits for the screening and counseling services above are limited to 26 visits in 12 months (over age 22 only, no limit for under age 22). Of these, only 10 visits are allowed for healthy diet counseling for high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Misuse of Alcohol and/or Drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits for the screening and counseling services above are limited to five visits per 12 months. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products

Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco; and candy-like products that contain tobacco. Coverage includes:

- Preventive counseling visits
- Treatment visits
- Class visits

to aid in the cessation of the use of tobacco products.

Benefits for the screening and counseling services above are limited to eight visits per 12 months. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan
- Services which are for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by a physician or under his or her direction
- Psychiatric, psychological, personality or emotional testing or exams

PRENATAL CARE

Prenatal care will be covered as preventive care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this preventive care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Limitations

Unless specified above, not covered under this preventive care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan
- Pregnancy expenses (other than prenatal care as described above)

Coverage for non-preventive pregnancy expenses can be found in the Pregnancy Expenses section.

COMPREHENSIVE LACTATION SUPPORT AND COUNSELING SERVICES

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider.

The "postpartum period" means the one-year period directly following the child's date of birth. Covered expenses incurred during the postpartum period also include the rental or purchase of breast-feeding equipment as described below.

Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting. Benefits for lactation counseling services are limited to six visits per 12 months (additional visits may be covered as physician office visits).

BREAST-FEEDING DURABLE MEDICAL EQUIPMENT

Coverage includes the rental or purchase of breast-feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump

Covered expenses include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital
- The purchase of:
  - An electric breast pump (non-hospital grade). (A purchase will be covered once every three years); or
  - A manual breast pump (A purchase will be covered once every three years)

If an electric breast pump was purchased within the previous three-year period, the purchase of an electric or manual breast pump will not be covered until a three-year period has elapsed from the last purchase of an electric pump.

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

The claims administrator reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. While you decide whether to rent or purchase your equipment, the decision to consider a rental or purchase as a covered expense is at the discretion of the claims administrator.

Limitations

Unless specified above, not covered under this preventive care benefit are charges incurred for services that are covered to any extent under any other part of this Plan.

FINDING A NETWORK PROVIDER FOR BREAST PUMP SERVICES

If a breast pump service or supply that you need is covered under this Plan but not available from a network provider in your area, please contact Member Services at the toll-free number on your ID card for assistance.

FAMILY PLANNING SERVICES — FEMALE CONTRACEPTIVES

For females with reproductive capacity, covered expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this preventive care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting. They are limited to two visits per calendar year.

The following contraceptive methods are covered expenses under this preventive care benefit:

VOLUNTARY STERILIZATION

Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this preventive care benefit do not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

CONTRACEPTIVES

Covered expenses include charges made by a physician for:

- Female contraceptives that are brand name and generic prescription drugs
- Female contraceptive devices including the related services and supplies needed to administer the device

Limitations

Unless specified above, not covered under this preventive care benefit are charges for:

- Services that are covered to any extent under any other part of this Plan
- Services and supplies incurred for an abortion
- Services which are for the treatment of an identified illness or injury
- Services that are not given by a physician or under his or her direction
- Psychiatric, psychological, personality, or emotional testing or exams
- Any contraceptive methods that are only "reviewed" and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures, or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care

FAMILY PLANNING SERVICES — OTHER

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury:

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Limitations

Not covered are:

- Reversal of voluntary sterilization procedures, including, but not limited to, related follow-up care
- Charges for services which are covered to any extent under any other part of this Plan
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care

See also the sections on *Family Planning Services — Female Contraceptives*, *Pregnancy Expenses* and *Treatment of Infertility*.

VISION CARE SERVICES

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a routine eye exam. The Plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.

LIMITATIONS

The Plan covers charges for one routine eye exam in any 24 consecutive month period.

PHYSICIAN AND HOSPITAL SERVICES

PHYSICIAN VISITS

Covered medical expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility. Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment or travel
- Allergy testing, treatment and injections
- Charges made by the physician for supplies, radiological services, X-rays, and tests provided by the physician

SURGERY

Covered expenses include charges made by a physician for:

- Performing your surgical procedure
- Pre-operative and post-operative visits
- Consultation with another physician to obtain a second opinion prior to the surgery

ANESTHETICS

Covered expenses include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

ALTERNATIVES TO PHYSICIAN OFFICE VISITS

WALK-IN CLINIC VISITS

Covered expenses include charges made by walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries
- The administration of certain immunizations administered within the scope of the clinic's license, but not if solely for employment or travel

Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.

HOSPITAL EXPENSES

Covered medical expenses include services and supplies provided by a hospital during your stay.

ROOM AND BOARD

Covered expenses include charges for room and board provided at a hospital during your stay. Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of an infectious illness or a weak or compromised immune system.

Room and board charges also include:

- Services of the hospital's nursing staff
- Admission and other fees
- General and special diets
- Sundries and supplies

OTHER HOSPITAL SERVICES AND SUPPLIES

Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay.

Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services
- Physicians and surgeons
- Operating and recovery rooms
- Intensive or special care facilities
- Administration of blood and blood products, but not the cost of the blood or blood products
- Radiation therapy
- Speech therapy, physical therapy, and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing, and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning

OUTPATIENT HOSPITAL EXPENSES

Covered expenses include hospital charges made for covered services and supplies provided by the outpatient department of a hospital.

Important Reminders

The Plan will only pay for nursing services provided by the hospital as part of its charge. The Plan does not cover private duty nursing services as part of an inpatient hospital stay.

If a hospital or other health care facility does not itemize specific room and board charges and other charges, the claims administrator will assume that 40% of the total is for room and board charge, and 60% is for other charges.

Hospital admissions need to be **precertified**.

In addition to charges made by the hospital, certain physicians, and other providers may bill you separately during your stay.

COVERAGE FOR EMERGENCY MEDICAL CONDITIONS

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition. See the Definitions section at the end of this SPD for what qualifies as an emergency.

The emergency care benefit covers:

- Use of emergency room facilities
- Emergency room physicians services
- Hospital nursing staff services
- Radiologist and pathologist services

Please contact your physician after receiving treatment for an emergency medical condition.

Emergency care in a hospital emergency room is covered at 80% after the annual deductible, whether in or out of network. Non-emergency care in a hospital emergency room is not covered. If you go to an out-of-network emergency room, the provider may not accept payment of your cost share as payment in full, and you may be billed for the difference between the provider's bill and what the Medical Plan pays. If you are billed for an amount exceeding your cost share (your annual deductible and 20% coinsurance), you are not responsible for paying that amount. Send the bill to your claims administrator at the address on your ID card to resolve the payment dispute with the hospital.

Urgent care services received at a non-hospital urgent care facility are covered 80% in network and 50% of the recognized charge out of network. Use of an urgent care provider for non-urgent services is not covered.

FOLLOW-UP TO EMERGENCY CARE

Follow-up care after a visit to an emergency room, which includes (but is not limited to) suture removal, cast removal and radiological tests such as X-rays, will not be covered if provided by an emergency room facility. You should contact your physician for any necessary follow-up care. If you use an out-of-network physician for emergency follow-up care, it will be covered at 50% of the recognized charge.

With the exception noted below for urgent care, if you visit a hospital emergency room for a non-emergency condition, the Plan will not cover your expenses. No other Plan benefits will pay for non-emergency care in the emergency room.

COVERAGE FOR URGENT CONDITIONS

Covered expenses include charges made by a hospital or urgent-care provider to evaluate and treat an urgent condition. See the Definitions section at the end of this SPD for what qualifies as an urgent condition.

Your coverage includes:

- Use of emergency room facilities when network urgent-care facilities are not in the service area and you cannot reasonably wait to visit your physician
- Use of urgent care facilities
- Physicians services
- Nursing staff services
- Radiologists and pathologists services

Please contact your physician after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the Plan will not cover your expenses.

ALTERNATIVES TO HOSPITAL STAYS

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A physician or dentist for professional services
- A surgery center
- The outpatient department of a hospital

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital, and
- The surgery is not normally performed in a physician's office.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the hospital, surgery center on the day of the procedure

- The operating physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia
- Services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this Plan are charges made for:

- The services of a physician or other health care provider who renders technical assistance to the operating physician
- Facility charges for office-based surgery

BIRTHING CENTER

Covered expenses include charges made by a birthing center for services and supplies related to your care in a birthing center for:

- Prenatal care
- Delivery
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery, or a shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier
- Services and supplies provided for circumcision of the newborn during the stay

Limitations

Unless specified above, not covered under this benefit are charges in connection with a pregnancy for which pregnancy-related expenses are not included as a covered expense.

HOME HEALTH CARE

Covered expenses include charges for home health care services when ordered by a physician as part of a home health plan and provided you are transitioning from a hospital or other inpatient facility, and the services are in lieu of a continued inpatient stay or homebound.

Covered expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a hospital or skilled-nursing facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. (These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.)

- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

Coverage for home health care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not a part of the Home Health Care Plan
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your same-gender domestic partner's family
- Services of a certified or licensed social worker
- Services for infusion therapy
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Services that are custodial care

The Plan does not cover custodial care, even if care is provided by a nursing professional, and family members or other caretakers cannot provide the necessary care.

Home health care needs to be **precertified** by the claims administrator.

SKILLED NURSING FACILITY

Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies, including:

- Room and board, up to the semi-private room rate. (The Plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system.)
- Use of special treatment rooms
- Radiological services and lab work
- Physical, occupational, or speech therapy
- Oxygen and other gas therapy
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services)
- Medical supplies

Admissions to a skilled nursing facility must be **precertified** by the claims administrator.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Charges made for the treatment of:
  - Drug addiction
  - Alcoholism
  - Senility
  - Mental retardation
  - Any other mental illness
- Daily room and board charges over the semi-private rate, unless needed due to an infectious disease or a weak or compromised immune system

HOSPICE CARE

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

Facility Expenses

The charges made by a hospital, hospice or skilled nursing facility for:

- Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a hospice care agency for:

- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for up to eight hours a day
- Part-time or intermittent home health aide services to care for you up to eight hours a day
- Medical social services under the direction of a physician. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation
  - Identification of available community resources
  - Assistance provided to you to obtain resources to meet your assessed needs
- Physical and occupational therapy
- Consultation or case management services by a physician
- Medical supplies
- Prescription drugs
- Bereavement counseling, but not more than 15 visits
- Psychological counseling
- Charges made by the providers below if they are not an employee of a hospice care agency and such agency retains responsibility for your care:
  - A physician for a consultation or case management

- A physical or occupational therapist
- A home health care agency for:
  - Physical and occupational therapy
  - Part-time or intermittent home health aide services for your care up to 8 hours a day
  - Medical supplies
  - Prescription drugs
  - Psychological counseling
  - Dietary counseling

Limitations

Unless specified above, not covered under this benefit are charges for:

- Daily room and board charges over the semi-private room rate
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling (This includes estate planning and the drafting of a will.)
- Homemaker or caretaker services (These are services that are not solely related to your care, including, but not limited to: sitter or companion services for either you or other family members, transportation, and maintenance of the house.)
- Respite care (This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.)

Inpatient hospice care and home health care must be precertified by the claims administrator.

OTHER COVERED HEALTH CARE EXPENSES

ACUPUNCTURE

The Plan covers charges made for acupuncture services provided by a physician, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure; or
- To treat an illness, injury or to alleviate chronic pain.

AMBULANCE SERVICE

Covered expenses include charges made by a professional ambulance, as described below:

GROUND AMBULANCE

Covered expenses include charges for transportation:

- To the first hospital where treatment is given in a medical emergency
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition

- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

AIR OR WATER AMBULANCE

Covered expenses include charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital, when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital, and the two conditions above are met.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an ambulance service is not required by your physical condition
- If the type of ambulance service provided is not required for your physical condition
- By any form of transportation other than a professional ambulance service

DIAGNOSTIC AND PREOPERATIVE TESTING

DIAGNOSTIC COMPLEX IMAGING EXPENSES

The Plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- Computed Axial Tomography (C.A.T.) scans
- Magnetic Resonance Imaging (MRI)
- Positron Emission Tomography (PET) Scans
- Any other outpatient diagnostic imaging service costing over $500

Complex imaging expenses for preoperative testing will be payable under this benefit.

OUTPATIENT DIAGNOSTIC LAB WORK AND RADIOLOGICAL SERVICES

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.

OUTPATIENT PREOPERATIVE TESTING

Prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician, or licensed diagnostic laboratory provided the

charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center
- Completed within 14 days before your surgery
- Performed on an outpatient basis
- Covered if you were an inpatient in a hospital
- Not repeated in or by the hospital or surgery center where the surgery will be performed
- Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed

Limitations

If your tests indicate that surgery should not be performed because of your physical condition, the Plan will pay for the tests, but the surgery will not be covered.

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME)

Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental, the initial purchase of DME if:

- Long-term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment is covered. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment is covered if:

- The replacement is needed because of a change in your physical condition, and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The Plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered durable medical equipment includes those items covered by Medicare unless excluded in the Services Not Covered section. The claims administrator reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to consider a rental or purchase as a covered expense is at the discretion of the claims administrator.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

Covered expenses include charges made for experimental or investigational drugs, devices, treatments, or procedures, provided all of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less
- Standard therapies have not been effective or are inappropriate
- The claims administrator determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment
- You are enrolled in an ongoing clinical trial that meets these criteria as determined by the applicable claims administrator in its sole discretion:

- The drug, device, treatment, or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the U.S. Food & Drug Administration or the U.S. Department of Defense) and conforms to the NCI standards
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI designated cancer center
- You are treated in accordance with protocol

If any of the conditions above are not met, the experimental or investigational treatment is not a covered expense.

PREGNANCY-RELATED EXPENSES

Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury. This includes prenatal visits, delivery, and postnatal visits.

For inpatient care of the mother and newborn child, covered expenses include charges made by a hospital for a minimum of:

- 48 hours after a vaginal delivery
- 96 hours after a Cesarean section
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

Covered expenses also include charges made by a birthing center (see page 40).

Note: Covered expenses also include services and supplies provided for circumcision of the newborn during the stay.

PROSTHETIC DEVICES

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The Plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an internal body part or organ, or an external body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition or normal growth or wear and tear
- It is likely to cost less to buy a new one than to repair the existing one
- The existing one cannot be made serviceable

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye

- Eye lens
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy
- A breast implant after a mastectomy
- Ostomy supplies, urinary catheters and external urinary collection devices
- Speech-generating device
- Wig or hairpiece as prescribed by a physician for hair loss due to injury, disease or treatment of disease, to a lifetime maximum of $200
- A cardiac pacemaker and pacemaker defibrillators
- A durable brace that is custom made for and fitted for you

The Plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Any item listed in Services Not Covered

SHORT-TERM REHABILITATION THERAPY SERVICES

Covered expenses include charges for short-term therapy services when prescribed by a physician as described below. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility, or hospice facility
- A physician.

Charges for the following short-term rehabilitation expenses are covered:

CARDIAC AND PULMONARY REHABILITATION BENEFITS

Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The Plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 sessions or a six-week period.

OUTPATIENT COGNITIVE THERAPY, PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY REHABILITATION BENEFITS

Covered services include:

- Physical therapy for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury, or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to

significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.

- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from illness or injury, or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words, and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period. Visits are unlimited, but Aetna will review your treatment after 25 visits to verify additional visits are medically necessary. Through HealthPartners, visits are limited to 15 per year, and HealthPartners will review your treatment after six visits to verify additional visits are medically necessary.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate

Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits.

Unless specifically covered above, not covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Down's syndrome and cerebral palsy, as they are considered both developmental and/or chronic in nature.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer
- Any services unless provided in accordance with a specific treatment plan
- Services for the treatment of delays in speech development, unless resulting from illness, injury, or congenital defect
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above
- Services not performed by a physician or under the direct supervision of a physician
- Treatment covered as part of the Spinal Manipulation Treatment benefit (see page 50). This applies whether or not benefits have been paid under that section.
- Services provided by a physician or physical, occupational or speech therapist who resides in your home, is a member of your family or your spouse's/same-gender domestic partner's family, or is your same-gender domestic partner

- Special education to instruct a person whose speech has been lost or impaired, to function without that ability (This includes lessons in sign language.)

RECONSTRUCTIVE OR COSMETIC SURGERY AND SUPPLIES

Covered expenses include charges made by a physician, hospital, or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury. Note: Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when:
  - The defect results in severe facial disfigurement, or
  - The defect results in significant functional impairment and the surgery is needed to improve function

RECONSTRUCTIVE BREAST SURGERY

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

SPECIALIZED CARE

CHEMOTHERAPY

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

RADIATION THERAPY BENEFITS

Covered expenses include charges for the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

OUTPATIENT INFUSION THERAPY BENEFITS

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility
- The outpatient department of a hospital
- A physician in his/her office or in your home

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment, and nursing services required to support the infusion therapy
- Professional services
- Total parenteral nutrition (TPN)
- Chemotherapy
- Drug therapy (includes antibiotic and antivirals)
- Pain management (narcotics)
- Hydration therapy (includes fluids, electrolytes, and other additives)

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis
- Insulin

Coverage for inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility benefit.

TREATMENT OF INFERTILITY

Covered expenses include only charges made by a physician to diagnose and to treat the underlying medical cause of infertility.

SPINAL MANIPULATION TREATMENT

Covered expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine. Visits are unlimited, but Aetna will review your treatment after 15 visits to verify additional visits are medically necessary.

TRANSPLANT SERVICES

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your covered dependents may require an organ transplant. Organ means solid organ, stem cell, bone marrow, and tissue.

- Heart
- Lung
- Heart/lung
- Simultaneous pancreas kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone marrow/stem cell
- Multiple organs replaced during one transplant surgery

- Tandem transplants (stem cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant). The network level of benefits is paid only for a treatment received at a facility designated by the Plan as an Institute of Excellence™ (IOE) (Aetna) or a Designated Transplant Center (DTC) (HealthPartners) for the type of transplant being performed. Each IOE or DTC facility has been selected to perform only certain types of transplants.

NETWORK COVERAGE AT IOE OR DTC ONLY

Services obtained from a facility that is not designated as an IOE or DTC for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE or DTC for other types of services.

The Plan covers:

- Charges made by a physician or transplant team
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be

considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant, or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

Phase 1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

Phase 2. Pre-transplant/candidacy screening: Includes human leukocyte antigen (HLA) typing/compatibility testing of prospective organ donors who are immediate family members.

Phase 3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant, prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs, physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s), cadaveric and live-donor organ procurement.

Phase 4. Follow-up care: Includes all covered transplant expenses, home health care services, home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the IOE/DTC program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE/DTC facility will be considered network care expenses.

To ensure coverage, all transplant procedures need to be precertified by the claims administrator.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including, but not limited to, bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
- Services that are covered under any other part of this Plan
- Services and supplies furnished to a donor when the recipient is not covered under this Plan;
- Home infusion therapy after the transplant occurrence
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the claims administrator

NETWORK OF TRANSPLANT SPECIALIST FACILITIES

Through the IOE/DTC network, you will have access to a provider network that specializes in transplants. Benefits may vary if a non-IOE/DTC or out-of-network provider is used. In addition, some expenses are payable only within the IOE/DTC network. The IOE/DTC facility must be specifically approved and designated by the claims administrator to perform the procedure you require. Each facility in the IOE/DTC network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

OBESITY TREATMENT

Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Prescription drugs

MORBID OBESITY SURGICAL EXPENSES

Covered medical expenses include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a covered person.

Coverage includes the following expenses as long as they are incurred within a two-year period:

- One morbid obesity surgical procedure including complications directly related to the surgery
- Pre-surgical visits
- Related outpatient services
- One follow-up visit

This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the Plan's covered medical expenses, subject to Plan limitations and maximums.

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including, but not limited to, surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications
- Exercise programs, exercise or other equipment
- Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions
- Services that are covered to any extent under any other part of this Plan

TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE

TREATMENT OF MENTAL DISORDERS

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See Services Not Covered for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a physician or licensed provider
- The written treatment plan is for a condition that can favorably be changed

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows.

Inpatient Treatment

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Inpatient care, partial hospitalizations and outpatient treatment must be precertified by the claims administrator.

Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Inpatient care, partial hospitalizations and outpatient treatment must be precertified by the claims administrator.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

TREATMENT OF SUBSTANCE ABUSE

Covered expenses include charges made for the treatment of substance abuse by behavioral health providers.

Not all types of services are covered. For example, educational services and certain types of therapies are not covered.

Inpatient care, partial hospitalizations and outpatient treatment must be precertified by the claims administrator.

Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a physician or licensed provider
- The written treatment plan is for a condition that can be favorably changed

Inpatient Treatment

This Plan covers room and board at the **semi-private** room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes treatment in a hospital for the medical complications of substance abuse, including detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

Treatment in a hospital is covered only when the hospital does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. This Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance abuse.

Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

ORAL AND MAXILLOFACIAL TREATMENT (MOUTH, JAWS AND TEETH)

Covered expenses include charges made by a physician, a dentist or hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues
- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles, and nerves), for surgery needed to:
  - Treat a fracture, dislocation, or wound
  - Cut out teeth that are partly or completely impacted in the bone of the jaw, teeth that will not erupt through the gum, other teeth that cannot be removed without cutting into bone,

the roots of a tooth without removing the entire tooth, cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth (This is only covered when not done in connection with the removal, replacement or repair of teeth.)
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement

- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition natural teeth damaged, lost, or removed, or other body tissues of the mouth fractured or cut due to injury. Any such teeth must have been free from decay or in good repair, and be firmly attached to the jawbone at the time of the injury. The treatment must be completed in the calendar year of the accident or in the next calendar year.

DENTAL WORK COVERED BY MEDICAL PLAN

Dental work is covered by the Medical Plan only if needed due to an injury. Other dental work may be covered by the Unisys Dental Plan.

If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth
- The first crown needed to repair each damaged tooth
- An in-mouth appliance used in the first course of orthodontic treatment after the injury

NUTRITIONAL SUPPLEMENTS

Covered expenses include charges incurred for nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician.

Nutritional Supplement Services are exempt from the annual deductible.

SERVICES NOT COVERED

Not every medical service or supply is covered by the Plan, even if prescribed, recommended, or approved by your physician. The Plan covers only those services and supplies that are medically necessary and included in the *Covered Medical Services* section. Charges made for the following are not covered except to the extent listed under the *Covered Medical Services* section.

For detailed information about what is not covered by the Medical Plan, call Aetna at **800-223-3580** or HealthPartners at **800-883-2177**.

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *Covered Medical Services* section.
- Allergy: Specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.
- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD.
- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, prescription drugs, or supplies, even if otherwise covered under this SPD. This also includes prescription drugs or supplies if:
  - Such prescription drugs or supplies are unavailable or illegal in the United States; or
  - The purchase of such prescription drugs or supplies outside the United States is considered illegal.
- Applied Behavioral Analysis: the Learning Experiences – An Alternative Program (LEAP), Treatment and Education of Autistic and Communication Handicapped Children (TEACHC), Denver and Rutgers programs.
- Behavioral Health Services:
  - Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse is specifically provided in the *What the Medical Plan Covers* section
  - Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field
  - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use
  - Treatment of antisocial personality disorder
  - Treatment in wilderness programs or other similar programs
  - Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of the mentally retarded in accordance with the benefits provided in the *Covered Medical Services* section of this SPD
- Blood, blood plasma, synthetic blood, blood products or substitutes, including, but not limited to, the provision of blood, other than blood-derived clotting factors. Any related services including, but not limited to, processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

- Charges for a service or supply furnished by a network provider in excess of the negotiated charge.
- Charges for a service or supply furnished by an out-of-network provider in excess of the recognized charge. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the Plan. Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
- Contraception, except as specifically described in the *Covered Medical Services* section, including, but not limited to, over-the-counter contraceptive supplies such as condoms, contraceptive foams, jellies and ointments.
- Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
  - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures
  - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body
  - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin
  - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary
  - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy)
  - Repair of piercings and other voluntary body modifications, including, but not limited to, removal of injected or implanted substances or devices
  - Surgery to correct gynecomastia
  - Breast augmentation
  - Otoplasty
- Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counseling except as specifically provided in the *Covered Medical Services* section.
- Court ordered services, including, but not limited to, those required as a condition of parole or release
- Custodial care
- Dental services: Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
  - Services of dentists, oral surgeons, dental hygienists, and orthodontists including, but not limited to, apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and

vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards
- Other devices to protect, replace or reposition teeth
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including, but not limited to, treatment of malocclusion or devices to alter bite or alignment

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

- Disposable outpatient supplies: Any outpatient disposable supply or device, including, but not limited to, sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, other home test kits, splints, neck braces, compresses, and other devices not intended for reuse by another patient.
- Drugs, medications and supplies:
  - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including, but not limited to, vitamins
  - Any services related to the dispensing, injection or application of a drug
  - Any prescription drug purchased illegally outside the United States, even if otherwise covered under this Plan within the United States
  - Immunizations related to work
  - Needles, syringes and other injectable aids, except as covered for diabetic supplies
  - Drugs related to the treatment of non-covered expenses
  - Performance enhancing steroids
  - Injectable drugs if an alternative oral drug is available
  - Outpatient prescription drugs
  - Self-injectable prescription drugs and medications
  - Any prescription drugs, injectibles, or medications or supplies provided by the customer or through a third-party vendor contract with the customer
  - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy
- Educational services:
  - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs
  - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders (including pervasive developmental disorders), training or cognitive rehabilitation, regardless of the underlying cause
  - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills

- Examinations:

  Any health examinations required:

  - By a third party, including, but not limited to, examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement
  - By any law of a government
  - For securing insurance, school admissions or professional or other licenses
  - To travel
  - To attend a school, camp, or sporting event or participate in a sport or other recreational activity

- Any special medical reports not directly related to treatment except when provided as part of a covered service.
- Experimental or investigational drugs, devices, treatments or procedures, except as described in the *Covered Medical Services* section.
- Facility charges for care, services or supplies provided in:

  - Rest homes
  - Assisted living facilities
  - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care
  - Health resorts
  - Spas, sanitariums
  - Infirmaries at schools, colleges, or camps

- Food items: Any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if it is the sole source of nutrition.
- Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

  - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes
  - Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury

- Growth/height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Hearing:

  - Any hearing service or supply that does not meet professionally accepted standards
  - Hearing exams given during a stay in a hospital or other facility

- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech

- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:
  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools
  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices
  - Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs
  - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature
  - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, and home monitoring
  - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury
  - Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness
  - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device

- Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
- Infertility: Except as specifically described in the *Covered Medical Services* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including, but not limited to:
  - Drugs related to the treatment of non-covered benefits
  - Injectable infertility medications, including, but not limited to, menotropins, hCG, GnRH agonists, and IVIG
  - Artificial insemination
  - Any advanced reproductive technology (ART) procedures or services related to such procedures, including, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI); artificial insemination for covered females attempting to become pregnant who are not infertile as defined by the Plan
  - Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal
  - Procedures, services, and supplies to reverse voluntary sterilization

- Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including, but not limited to, fees for laboratory tests
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including, but not limited to, thawing charges
- Home ovulation prediction kits or home pregnancy tests
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures
- Ovulation induction and intrauterine insemination services if you are not infertile

- Maintenance care
- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies including, but not limited to:

  - Annual or other charges to be in a physician's practice
  - Charges to have preferred access to a physician's services such as boutique or concierge physician practices
  - Cancelled or missed appointment charges or charges to complete claim forms
  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including, but not limited to:

    - Care in charitable institutions
    - Care for conditions related to current or previous military service
    - Care while in the custody of a governmental authority
    - Any care a public hospital or other facility is required to provide
    - Any care in a hospital or other facility owned or operated by any Federal, state or other governmental entity, except to the extent coverage is required by applicable laws

- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Non-medically necessary services, including, but not limited to, those treatments, services, prescription drugs and supplies that are not medically necessary, as determined by the claims administrator, in its sole discretion, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician.
- Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including, but not limited to, telephone, television, internet, barber or beauty service or other guest services;

housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

- Private duty nursing during your stay in a hospital and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *Covered Medical Services* section.
- Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including, but not limited to:
  - Surgical procedures to alter the appearance or function of the body
  - Hormones and hormone therapy
  - Prosthetic devices
  - Medical or psychological counseling
- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.
- Services of a resident physician or intern rendered in that capacity.
- Services provided where there is no evidence of pathology, dysfunction, or disease except as specifically provided in connection with covered routine care and cancer screenings.
- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including, but not limited to:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services
- Services, including, but not limited to, those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section.
- Services that are not covered under the Plan.
- Services and supplies provided in connection with treatment or care that is not covered under the Plan.
- Speech therapy for treatment of delays in speech development, except as specifically provided in the *Covered Medical Services* section. For example, the Plan does not cover therapy when it is used to improve speech skills that have not fully developed.
- Spinal disorder, including, but not limited to, care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including, but not limited to, manipulation of the spine treatment, except as specifically provided in the *Covered Medical Services* section.
- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including, but not limited to:
  - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching
  - Drugs or preparations to enhance strength, performance, or endurance

- Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include pervasive developmental disorders (including, but not limited to, autism), Down syndrome, and cerebral palsy, as they are considered both developmental and/or chronic in nature.
- Therapies and tests: Any of the following treatments or procedures:
  - Aromatherapy
  - Bio-feedback and bioenergetic therapy
  - Carbon dioxide therapy
  - Chelation therapy (except for heavy metal poisoning)
  - Computer-aided tomography (CAT) scanning of the entire body
  - Educational therapy
  - Gastric irrigation
  - Hair analysis
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds
  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery
  - Lovaas therapy
  - Massage therapy
  - Megavitamin therapy
  - Primal therapy
  - Psychodrama
  - Purging
  - Recreational therapy
  - Rolfing
  - Sensory or auditory integration therapy
  - Sleep therapy
  - Thermograms and thermography
- Tobacco use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, but not limited to, counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the *Covered Medical Services* section.
- Transplant: Coverage does not include charges for:
  - Outpatient drugs including, but not limited to, bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
  - Services and supplies furnished to a donor when recipient is not a covered person
  - Home infusion therapy after the transplant occurrence
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness

- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by the claims administrator.

- Transportation costs, including, but not limited to, ambulance services for routine transportation to receive outpatient or inpatient services except as described in the *Covered Medical Services* section.
- Unauthorized services, including, but not limited to, any service obtained by or on behalf of a covered person without precertification when required. This exclusion does not apply in a medical emergency or in an urgent care situation.
- Vision-related services and supplies, except as described in the *Covered Medical Services* section. The Plan does not cover:
  - Special supplies such as non-prescription sunglasses and subnormal vision aids
  - Vision service or supply which does not meet professionally-accepted standards
  - Eye exams during your stay in a hospital or other facility for health care
  - Eye exams for contact lenses or their fitting
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frame
  - Replacement of lenses or frames that are lost or stolen or broken
  - Acuity tests
  - Eye surgery for the correction of vision, including, but not limited to, radial keratotomy, LASIK and similar procedures
  - Services to treat errors of refraction
- Weight: Any treatment, drug, service, or supply intended to decrease or increase body weight, control weight, or treat obesity, including, but not limited to, morbid obesity, regardless of the existence of comorbid conditions; except as specifically provided in the *Covered Medical Services* section, including but not limited to:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including, but not limited to, morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications
  - Counseling, coaching, training, hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement
- Work related: Any illness or injury related to employment or self-employment including, but not limited to, any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or Federal law. A source of coverage or reimbursement will be considered available to you

even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

PRESCRIPTION DRUGS

PRESCRIPTION DRUG BENEFITS

RETAIL RX (31-DAY SUPPLY)	IN-NETWORK	OUT-OF-NETWORK *(You pay the amount below plus any foregone discounts)*
Preventive Care Drugs (You Pay)	Annual deductible waived, subject to generic, preferred, or non-preferred pricing below	After annual deductible, subject to generic, preferred, or non-preferred pricing below
Generic (You Pay)	20%* with lower of $15 minimum or actual cost, maximum $30 (generic push)	40%* with $30 minimum, no maximum (generic push)
Preferred Brand Name (You Pay)	30%* with $30 minimum, $60 maximum (generic push)	40%* with $60 minimum, no maximum (generic push)
Non-Preferred Brand Name (You Pay)	40%* with $40 minimum, $80 maximum (generic push)	40%* with $80 minimum, no maximum (generic push)
MAIL ORDER RX (90-DAY SUPPLY)		
Preventive Care Drugs (You Pay)	Annual deductible waived, subject to generic, preferred, or non-preferred pricing below	N/A
Generic (You Pay)	20%* with lower of $30 minimum or actual cost, maximum $60 (generic push)	N/A
Preferred Brand Name (You Pay)	30%* with lower of $60 or discounted cost minimum, maximum $120 (generic push)	N/A
Non-Preferred Brand Name (You Pay)	40%* with $80 minimum, $160 maximum network (generic push)	N/A

*After annual deductible

PREVENTIVE CARE DRUGS

The Medical Plan includes the Prescription Drug Program administered by Express Scripts. Express Scripts has negotiated discounted charges for most drugs, so you pay less than the regular retail price. The Medical Plan annual deductibles apply to prescription drugs, except for preventive drugs. This means you pay 100% of the discounted price of non-preventive prescription drugs until your Medical Plan annual deductible is met. Then you pay coinsurance, subject to a minimum and maximum amount, as shown in the chart on the previous page for 2015. For most preventive drugs, you pay the coinsurance shown in the chart below, without having to first meet the Medical Plan annual deductible.

Prescription drugs that can help keep you from developing a health condition are called preventive care drugs or maintenance medications. Under the Consumer Health Plan, prescription drugs that are deemed preventive are not subject to the annual deductible. Preventive care drugs include prenatal vitamins, beta blockers (for high blood pressure), lipid-lowering agents (for high cholesterol) and diabetic medications.

GENERIC AND BRAND NAME DRUGS

A generic drug is a prescription drug identified by its chemical name that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent to and interchangeable with drugs having an identical amount of the same active ingredient. Your share of the cost for a generic drug is lower than for brand-name drugs.

A preferred brand name drug, sometimes called a formulary drug, is a brand-name drug that is on Express Script's list of approved (formulary) drugs. The list is reviewed by a panel of physicians and pharmacists. The purpose of the list is to promote the use of prescription medications that meet your medical needs at the lowest cost to the Medical Plan. Preferred brand name drugs cost more than generic drugs, but less than non-preferred brand name drugs. You can check **www.express-scripts.com** to see if your medication is considered a preferred brand name drug.

If you present a prescription for a non-preferred drug at a retail pharmacy, the pharmacist may contact your doctor to ask if a similar preferred drug may be appropriate for you. Your doctor makes the final decision. If the non-preferred drug is identical to a preferred drug because the active ingredients are the same, the retail pharmacist will dispense the preferred drug. Mail order pharmacists will not contact the doctor if a non-preferred drug is prescribed, unless a generic is available.

USING BRAND NAME WHEN GENERIC IS AVAILABLE

If a brand name drug is requested by you or your physician (for example, your doctor indicates "dispense as written" (DAW) on the prescription) when a generic is available, you will be required to pay the generic coinsurance rate plus the full difference between the brand name discounted price and the discounted generic price. The difference in cost is not a covered expense and does not apply toward your deductible.

There are a small number of prescription drugs that are excluded from the Medical Plan. If you

do not find your prescription drug on the preferred list, contact Express Scripts toll-free at **800-903-4734** or online at **www.express-scripts.com** to validate if your prescription is covered under the Medical Plan. If it is not covered, it is generally because there are generic or brand name equivalents available.

PREVENTIVE MEDICINES COVERED AT 100%

The preventive medicines in the following chart are covered at no cost to you, as required by the U.S. Patient Protection and Affordable Care Act.

PREVENTIVE MEDICINE	AVAILABLE TO
Aspirin, generic, 325 mg or less	Males age 45 – 79, females age 55 – 79
Folic acid, generic, 0.4 – 0.8 mg strengths only, single entity or combination product	Women through age 50
Iron supplements, generic, single entity or combination product	Infants, birth through 12 months
Smoking cessation, generic plus Chantix	Adults age 18 or older
Women's contraceptives, generic plus SS*, MS DAW1**	Women through age 50
Vitamin D, generic, single entity D2 or D3 containing 1,000 International Units (IU) or less per dose, may be combined with calcium	Age 65 or older
Bowel preparation agents, generic plus SS* brand	Adults age 50 – 75; two prescriptions in 365 days

*SS means brand-name medications for which there is no generic alternative.

*MS DAW1 means multi-source drugs with generic alternatives where the prescriber indicates that the drug is to be Dispensed as Written.

You pay coinsurance for other preventive medications, with no annual deductible. To find out if a drug is considered preventive, call Express Scripts at **800-903-4734.**

FILLING A PRESCRIPTION

RETAIL PHARMACIES

Express Scripts maintains a network of participating retail pharmacies. You will receive a separate prescription drug ID card to use whenever you or a covered dependent fill a prescription at a network retail pharmacy. If you have not yet received your ID card or you forget to bring it to the pharmacy, you may be charged the full cost of the prescription. Then you must file a form with Express Scripts to request reimbursement.

The maximum quantity available through a retail pharmacy is a 31-day supply. Quantities may be adjusted downward based on clinical guidelines or other requirements.

If you need a temporary ID card or require additional or replacement cards, or to find a network pharmacy, go to **www.express-scripts.com** or call Express Scripts at **800-903-4734.**

EXPRESS SCRIPTS BY MAIL

You can save by using the mail-order pharmacy if you have a prescription for more than a two-month supply. You may receive up to a 90-day supply at one time. Ask your doctor to write a prescription for a 90-day supply plus refills for up to one year, if appropriate. Many physicians' offices are already set up to submit prescriptions to Express Scripts for you after you show your drug ID card. If necessary, you may submit a prescription by completing the mail-order form available online at **www.express-scripts.com** and mailing it to Express Scripts at the address shown. Alternatively, you may obtain a physician's form online for your doctor to complete and fax to Express Scripts.

NON-NETWORK PHARMACIES

If you use a non-network retail pharmacy, you pay the entire cost of the prescription and submit a claim to Express Scripts. Claim forms are available online at **www.express-scripts.com** or by calling Express Scripts at **800-903-4734**. The instructions are included on the claim form. Your share of the cost is based on two times the coinsurance rate and minimum that applies to a network pharmacy. You pay the discounts foregone by failing to use a network pharmacy. If you receive a brand name drug when a generic is available, you also pay the full difference between the discounted network cost for the brand name drug and for the generic drug.

SPECIALTY DRUGS

Some specialty drugs are only available from the Express Scripts Specialty Pharmacy. These are self-injectable drugs and other specialty medications that may need special handling or refrigeration. If you are unsure if you are on a specialty medication, visit **www.express-scripts.com** for more information. If you have questions about the program, you can talk to a specialty pharmacist 24/7 by calling **866-848-9870**.

PRESCRIPTIONS OUTSIDE THE U.S.

If you receive a prescription while outside the U.S., the Plan reimburses in the same manner as for a non-network pharmacy. Only drugs covered in the U.S. are eligible for reimbursement. Prescriptions approved for use in other countries that have not been approved in the U.S. are not covered.

COVERED PRESCRIPTIONS

For a prescription to be covered, it must be:

- Medically necessary
- Prescribed by a physician
- Dispensed by a licensed pharmacist through a licensed pharmacy
- For 31 days or less for a retail pharmacy or 90 days or less for Express Scripts by Mail
- Approved by the FDA as needing a doctor's prescription for dispensing
- Filled or refilled within one year from the doctor's order

The following are also covered:

COVERED PHARMACY ITEMS
▪ Allergy serums ▪ Contraceptives and contraceptive devices available only by prescription (except emergency contraceptives) ▪ Over-the-counter diabetic supplies, except blood glucose monitors and insulin pumps ▪ Insulin, insulin pens, needles and syringes ▪ Smoking cessation products that require a prescription ▪ Some self-injectable medications, subject to prior authorization ▪ Medication for obesity, only if body weight is greater than 150% of expected body weight and a medical condition is directly exacerbated by the obesity (such as hypertension, cardiac disease, respiratory disease or Type I diabetes), and other requirements are met ▪ Viagra and lifestyle drugs, only if required to treat an underlying medical condition resulting from injury or illness ▪ Methadone ▪ Yohimbine ▪ Ostomy supplies ▪ Methotrexate ▪ Retin A/Avita through age 35

PHARMACY ITEMS NOT COVERED

The following items are not covered by the Prescription Drug Program.

PHARMACY ITEMS NOT COVERED
▪ Appetite suppressants ▪ Infertility medications (except to restore normal bodily function for non-infertility purposes; prior authorization required) ▪ Drugs labeled "Caution—limited by Federal law to investigational use," or experimental drugs, even if a charge is made to the individual ▪ Injectable drugs administered by a health care professional (may be covered by the Medical Plan) ▪ Take-home drugs dispensed by a hospital upon discharge (may be covered by the Medical Plan) ▪ Medications with no approved FDA indications ▪ Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only ▪ Medications covered under Workers' Compensation or similar legislation

PHARMACY ITEMS NOT COVERED
■ Over-the-counter medications or equivalents
■ Prescribed medications that have an over-the-counter equivalent, unless your doctor indicates that you tried the over-the-counter drug and it did not relieve your symptoms
■ Over-the-counter smoking cessation products
■ Prescriptions filled or refilled after one year from the doctor's order
■ Quantities in excess of manufacturer's recommended dispensing
■ Replacements for prescriptions that have been lost, stolen or broken
■ Vitamins, minerals, food supplements, food substitutes, or nutritional supplements for any reason
■ Durable or disposable medical devices, such as crutches, insulin pumps, colostomy supplies, and nebulizers (may be covered under the Medical Plan)
■ Non-Federal legend drugs
■ Emergency contraceptives
■ Homeopathic drugs
■ Dental fluoride products
■ Blood glucose monitors
■ Retin-A/Avita for age 36 and over
■ Mifeprex
■ Therapeutic devices or appliances
■ Biologicals, immunization agents or vaccines
■ Blood or blood plasma products

While prescription vitamins are not covered, Express Scripts by Mail will provide prescription vitamins at a discounted rate if the vitamin is only available through prescription and it is required therapy for a specific medical condition or pregnancy.

CLINICAL MANAGEMENT PROGRAMS

The Prescription Drug Program includes several clinical management programs designed to support the cost-effective and medically appropriate use of prescription drugs. A list of drugs subject to the clinical management programs is available at **www.express-scripts.com** or you may call Express Scripts at **800-903-4734** to find out if your prescription is subject to clinical management.

PRIOR AUTHORIZATION

Some drugs are subject to a review called prior authorization before they can be dispensed. If you present a prescription for one of these drugs at a retail pharmacy, the pharmacist will tell you that the prescription must be submitted to Express Scripts for review before it can be filled. If you submit a prescription to Express Scripts by Mail, the mail order pharmacist will handle the review. Express Scripts will request additional information from your doctor as part of the review.

Depending on the availability of information from your doctor's office, review could take from 24 hours to one or two business days.

If coverage is approved, you pay your normal coinsurance. If coverage is not approved, you pay the full cost of the drug or, if appropriate, you can talk to your doctor about alternatives. You have the right to appeal the decision.

Prior authorization approvals expire at the end of the initial prescription period or one year from the date of the first fill, whichever comes first.

DRUGS SUBJECT TO CLINICAL MANAGEMENT

A list of drugs subject to the clinical management programs is available at **www.express-scripts.com** or you may call Express Scripts at **800-903-4734** to find out if your prescription is subject to clinical management.

STEP THERAPY

Step therapy applies when there is a range of different drugs available to treat a medical condition. You are required to first try the safest, most inexpensive treatment before a prescription will be filled for a more-expensive drug with more side effects.

The first step in a step therapy process is usually a simple, inexpensive treatment known to be safe and effective for most people. This is called "first-line" therapy and could involve treatment with over-the-counter drugs or generic drugs. First-line therapies do not require prior authorization.

If first-line therapy doesn't work or causes problems, a "second-line" therapy may be tried. Second-line therapies have more side effects, may be more difficult to take, and may be more expensive than first-line alternatives. There may also be "third-line" therapies that require trials of first-line and second-line therapies before being covered.

If you present a prescription for a second-line or third-line drug, the Express Scripts system will check your drug history to determine if you have tried the appropriate first-line therapies. If your prescription records indicate you have not tried first-line therapy, the second-line drug is not covered. If the request is for a third-line therapy, then you must have tried a first-line and second-line therapy or the third-line drug is not covered.

Drugs subject to step therapy include brand name drugs with a generic equivalent, growth hormones, certain topical medications, proton pump inhibitors, and certain drugs to treat Alzheimer's disease, depression and allergies. A list of drugs currently subject to the step therapy program is available at **www.express-scripts.com** or you may call Express Scripts at **800-903-4734** to find out if your prescription is subject to step therapy. Most of the Plan's step therapy programs have exceptions for certain medications and/or participant medical histories. For certain medical histories, a second-line or third-line medication may be approved without a trial of a first-line medication.

DOSE MANAGEMENT

Some drugs are subject to protocols that determine the quantity and duration that are

appropriate to treat the majority of cases. If you submit a prescription for one of these drugs that is for a longer period or greater dosages or quantities than established by the protocol, prior authorization is required before the excess is approved for coverage.

QUANTITY LIMITS

The FDA establishes limits on the maximum recommended dosage for several drugs. Drug manufacturers may also specify maximum quantity limits. Express Scripts will fill prescriptions for these drugs for no more than the maximum recommended dosage. For example, if the maximum recommended dosage is two pills per day for two weeks, a prescription for 50 pills would be reduced to 28. Drugs subject to quantity limits include certain drugs to treat migraine headaches or pain.

DOSE OPTIMIZATION

Dose optimization is a voluntary program. Express Scripts may contact your doctor to suggest changing a daily dosage regimen from multiple lower strength doses to a single higher dose if clinical guidelines suggest that such a change is safe and cost-effective. The medication is covered whether or not your doctor changes the dosage regimen. For example, instead of taking two 5 milligram pills per day, you might be able to take one 10 milligram pill.

LIMITATIONS ON COMPOUND MEDICATIONS

Some compound medications are not covered by the Prescription Drug Program. Compound medications require a licensed pharmacist to combine, mix or alter the ingredients when filling a prescription. Their quality, safety and/or effectiveness is not verified by the FDA. To avoid paying the full cost for these medications, ask your doctor for prescriptions for FDA-approved drugs rather than compound medications.

LIMITATIONS ON NEW MEDICATIONS

Newly approved specialty medications are not automatically added as a covered expense immediately upon their launch. Coverage decisions are based on a number of criteria, including the availability and efficacy of existing medications and the projected effectiveness of the new drug.

COORDINATION WITH OTHER GROUP COVERAGE

The Prescription Drug Program does not have a coordination of benefits provision. If you have drug coverage available elsewhere, you must decide at the time you fill your prescription whether to claim your benefits under the Unisys Medical Plan or your other drug coverage.

NOTICE OF CREDITABLE COVERAGE FOR MEDICARE PART D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a prescription drug benefit to Medicare, effective January 1, 2006. This coverage is referred to as Medicare Part D. If you are entitled to Medicare Part A and/or Part B, you are eligible for Part D of Medicare. All Medicare prescription drug plans must provide at least a standard level of coverage set by Medicare. Some may exceed the Medicare requirements for a higher monthly premium.

All of the Medical Plan options available to eligible active associates and their covered dependents provide coverage for prescription drugs that meets the qualifications to be considered creditable coverage under MMA. Because you have creditable coverage if you

participate in any of the Medical Plan options while you are an active associate or the dependent of an active associate, you can defer your participation in Medicare Part D without penalty until after you leave the Company.

If you are eligible for Medicare, you have the right to request a notice verifying that you have creditable coverage for prescription drugs. To request this notice, contact the Unisys Benefits Service Center (UBSC) at **877-864-7972**, Monday to Friday (except holidays), 9:00 a.m. to 5:00 p.m., Eastern Time.

Note: If you are eligible for and enroll in a Medicare Part D prescription drug plan, you will not receive a benefit from both the Medicare Part D plan and the Prescription Drug Program through your Medical Plan option for any of the Medical Plan options described in this SPD. You will need to choose which benefits to use each time you obtain prescription drugs.

WELLNESS AND DISEASE MANAGEMENT

The Medical Plan includes several wellness features. The Medical Plan covers preventive care at 100% in network with no annual deductible, and 50% out of network subject to the annual deductible, offers health care advocacy services, and rewards you with lower contributions if you and your household members do not smoke or quit smoking.

BIOMETRIC SCREENING DISCOUNT

You can earn the Biometric Screening Discount by participating in a voluntary biometric screening to help educate you about your health and how you can improve it. The results of the screening will not impact this discount or be shared with Unisys. To earn the Biometric Screening Discount in 2015, associates and spouses/same-gender domestic partners who are enrolled in the Consumer Health Plan and complete voluntary biometric screenings in a timely manner will receive a $100 monthly contribution discount per associate and spouse/same-gender domestic partner. Biometric screenings do not apply to children. Information about any Biometric Screening will be provided each year in your Annual Enrollment materials.

NON-TOBACCO USER DISCOUNT

If you and your household members are tobacco free and pledge not to use tobacco in the future, Unisys rewards you with a $90 per month (per household) contribution discount. Tobacco use is self-reported during Annual Enrollment. Misrepresenting whether or not anyone in your household utilizes tobacco may result in disciplinary action up to and including termination of employment, in accordance with Unisys policies.

If it is unreasonably difficult for you or a family member to meet the requirements due to a health factor, or if it is medically inadvisable for you, please contact the Unisys Benefits Service Center (UBSC) toll-free at **877-864-7972** to see if you may be otherwise eligible for the discount.

HOUSEHOLD MEMBERS

The contribution discount for a tobacco-free household applies only if you and all your household members are tobacco free. Members of your household include anyone living with you, whether or not they are covered under the Medical Plan.

TELADOC

Teladoc is a service that allows you to speak via telephone or video conference (available in most states*) with a board-certified physician anytime, provided you are enrolled in the Consumer Health Plan. Whether on vacation or traveling for work, Teladoc is there for you 24/7/365. Teladoc's board-certified physicians can diagnose, recommend treatment, and prescribe medication around the clock for less than the cost of an urgent care of emergency room (ER) visit. Teladoc costs you $40 per consultation and these charges count toward your annual out-of-pocket maximum and deductible. Similar to your family physician, Teladoc will file the claims directly with Aetna or HealthPartners, and you will be charge accordingly.

* Please note, state regulations prohibit phone consultations in Idaho and video consultations in Texas. Teladoc is not offered in Arkansas at this time. Teladoc is unavailable outside of the U.S.

If you are enrolled in the Aetna or HealthPartners Consumer Health Plan, visit **www.teladoc.com/Unisys** or call toll-free 24 hours a day/7 days a week/365 days a year at **855-Teladoc (835-2362)**.

HEALTHADVOCATE™

HealthAdvocate™ is an independent third-party resource that can assist you and your eligible family members with all health care-related questions without charge. They can assist you with claims payment questions, help you find a provider, answer general health questions, provide cost estimates if you need services, and much more. Contact HealthAdvocate™ toll-free 24 hours a day/7 days a week at **866-695-8622** or visit **www.healthadvocate.com**. You do not need to enroll in the Unisys Consumer Health Plan to take advantage of this free service. Specific services include:

- Find the right doctors – HealthAdvocate™ will locate the right hospitals, dentists and other leading health care providers anywhere in the U.S.
- Schedule appointments – HealthAdvocate™ can help expedite the earliest appointments with providers including hard-to-reach specialists and arrange treatments and tests.
- Help resolve medical claims – HealthAdvocate™'s experts get to the bottom of your issue to assist with negotiating billing and payment arrangements.
- Assist with eldercare – HealthAdvocate™ addresses senior issues such as Medicare and related health care issues, including those facing your parents and parents-in-law.
- Assist in the transfer of medical records – HealthAdvocate™ will handle the details of transferring X-rays and lab results.
- Work with insurance and other companies – HealthAdvocate™'s team works on your behalf to obtain appropriate approvals for needed services.
- Answer questions – HealthAdvocate™ helps you become informed about test results, treatments and medications prescribed by your physician.
- Get estimates – HealthAdvocate™'s new smartPhone app features the Health Cost Estimator™ tool for pricing estimates of common medical procedures in your area.
- Basic Health Information and Tips – HealthAdvocate™'s Health and Wellness blog is constantly being updated with new findings and tips to help you stay healthy. Visit the blog at **http://blog.healthadvocate.com**.

COORDINATION OF BENEFITS

WHEN THERE IS MORE THAN ONE HEALTH PLAN

Some people have health coverage in addition to coverage under this Plan. To avoid providing duplicate benefits, the Plan has a "coordination of benefits" provision. Under the coordination of benefits provision, the amount normally reimbursed under this Plan is reduced to take into account payments made by other group health care plans, any other types of group health care coverage and the legally required level of benefits under no-fault auto insurance.

When this Plan and another health expense plan applies, the order in which the plans will pay benefits uses the first rule of these rules that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan that covers a person other than as a dependent will be deemed to pay its benefits before a plan that covers the person as a dependent; except that if the person is also a Medicare beneficiary and 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;

   The benefits of a plan that covers the person as a dependent will be determined before the benefits of a plan that covers the person as other than a dependent and is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan that covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision 3 but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in 3 above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      - If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined

before the benefits of a plan which covers the child as a dependent of the parent without custody.

- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

- The benefits of a plan which covers the person on whose expenses the claim is based as a:
  - Laid-off or retired associate; or
  - The dependent of such person
- Shall be determined after the benefits of any other plan which covers such person as:
  - An associate who is not laid-off or retired; or
  - A dependent of such person.

If the other plan does not have a provision regarding laid-off or retired associates, and as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to Federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision regarding right of continuation pursuant to Federal or state law, and as a result, each plan determines its benefits after the other, then the paragraph above will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all other plans for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any other plan both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to the claims administrator for consideration that have been grouped together for administrative purposes as a "claim transaction" in accordance with the claims administrator’s then current rules.

In order to administer this provision, the claims administrator can release or obtain data and make or recover payments.

CONTINUATION OF COVERAGE

COBRA CONTINUATION COVERAGE

A Federal law called the U.S. Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) allows you and your covered dependents to continue your medical, dental and vision coverage after it would otherwise end due to a qualifying event, subject to certain conditions and your timely payment of contributions.

COBRA does not apply to same-gender domestic partners or their children if they are not also your Federal income tax dependents. However, Unisys offers COBRA-like continuation coverage to same-gender domestic partners and their children (who are not Federal income tax dependents) that generally mirrors what is offered through COBRA (except, for example, the income tax treatment of such coverage, etc.).

The qualifying events that result in eligibility for COBRA or COBRA-like coverage and the maximum coverage periods available are listed below.

QUALIFYING EVENT CAUSING LOSS OF HEALTH COVERAGE	COVERED PERSONS ELIGIBLE TO ELECT CONTINUATION	MAXIMUM CONTINUATION PERIODS
Your active employment ends	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the Plan	Your dependent children	36 months
You die	Your dependents	36 months

You have 60 days from the qualifying event to elect COBRA or COBRA-like coverage. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

DISABILITY MAY INCREASE MAXIMUM CONTINUATION TO 29 MONTHS

IF YOU OR YOUR COVERED DEPENDENTS ARE DISABLED

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18-month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18-month maximum continuation period
- Qualify for an additional 11-month period, subject to the overall COBRA conditions
- Must notify the UBSC within 60 days of the disability determination status and before the 18-month continuation period ends
- Must notify the UBSC within 30 days after the date of any final determination that you or a covered dependent are no longer disabled.
- Are responsible to timely pay the contributions through the 29th month

IF THERE ARE MULTIPLE QUALIFYING EVENTS

A covered dependent could qualify for an extension of the 18- or 29-month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

YOUR CONTRIBUTIONS FOR CONTINUATION COVERAGE

Your contributions are regulated by law, and the cost to you is the group rate (that is, both the associate and employer portions) plus a 2% administrative fee. Your failure to pay the required contributions by the due date shown on the applicable billing statement results in the irrevocable termination of coverage retroactive to the end of the period covered by the last contributions made.

ENROLLING FOR COBRA OR COBRA-LIKE COVERAGE

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and timely submit an application for continued health coverage, which is an election notice of your intent to continue coverage
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later
- Agree to pay the required contributions

WHEN YOU ACQUIRE A DEPENDENT DURING A CONTINUATION PERIOD

If through birth, adoption, placement in your home for adoption, a stepchild joining your household, court assignment of legal guardian status, marriage or entering a qualifying same-gender domestic partnership, you acquire a new dependent during the continuation period, your dependent can be added to the Plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent. See page 6 for a detailed list of eligible dependents.
- The UBSC is notified about your dependent within 31 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis

WHEN COBRA OR COBRA-LIKE COVERAGE ENDS

Your COBRA or COBRA-like coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the applicable 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled or eligible for an extended maximum)
- You or your covered dependents do not timely pay required contributions
- You or your covered dependents become covered under another group plan
- The date Unisys no longer offers a group health plan
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other Federal law
- You or your dependent dies

COMPANY-SUBSIDIZED COBRA OR COBRA-LIKE COVERAGE

Unisys will pay the employer portion of the cost of COBRA or COBRA-like coverage for you and your covered dependents as shown in the following chart. To keep your coverage in effect, you must pay the associate contribution that applies to active associates. The period of Company-subsidized COBRA counts toward your maximum months of COBRA coverage.

IF TERMINATION IS DUE TO	THEN COBRA IS SUBSIDIZED
Workforce reduction or lay-off	Until the later of (1) three months from Separation Date or (2) one week per full year of service up to a maximum of 26 weeks
Your death with less than 25 years of service	For six months for your covered dependents
Unpaid Leave of Absence (non-FMLA)	Until the earlier of (1) three months from the start of an approved unpaid Leave of Absence or (2) the date on which the unpaid Leave of Absence is no longer approved or you return to work

The UBSC bills you (or your dependents) for required contributions during the Company-subsidized COBRA coverage period. The required contributions are the same rates that apply to active associates. However, contributions are paid on an after-tax basis for Federal tax purposes. Failure to timely pay the required contributions will result in loss of coverage.

CONTINUATION OF ACTIVE COVERAGE

Your coverage as an active associate will continue for you and/or your covered dependents during the following periods when you are absent from work, as long as you timely pay your required contributions at the same rates that apply to active associates. If you are not receiving enough pay to cover your required contributions, you must make arrangements with the UBSC for direct billing. These periods of continued active coverage do not count toward your maximum months of COBRA coverage when your employment terminates:

IF YOUR ABSENCE FROM WORK IS DUE TO	THEN YOUR ACTIVE COVERAGE CONTINUES
Approved disability leave of absence, first 26 weeks	For 26 weeks
Return to active employment in a rehabilitative status after eligibility for benefits under the Unisys Long-Term Disability (LTD) Plan	For as long as your rehabilitative employment lasts, at the same level as when you became disabled (for example, if you were regular full-time when your disability occurred, your rates for Medical coverage will be the same as an active associate's, even if your rehabilitative employment is regular part-time)
Approved unpaid leaves of absence due to Family and Medical Leave Act (FMLA)	During the approved FMLA period
Your death with 25 or more years of service	For up to six months for your covered dependents

If an Annual Enrollment occurs during coverage for one of the reasons above, you (or your dependents) may change elections in the same manner as active associates. Any default provisions that apply to active associates who do not make an election will apply if you or your dependents do not make an election.

SUBROGATION

SUBROGATION AND RIGHT OF REIMBURSEMENT

The Medical Plan does not cover medical expenses that are the legal responsibility of another person to pay, such as medical expenses resulting from an accident for which another person is liable. However, the Plan will cover the expenses, subject to a right to be reimbursed from any recovery you may receive from the liable person or insurance company, as described in this section.

DEFINITIONS

As used throughout this provision, the term responsible party means any party actually, possibly, or potentially responsible for making any payment to a covered person due to a covered person's injury, illness or condition. The term responsible party includes, but is not limited to, the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term insurance coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first-party insurance coverage.

For purposes of this provision, a covered person includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

SUBROGATION

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a covered person has against any responsible party with respect to any payment made by the responsible party to a covered person due to a covered person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to be reimbursed for such benefits in full and no portion of the Plan's recovery shall be reduced by the fees or costs (including, but not limited to, attorney's fees) associated with any claim, lawsuit, or settlement agreement in connection with any recovery, without the express written consent of the Plan Administrator.

REIMBURSEMENT

In addition, if a covered person receives any payment from any responsible party or insurance coverage as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the covered person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the covered person receives from any responsible party (regardless of any expenses, costs or attorneys fees deducted from such amount).

CONSTRUCTIVE TRUST

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that if he/she receives any payment from any responsible party as a result of an injury,

illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the Plan.

LIEN RIGHTS

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any insurance coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the covered person, the covered person's representative or agent, the responsible party, the responsible party's insurer, representative, or agent, and/or any other source possessing funds representing the amount of benefits paid by the Plan.

FIRST-PRIORITY CLAIM

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person acknowledges that the Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered person that is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered person to pursue the covered person's damage claim.

APPLICABILITY TO ALL SETTLEMENTS AND JUDGMENTS

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses (including, but not limited to, attorneys fees). The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, noneconomic damages and/or general damages only.

COOPERATION

The covered person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the covered person. The covered person and his/her agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by the covered person, may result in the termination of health benefits for the covered person or the institution of court proceedings against the covered person.

NO PREJUDICE

The covered person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The covered person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. The Plan reserves the right to notify the responsible party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

INTERPRETATION

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

JURISDICTION

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

WORKERS' COMPENSATION

If benefits are paid under this Medical Plan and the claims administrator determines you received Workers' Compensation benefits for the same incident, the claims administrator has the right to recover as described under the Subrogation and Right of Reimbursement provision. The claims administrator, on behalf of the Plan, will exercise its right to recover against you. The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise

You hereby agree that, in consideration for the coverage provided by this Medical Plan, you will notify the claims administrator of any Workers' Compensation claim you make and that you agree to reimburse the claims administrator on behalf of the Plan as described above.

If benefits are paid under this Medical Plan and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, the claims administrator, on behalf of the Plan, has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

CLAIMS AND APPEALS

MEDICAL CLAIMS AND APPEALS

The claims and appeals procedures described in this section apply to the Medical Plan. The claims and appeals procedures for the Dental and Vision Plans can be found in the SPDs for those Plans.

Disagreements about benefit eligibility or payment amounts can occasionally arise. In most cases, the appropriate claims administrator resolves them quickly. If you can't resolve the disagreement, formal claim and appeal procedures are in place for your use.

CLAIMS RELATED TO ELIGIBILITY, ENROLLMENT OR CONTRIBUTIONS

All determinations as to your eligibility or the eligibility of your dependents for coverage under the Plan that are not accompanied by a claim for benefits will be made by the Unisys Benefits Service Center (UBSC). The UBSC is the claims administrator for determining eligibility, processing enrollments, allowing changes to benefits elections due to a Qualifying Life Event, and determining the required contributions for your coverage based on your elections.

If you have a complaint or disagreement about eligibility, enrollment or contributions, call the UBSC at **877-864-7972**. The UBSC will attempt to resolve your complaint on an informal basis. Most disagreements can be resolved at this level.

If you disagree with an oral determination, you or your authorized representative can file a written claim on a Claim Initiation Form (available from the UBSC) (see details below as to what should be included in the written claim) within 90 calendar days of the date of the oral determination (or the date the oral determination should have been made). Failure to submit a written claim within the 90-day time frame results in the loss of your rights to take such an action. Your Claim Initiation Form should be timely submitted to:

Claims and Appeals Management Team (CAMT)
PO Box 1407
Lincolnshire, IL 60069

Your claim may be approved or denied. You will generally be notified of the determination within 90 calendar days after the date your completed Claim Initiation Form or a written claim is received (up to 90 additional calendar days are available under special circumstances, in which case the UBSC will indicate the circumstances requiring the extension and the date by which a decision is expected). If your eligibility claim affects a claim for benefits that is an urgent-care claim, a concurrent care claim, a pre-service claim, or a post-service claim, the UBSC will process your eligibility claim within the time frames required for such medical benefit claims, as described below.

If your appeal is denied, the denial letter will contain:

- The specific reason or reasons for the denial.
- References to the specific Unisys Medical Plan provisions on which the denial is based.
- A statement that you are entitled to receive, free of charge upon written request, reasonable access to and copies of, all documents, records and other information that is relevant to your appeal.
- A statement that you have the right to bring a civil action under section 502(a) of ERISA following an adverse decision on appeal, provided such action is brought in a timely manner.

If the UBSC denies your eligibility, enrollment or contributions claim, you or your authorized representative may appeal the denial by submitting a written request to the Appeals Administrator within 180 calendar days after you receive the written notice denying your written claim.

CLAIMS FOR MEDICAL BENEFITS

Claims for medical or prescription drug benefits are made to the applicable claims administrator. Aetna and HealthPartners are the claims administrators for the medical benefits and Express Scripts is the claims administrator for prescription drug benefits (see next section for Prescription Drug claims and appeals). The determination of the claims administrator is final, except for your right to timely file a written appeal (see below).

If you participate in the Kaiser HMO, your appeals procedure is explained in the SPD for that option.

FILING HEALTH CLAIMS UNDER THE PLAN

Under the Plan, you may file written claims for Plan benefits and file written appeals of adverse claim determinations. Any reference to “you” in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

Your written claim for benefits must contain:

- Your name and address,
- Your identification number and contract number shown on your medical identification card (not your Prescription Drug identification card) and the same information for the patient if you are not the patient,
- The patient’s date of birth and relationship to you,
- Itemized statement from the provider showing the dates of service, the diagnosis code, the procedure codes for their services, the full name and address of the provider, and the charge for each service (for pre-service claims, the proposed dates of service and charges should be provided),
- If the services are required as the result of an accidental injury or urgent medical need, provide all details — be sure to include how, when, and where the situation arose; and
- Other group coverage that may apply. The Company follows “coordination of benefits” provisions to determine your benefit payments under the Plan (see the *Coordination of Benefits* section on page 78).

Your claim should be mailed to the claims administrator for your Plan at the following address:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

Or fax to: **859-425-3379**.

HealthPartners
Member Services Department
HealthPartners, Inc.
8170 33rd Ave., South
P.O. Box 1309
Minneapolis, MN 55440-1309

If your claim is denied in whole or in part, you will receive a written notice of the denial from the claims administrator. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

URGENT CARE CLAIMS

An "Urgent Care Claim" is any claim for medical care or treatment for which (1) the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, as determined by the claims administrator in its sole discretion, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or (2) if a physician with knowledge of your medical condition determines that it is.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the claims administrator or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible, taking into account your medical circumstances, but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, taking into account your medical circumstances, but not less than 48 hours, to provide the information, and you will be notified of the decision no later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

OTHER CLAIMS (PRE-SERVICE AND POST-SERVICE)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. For prescription drugs, a pre-service claim is for a prescription drug that requires prior authorization in advance of receipt. You will be notified of the decision within a reasonable period of time appropriate to your medical circumstances, but no later than 15 days after receipt of the pre-service claim. For other claims (post-service claims), you will be notified of the decision no later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days if the claims administrator determines that an extension is necessary due to special circumstances. In that case, you will be notified of the extension before the end of the applicable initial 15-day or 30-day period indicating the circumstances requiring the extension and the date by which a decision is expected. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the claims administrator's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which are unclear or fail to name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a representative the claims administrator responsible for handling benefit matters, or which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within five days after receipt of the claim (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

CONCURRENT CARE REVIEW CLAIM (ONGOING COURSE OF TREATMENT)

A concurrent-care review claim is a claim relating to the continuation or reduction of an ongoing course of treatment to be provided over a period of time or number of treatments.

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the claims administrator and receive a decision on that appeal before the termination or reduction takes effect. If the ongoing course of treatment involves urgent care and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision as soon as possible, taking into account your medical circumstances, but in any event within 24 hours after receipt of the request.

HEALTH CLAIMS – STANDARD APPEALS

As an individual enrolled in the Plan, you have the right to file a written appeal with the claims administrator from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit)
- Coverage and other determinations under the Plan’s provisions, including Plan limitations or exclusions
- The results of any utilization review activities
- A decision that the service, supply or prescription drug is experimental or investigational
- A decision that the service or supply is not medically necessary

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (the claims administrator) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

EXHAUSTION OF INTERNAL APPEALS PROCESS

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if the claims administrator, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable Federal law, you are considered to have exhausted the Plan’s appeal requirements (Deemed Exhaustion) and may proceed with External Review or may pursue any available remedies under Section 502(a) of ERISA or under state law, as applicable (see page

96 for more details on your ability to file a legal action in a timely manner).

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if these three conditions apply:

- A rule violation was minor and is not likely to influence a decision or harm you
- It was for a good cause or was beyond the claims administrator's or the Plan's or its designee's control
- It was part of an ongoing good faith exchange between you and the claims administrator or the Plan

This exception is not available if the rule violation is part of a pattern or practice of violations by the claims administrator or the Plan.

You may request a written explanation of the violation from the claims administrator, and the claims administrator must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin upon your receipt of such notice.

FULL AND FAIR REVIEW OF CLAIM DETERMINATIONS AND APPEALS

The claims administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to the claims administrator at the address provided in this SPD, or, if your appeal is of an urgent nature, you may call the claims administrator's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

A representative of the claims administrator may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal in writing the determination to the claims administrator. You will be notified of the decision within a reasonable period of time, but no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that the claims administrator provide you, free

of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, you can initiate an expedited appeal by calling the phone number included in your denial, or the claims administrator 's Member Services. The claims administrator's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and the claims administrator by telephone, facsimile, or other similar method. You will be notified of the decision as soon as possible, taking into account the medical circumstances, but no later than 36 hours after the appeal is received.

If your appeal is denied in whole or in part, the claims administrator will provide you with a written notice of the denial that will include the following:

- The specific reason or reasons for the appeal denial.
- Reference to the specific Plan provisions on which the appeal denial is based.
- A statement that you are entitled to receive, free of charge upon written request, reasonable access to, and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits.
- If the appeal denial is based on an internal rule, guideline, protocol or other similar criterion, the appeal denial will indicate this and either provide a copy or provide a statement that you are entitled to receive, free of charge upon written request, a copy of the rule, guideline, protocol, or other similar criterion that was relied upon in making the appeal determination.
- If the appeal denial is based on medical necessity or experimental/investigative treatment or similar exclusion or limit, the denial will either explain the scientific or clinical judgment for the determination, including how the terms of the Plan were applied to your circumstances, or will indicate that you are entitled to receive such explanation, free of charge upon written request.
- A description of the second-level appeals procedures and the time limits that apply. The description will include a statement that you have the right to bring a civil action under Section 502(a) of the Federal Employee Retirement Income Security Act of 1974, as amended (ERISA) following an adverse decision on second-level appeal, provided such action is brought within one year after the date the final adverse appeal decision is issued or should have been issued. Failure to bring a civil action within this time frame results in the loss of your rights to bring such an action.

SECOND LEVEL APPEAL

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal within 60 days of receipt of the level one appeal decision. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

HEALTH CLAIMS – VOLUNTARY APPEALS

External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from the claims administrator will describe the process to follow if you wish to pursue an External Review and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to the claims administrator within 123 calendar days after the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations (or Plan deadline for filing a lawsuit) will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and any of the following are satisfied:

- The claims administrator, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under Federal law (except for minor violations)
- The standard levels of appeal have been exhausted
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage that has retroactive effect

An Adverse Benefit Determination by the UBSC based upon your eligibility, processing enrollments, allowing changes to benefits elections due to a Qualifying Life Event, and determining the required contributions for your coverage based on your elections is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

The ERO refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, the claims administrator and the Plan unless otherwise allowed by law.

Preliminary Review

Within five business days following the date of receipt of the request, the claims administrator must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided; the determination does not relate to eligibility, processing enrollments, allowing changes to benefits elections due to a Qualifying Life Event, and determining the required contributions for your coverage based on your elections; you have exhausted the internal appeals process (unless Deemed Exhaustion applies); you have provided all paperwork necessary to complete the External Review; and you are eligible for external review.

Within one business day after completion of the preliminary review, the claims administrator must issue you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the U.S. Employee Benefits Security Administration (toll-free number **866-444-EBSA (3272)**). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the claims administrator must allow you to perfect the request for External Review within the 123-calendar-day filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

The claims administrator will assign an ERO accredited as required under Federal law to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one business day after making the decision, the ERO must notify you, the claims administrator and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and appeal and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records
- The attending health care professional's recommendation
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations

- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in the notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, the claims administrator and the Plan.

After a Final External Review Decision, the ERO must maintain records of all appeals and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or state or Federal oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal
- A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility

Immediately upon receipt of the request for expedited External Review, the claims administrator will determine whether the request meets the reviewability requirements set forth above for standard External Review. The claims administrator must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, the claims administrator will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, the claims administrator and the Plan.

RIGHTS AFTER APPEAL/TIME PERIOD FOR BRINGING LAWSUIT AFTER APPEAL IS DENIED

If you wish to seek judicial review of an adverse second-level appeal decision (that is, the denial

on second-level appeal or, in the case of urgent-care claims, the first-level appeal decision of the Appeals Administrator), in whole or in part, you must file any suit or legal action, including, without limitation, a civil action under Section 502(a) of ERISA, within one year after the date of the final decision on the adverse action. The formal claims and appeals procedure described above must be exhausted before you can seek judicial review, including, without limitation, under Section 502(a) of ERISA.

Failure to bring a civil action within this time frame results in the loss of your rights to bring such an action.

PRESCRIPTION DRUG CLAIMS AND APPEALS

TYPES OF CLAIMS

There are three types of claims that apply under the Prescription Drug Program as noted below. The procedures for making claims determination vary, depending on the type of claim.

POST-SERVICE CLAIM

A post-service claim is a claim for payment after services occur and applies to payments that are not conditional on seeking approval before obtaining services.

PRE-SERVICE (NON-URGENT) CLAIM

A pre-service (non-urgent) claim is a claim for a benefit that requires prior authorization in advance of receiving a prescription drug. The prior authorization process is noted beginning on page 72.

URGENT-CARE CLAIM

A claim is an urgent-care claim:

- If it is determined that waiting to apply the claims review procedures for nonurgent-care claims
  - Could seriously jeopardize your life or your health, or your ability to regain maximum function as determined by Express Scripts, acting on behalf of the Prescription Drug Program and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or
  - In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim; or
- If a physician with knowledge of your medical condition determines that it is.

INFORMATION NEEDED FOR A CLAIM

Each time you visit an Express Scripts network pharmacy to obtain a new prescription or refill and show your prescription drug identification card, you are filing a claim.

You also file a claim each time you request a prescription or refill through the Express Scripts By Mail pharmacy.

If you obtain a prescription from a non-network pharmacy or fail to use your prescription drug identification card at a network pharmacy — that is, you pay 100 percent of the prescription price

at the time of purchase — you (or your authorized representative) need to file a written claim. Information on how to file a written claim is provided below and on the following pages.

INFORMATION NEEDED FOR A WRITTEN CLAIM

A claim form is available online at **www.express-scripts.com** or you can request a form by calling Express Scripts toll free at:

- **800-903-4734**, available 24 hours a day/seven days a week
- TTY text phone at **800-789-1089** for the hearing impaired

Your written claim for benefits should include all of the following information:

- Your name and address
- Your group and identification number shown on your prescription drug identification card (not your medical identification card) and the same information for the patient if you are not the patient
- The patient's date of birth and relationship to you
- The name, address and phone number for the pharmacy that filled the prescription
- Itemized receipts showing the date the prescription was filled, the doctor prescribing the medication, the 11-digit NDC (drug number — Express Scripts needs the 11-digit number for each ingredient used if it is a compound prescription), the name of the drug and strength of the drug, the quantity and number of days' supply, the prescription number and the amount paid

Express Scripts is the claims administrator for the Prescription Drug Program. As the claims administrator, Express Scripts is responsible for processing claims for benefits under the Program. Benefits under the Program are paid only if Express Scripts, acting as the claims administrator, decides, in its sole discretion, that you are entitled to them.

Your written claim should be forwarded by you (or your authorized representative) to Express Scripts at:

Express Scripts Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

CLAIM-FILING LIMITATIONS

Your written claim for benefits should be submitted as early as possible, and in no event later than 12 months after you receive the prescription. If the Company terminates claims processing arrangements with Express Scripts or terminates the Prescription Drug Program, benefit requests for prescriptions filled prior to such termination must be received by Express Scripts within 90 days of the termination. You will be notified in advance of any such action.

TIME PERIODS FOR RESPONDING TO INITIAL CLAIM

Express Scripts will respond to your claim as follows:

Post-service claim*:* within a reasonable period of time, but not later than 30 days after receipt of the claim.

If Express Scripts determines that an extension is necessary due to special circumstances, Express Scripts will notify you within the initial 30-day period that up to an additional 15 days is needed to review your claim. Express Scripts will indicate the circumstances requiring the

extension and the date by which a decision is expected.

If an extension is necessary because you failed to provide information required to evaluate your claim, the notice of extension will describe the needed information and you will have no less than 45 days from the date you receive the notice to provide the requested information. In the event that a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit determination is suspended from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Pre-service (non-urgent) claim*:* within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.

If Express Scripts determines that an extension is necessary due to special circumstances, Express Scripts will notify you within the initial 15-day period that up to an additional 15 days is needed to review your claim. Express Scripts will indicate the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary because you failed to provide information required to evaluate your claim, the notice of extension will describe the needed information and you will have no less than 45 days from the date you receive the notice to provide the requested information. In the event that a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit determination is suspended from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the pre-service (non-urgent) claim is unclear or fails to follow the Prescription Drug Program's procedures — for example, it fails to name a specific claimant and/or provide the complete information on the drug for which approval is requested, including the strength, dosage, quantity and number of days supply — notification requesting additional information will be provided as soon as possible, but not later than five days after receipt of the claim.

Express Scripts will notify you of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- Receipt of the specified information, or
- The end of the period given to you to provide the specified additional information.

Urgent-care claim*:* as soon as possible, taking into account your medical circumstances, but no later than 72 hours after receipt of the claim.

If Express Scripts determines that additional information is necessary to review your claim, they will notify you as soon as possible, but no later than 24 hours after receipt of the claim and provide you with a description of the additional information needed. You will have a reasonable amount of time, taking into account your circumstances, but no less than 48 hours from the time you receive this notice, to provide the requested information.

If the urgent care claim is unclear or fails to follow the Prescription Drug Program's procedures — for example, it fails to name a specific claimant and/or provide the complete information on the drug for which approval is requested, including the strength, dosage, quantity and number of days supply — notification requesting additional information will be provided as soon as possible, but not later than 24 hours after receipt of the claim.

Express Scripts will notify you of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- Receipt of the specified information, or
- The end of the period given to you to provide the specified additional information.

DETERMINATION FOR YOUR INITIAL WRITTEN CLAIM

You receive an explanation of benefits (EOB) statement that indicates the determination made on your claim, any payments made and the balance of the submitted expense that is your responsibility. However, the determination for an urgent-care claim may be provided to you orally (that is, by telephone, facsimile or other expedited means of communication) and then followed by a written notification.

PAYEES

Benefits for covered prescriptions processed by network retail pharmacies or Express Scripts By Mail are payable to the pharmacy. Benefits for written claims are payable to you, the eligible associate. Any payment made in accordance with this provision fully discharges liability to the extent of such payments.

NOTICE AND INFORMATION CONTAINED IN THE NOTICE DENYING THE INITIAL CLAIM

If your written claim is denied in whole or in part, you will receive a written notice of the denial from Express Scripts — however, initial notice of a denied pre-service, urgent-care claim may be provided to you orally (that is, by telephone, facsimile or other expedited means of communication) and then followed by a written notification no later than three days after the oral notification. This notice will include all of the following:

- The specific reason or reasons for the claim denial.
- Reference to the specific Prescription Drug Program provisions on which the claim denial is based.
- A description of any additional material or information necessary for you to perfect your claim and an explanation as to why such material or information is necessary.
- If the claim denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will indicate this and either provide a copy or provide a statement that you are entitled to receive, free of charge upon written request, a copy of the rule, guideline, protocol or other similar criterion that was relied upon in making the claim determination.
- If the claim denial is based on experimental/investigative drugs or similar exclusion or limit, the denial will either explain the professional judgment for the determination, including how the terms of the Prescription Drug Program were applied to your circumstances, or will indicate that you are entitled to receive such explanation, free of charge upon written request.
- A description of the Prescription Drug Program's formal appeals procedures and the time limits that apply (including any special rules for appeals of urgent care claims). The description will include a statement that you have the right to bring a civil action under Section 502(a) of the Federal Employee Retirement Income Security Act of 1974, as amended (ERISA) following an adverse decision on appeal, provided such action is brought within one year after the date the final adverse appeal decision is issued or should have been issued. Failure to bring a civil action within this time frame results in the loss of your rights to bring such an action.

INFORMAL COMPLAINT PROCEDURE

You have the right to register complaints about network retail pharmacies and Express Scripts By Mail pharmacy, and about benefit determinations made by Express Scripts. Express Scripts is obligated to hear and resolve complaints according to the procedures described below. If you have a claim for benefits that has been denied, you are not required to submit a complaint under the informal complaint process as a condition to filing a formal appeal under the formal appeal procedures that are described beginning below.

If you have a complaint, call Express Scripts Member Services toll free at **800-903-4734**, available 24 hours a day, seven days a week (TTY text phone at **800-789-1089** for the hearing impaired).

To assist in the investigation of your complaint or disagreement, provide as many of the pertinent details relating to your complaint as possible.

The Member Services representative will assist you in trying to resolve the complaint or disagreement on an informal basis. The representative also will document the complaint. Most disagreements can be resolved at this level.

Please note that utilizing this informal complaint procedure does not change or delay any deadlines in the formal appeals procedure described below.

FORMAL APPEALS PROCEDURE

This section describes the procedure for appealing an adverse benefits determination (that is, a claim denial) by Express Scripts. As the Appeals Administrator, Express Scripts has the power in its sole discretion, to interpret and construe the provisions of the Prescription Drug Program, and to decide such questions as may arise in connection with the operation of the Prescription Drug Program, including interpretation of ambiguous provisions of the Prescription Drug Program, determination of disputed facts, and application of the provisions of the Prescription Drug Program to unanticipated circumstances. Express Scripts's determination as the Appeals Administrator is subject to review only for abuse of discretion.

A request for an expedited appeal of an adverse benefit determination related to an urgent-care claim may be submitted orally or in writing by you (or your authorized representative) and all necessary information, including Express Scripts's determination on review, will be transmitted between Express Scripts and you (or your authorized representative) by telephone, facsimile or other expedited means of communication.

The appeals process ensures that your written appeal (or oral appeal in the case of an urgent-care claim) receives the following considerations:

- The review does not afford deference to the initial adverse benefit determination (that is, the claim denial).
- The review is conducted on behalf of Express Scripts by an individual who was not involved in making the adverse benefit determination that is the subject of the appeal. This means that the reviewer did not make the adverse benefit determination and is not the subordinate of the person who made the adverse benefit determination.
- The appeal decision is made after consultation with a professional pharmacist who has training and experience in the field of pharmacy appropriate to the services involved in your initial claim if the benefit determination was based in whole or in part on professional judgment (*for example,* whether a particular prescription is experimental/investigative in nature). This consulting professional pharmacist is not a person who was consulted in

connection with the adverse benefit determination and is not a subordinate of a person who was consulted in connection with the adverse benefit determination that is the subject of the appeal.

- The professional pharmacist whose advice was obtained on behalf of the Prescription Drug Program in connection with the adverse benefit determination will be identified, even if the advice was not relied upon in making the benefit determination.

FIRST-LEVEL APPEAL

Express Scripts is the Appeals Administrator for first-level appeals.

If Express Scripts denies your initial claim for benefits in whole or in part, you (or your authorized representative) may appeal the denial by submitting a written request (or an oral request in the case of a pre-service, urgent-care claim) to Express Scripts at:

Attn: Administrative Reviews/Coverage Appeals
Express Scripts Health Solutions
8111 Royal Ridge Parkway
Irving, TX 75063

If you choose to seek an oral determination for a pre-service urgent-care appeal, you (or your authorized representative) can reach Express Scripts toll free at:

- **800-864-1135**, if the denial is based on a clinical determination, or
- **800-946-3979**, if the denial is based on an administrative rule.

Both toll-free numbers are available 24 hours a day, seven days a week.

Your appeal must be submitted within 180 calendar days after you receive the notice denying your initial claim for benefits.

Your written appeal (or your oral appeal in the case of a pre-service urgent-care appeal) should include all of the following information:

- Your name and address;
- Your group and identification number shown on your prescription drug identification card (not your medical identification card) and the same information for the patient if you are not the patient;
- The patient's date of birth and relationship to you;
- The name, address and phone number for the pharmacy that filled the prescription;
- Itemized receipts showing the date the prescription was filled, the doctor prescribing the medication, the 11-digit NDC (drug number — Express Scripts needs the 11-digit number for each ingredient used if it is a compound prescription), the name of the drug and strength of the drug, the quantity and number of days' supply, the prescription number and the amount paid.

You can include with your appeal any written comments, documents, records and other information relating to your claim for benefits that you believe supports your appeal – even if the information was not submitted with the initial claim for benefits. Upon written request, you can obtain, free of charge, reasonable access to and copies of, all documents, records and other information that is relevant to your claim for benefits.

Express Scripts will re-examine your initial claim to ensure that no errors were made in the previous determinations, and if no errors are identified, will make a determination on the appeal.

If errors are identified, the initial claim will be reprocessed under the terms of the Prescription Drug Program.

TIME PERIOD FOR RESPONDING TO FIRST-LEVEL APPEALS

If the initial claim denial is overturned as the result of your first-level appeal, you will be notified and your claim will be reprocessed.

If your appeal is denied, Express Scripts will respond within the following time periods:

- **Post-service claim:** within a reasonable period of time, but not later than 30 calendar days after receipt of the written appeal.
- **Pre-service (non-urgent) claim:** within a reasonable period of time appropriate to the medical circumstances, but not later than 15 calendar days after receipt of the written appeal.
- **Urgent-care claim:** as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the written or oral appeal. This is your only level of appeal for an urgent-care claim.

NOTICE AND INFORMATION CONTAINED IN NOTICE DENYING APPEAL

As stated earlier, if the initial claim denial is overturned as the result of your first-level appeal, you will be notified and your claim will be reprocessed.

If your first-level appeal is denied in whole or in part, Express Scripts will provide you with a written notice of denial – however, initial notice of a denied urgent-care appeal may be provided to you orally (that is, by telephone, by facsimile or other expedited means of communication) and then followed by a written notification. This notice will include the following:

- The specific reason or reasons for the appeal denial.
- Reference to the specific Prescription Drug Program provisions on which the appeal denial is based.
- A statement that you are entitled to receive, free of charge upon written request, reasonable access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits.
- If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will indicate this and either provide a copy or provide a statement that you are entitled to receive, free of charge upon written request, a copy of the rule, guideline, protocol or other similar criterion that was relied upon in making the appeal determination.
- If the appeal denial is based on experimental/investigative drugs or similar exclusion or limit, the denial will either explain the professional judgment for the determination, including how the terms of the Prescription Drug Program were applied to your circumstances, or will indicate that you are entitled to receive such explanation, free of charge upon written request.
- A description of the second-level appeals procedures and the time limits that apply. The description will include a statement that you have the right to bring a civil action under Section 502(a) of the Federal Employee Retirement Income Security Act of 1974, as amended (ERISA) following an adverse decision on appeal, provided such action is brought within one year after the date the final adverse appeal decision is issued or should have been issued. Failure to bring a civil action within this time frame results in the loss of your rights to bring such an action. Note: Given the medical circumstances for urgent-care claims, second-

level appeals do not apply for urgent-care claims and Express Scripts' first-level appeal decision for urgent-care claims is final, binding and conclusive for all parties related to the claim.

SECOND-LEVEL APPEAL

Express Scripts is the Appeals Administrator for the determination of second-level appeals. Note: There are no second-level appeals for pre-service, urgent-care claims as noted above.

If Express Scripts denies your first-level appeal for benefits in whole or in part, within 180 calendar days after you receive the notice denying your first-level appeal (or the date your first-level appeal should have been made), you (or your authorized representative) may appeal the denial by submitting a written request for a second-level appeal addressed to Express Scripts at:

Attn: Administrative Reviews/Coverage Appeals
Express Scripts Health Solutions
8111 Royal Ridge Parkway
Irving, TX 75063

Failure to submit your second-level appeal within this time frame results in the loss of your rights to take such action.

Express Scripts will re-examine your appeal to ensure no errors were made in the previous determinations. If errors are identified, the initial claim will be re-processed under the terms of the Prescription Drug Program. If no errors are identified, Express Scripts will consider your second-level appeal, including all information you (or your authorized representative) submitted, as well as all information considered in the initial claims submission and determination and the first-level appeal submission and determination.

Your written second-level appeal should include all of the following information:

- Your name and address;
- Your group and identification number shown on your prescription drug identification card (not your medical identification card) and the same information for the patient if you are not the patient;
- The patient's date of birth and relationship to you;
- The name, address and phone number for the pharmacy that filled the prescription;
- Itemized receipts showing the date the prescription was filled, the doctor prescribing the medication, the 11-digit NDC (drug number — Express Scripts needs the 11- digit number for each ingredient used if it is a compound prescription), the name of the drug and strength of the drug, the quantity and number of days' supply, the prescription number and the amount paid.

You can include with your second-level appeal written comments, documents, records and other information relating to your claim for benefits — even if the information was not submitted with your initial claim for benefits or first-level appeal. Upon written request, you can obtain, free of charge, reasonable access to and copies of, all documents, records and other information that is relevant to your claim for benefits and your first-level appeal.

TIME PERIOD FOR RESPONDING TO SECOND-LEVEL APPEALS

If the adverse determination (that is, denial) from the first-level appeal is overturned as the result of your second-level appeal, you will be notified and your claim will be reprocessed.

If your second-level appeal is denied, Express Scripts will respond within the following time frames:

- Post-service claim: within a reasonable period of time, but not later than 30 calendar days after receipt of the written second-level appeal.
- Pre-service (non-urgent) claim: within a reasonable period of time appropriate to the medical circumstances, but not later than 15 calendar days after receipt of the written second-level appeal.

NOTICE AND INFORMATION CONTAINED IN NOTICE DENYING APPEAL

As noted earlier, if the adverse determination (that is, denial) from the first-level appeal is overturned as the result of your second-level appeal, you will be notified and your claim will be reprocessed.

If your second-level appeal is denied in whole or in part, you will receive a written notice of the denial from Express Scripts. This notice will include the following:

- The specific reason or reasons for the appeal denial.
- Reference to the specific Prescription Drug Program provisions on which the denial is based.
- A statement that you are entitled to receive, free of charge upon written request, reasonable access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits.
- If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will indicate this and either provide a copy or provide a statement that you are entitled to receive, free of charge upon written request, a copy of the rule, guideline, protocol or other similar criterion that was relied upon in making the appeal determination.
- If the denial is based on experimental/investigative drugs or similar exclusion or limit, the denial will either explain the professional judgment for the determination, including how the terms of the Prescription Drug Program were applied to your circumstances, or will indicate that you are entitled to receive such explanation, free of charge upon written request.
- A statement that you have the right to bring a civil action under Section 502(a) of the Federal Employee Retirement Income Security Act of 1974, as amended (ERISA) following an adverse decision on appeal, provided such action is brought within one year after the date the second-level adverse appeal decisions is issued or should have been issued. Failure to bring a civil action within this time frame results in the loss of your rights to bring such an action.

Express Scripts' second-level appeal decision is final, binding and conclusive for all parties related to the claim, subject to applicable law.

TIME PERIOD FOR BRINGING LAWSUIT AFTER SECOND-LEVEL APPEAL IS DENIED

If you wish to seek judicial review of an adverse second-level appeal decision of a pre-service, non-urgent care claim or of a post-service claim (that is, the denial on second-level appeal, or in the case of an urgent-care claim, an adverse first-level appeal decision), in whole or in part, you must file any suit or legal action, including, without limitation, a civil action under Section 502(a) of ERISA, within one year after the date you received the final decision on the adverse action. The formal claims and appeals procedure described above must be exhausted before you can seek judicial review, including, without limitation, under Section 502(a) of ERISA.

Failure to bring a civil action within this time frame results in the loss of your rights to bring such an action.

DELAYED PAYMENTS

In the event that a benefit claim is denied in whole or in part and a complaint is filed or an appeal is made, there is no obligation to pay any part of the disputed expense until a final determination has been made under the second-level appeals procedure (or the first-level appeals procedure in the case of an urgent-care claim).

ADMINISTRATIVE INFORMATION

The following section entitled Plan Information contains information about the Medical Plan. Plan information for the Dental and Vision Plans can be found in the SPDs for those Plans. The other sections in this chapter apply to the Medical, Dental and Vision Plans.

PLAN INFORMATION

REQUIRED INFORMATION	UNISYS MEDICAL PLAN
Plan Name	Unisys Medical Plan
Plan Number	537
Type of Plan	Welfare benefit plan – group health care plan
Plan Year	Calendar year
Plan Sponsor	Unisys Corporation 1133 College Drive Bismarck, ND 58501 Phone: **701-221-7000**
Plan Administrator	Unisys Medical Plan 801 Lakeview Drive, Suite 100/MS LLSE Blue Bell, PA 19422 Attn: Plan Manager (for Plan administration issues)
Plan Sponsor Tax ID Number (EIN)	38-0387840
Agent for Service of Legal Process	General Counsel Unisys Corporation 801 Lakeview Drive, Suite 100 Blue Bell, PA 19422 Service of process may also be made upon the Plan Manager at the above address
Type of Funding	Employer and associate contributions
Type of Administration	Administrative services contracts with Aetna, HealthPartners and Express Scripts Insurance contract with Kaiser Permanente

AMENDMENT OR TERMINATION

Although Unisys does not presently intend to do so, Unisys reserves the right to change the Plan. This includes modification of contributions, deductibles, copayments, coinsurance rates, out-of-pocket maximums, levels of benefits payable, covered expenses, and any other term or condition of the Plan.

The decision by Unisys to change the Plan may be due to changes in Federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or a policy involving an insurance company or any other reason. A Plan change may transfer Plan assets and liabilities to another plan or split the Plan into two or more parts. If Unisys makes a change or ends the Plan, it may or may not decide to establish a different plan providing similar benefits.

Unisys also reserves the right to terminate the Plan at any time and for any reason. Should the Plan be terminated, coverage for all participants and family members would end.

FAMILY MEDICAL LEAVE ACT

In accordance with the U.S. Family and Medical Leave Act of 1993 (FMLA), if eligible, you are allowed up to 12 weeks of unpaid leave for:

- Your own serious illness
- The birth of your child or a child's placement with you for adoption
- To care for a seriously ill child (including a child for whom you have assumed the obligations of a parent, even if you are not the biological or legal parent)
- A covered family member's call to active duty in the U.S. Armed Forces

FMLA also includes a special leave entitlement that permits eligible associates to take up to 26 weeks of leave to care for a covered service member who has incurred a serious injury or illness while on active duty. FMLA benefits may be taken continuously or on an intermittent schedule, but can total no more than 26 weeks in a 12-month period.

To be eligible for FMLA, you must have at least 12 months of continuous service with Unisys and have worked 1,250 hours within the 12 months preceding the leave.

BENEFIT COVERAGE DURING FMLA

During approved FMLA leaves, both you and Unisys continue to pay the designated cost for benefit coverage. After the expiration of the leave period or your notice that you will not return to work, you will be offered continued coverage under COBRA.

THE FEDERAL UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

As required by Federal law, Unisys provides benefits during or following a period of qualified military service. You must continue to pay your share of your coverage cost during your military leave of absence. If Unisys pays a portion of the coverage payment on your behalf to continue your coverage while you are on military leave, you may be required to reimburse Unisys for your portion of the coverage payment whether or not you return to work.

If you do not continue your coverage during your military leave, your coverage will be reinstated when you return to Company employment on a timely basis from military leave.

A special event similar to a COBRA qualifying event applies under USERRA if you leave your civilian job to perform U.S. military service.

- If health care coverage is lost because of U.S. uniformed service, you may elect to continue COBRA-like coverage for up to 24 months after your absence begins, or less if you fail to return from service or fail to apply for reemployment on a timely basis before the end of the 24-month period.
- You must pay 102% of the full cost for this coverage (that is, 102% of both the associate and employer portions). However, if your uniformed service was for 30 or fewer calendar days, you must pay only the same amount for such coverage that an active associate would have paid.

This continued health care coverage under USERRA is separate from COBRA coverage.

NO ALIENATION OF BENEFITS

Your rights and benefits under the Plan cannot be assigned, sold, pledged, encumbered, transferred, or otherwise alienated to your creditors or anyone else, and any attempt to do so will be null and void. However, you may assign your right to benefits to a provider who rendered medical, dental, or vision services.

The Plan Administrator reserves the right to pay Plan benefits to someone acting on your behalf if you are not competent to receive Plan benefits, or to your estate if you die while Plan benefits are still owed to you. If the Plan Administrator pays benefits to a third party in good faith, benefits will not be paid again.

COURT ORDERS

If you become divorced, certain court orders could require you to provide health care coverage to your dependent child(ren). A court order of this type is known as a Qualified Medical Child Support Order (QMCSO). If the QMCSO satisfies legal requirements and you are eligible to participate, you may enroll yourself and your eligible children covered by the QMCSO in the Plan. A copy of the QMCSO procedures may be requested from the UBSC. However, the Plan does not cover ex-spouses regardless of whether you are legally required to pay for their medical coverage in a court order.

RECOVERY OF OVERPAYMENTS

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

GOVERNING LAW

Except to the extent preempted or superseded by ERISA, all questions pertaining to the validity, construction and operation of the Plan are determined in accordance with the laws of the

Commonwealth of Pennsylvania, without regard to any choice of law provisions.

YOUR RIGHTS UNDER ERISA

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD (the Plan Administrator may make a reasonable charge for the copies).
- Receive a summary of the Plan's annual financial report (the Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report).

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue group health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying COBRA Event. You or your dependents may have to pay for such coverage.
- Review this SPD (and any subsequent summaries of material modifications) and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.
- Receive a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer (in the case of Unisys, this is provided by the Unisys Benefits Service Center) when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under a plan after you leave the Company.

If you wish to seek judicial review of an adverse final appeal decision (that is, the denial on the final level of appeal), in whole or in part, you must file any suit or legal action, including, without limitation, a civil action under Section 502(a) of ERISA, within one year after the date of the final decision on the adverse action. The formal claims and appeals procedure described above must be exhausted before you can seek judicial review, including, without limitation, under Section 502(a) of ERISA. Failure to bring a civil action within this time frame results in the loss of your rights to bring such an action.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

If your written claim for a benefit is denied or ignored, in whole or in part, you or your representative have a right to know why this was done, to obtain copies of documents relating to the decisions without charge, and to appeal in writing any claim denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the rights above. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, or if you have an unresolved issue with respect to a Qualified Medical Child Support Order (QMCSO), you may file suit in a state or Federal court. If it should happen that a Plan’s fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States 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 if, for example, it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan, please contact the Plan Administrator. If you have any questions about this SPD or about your rights under ERISA, you may contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 to discuss questions about this statement of rights or about any rights under ERISA. The Plan Administrator will be happy to furnish the address and telephone number. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

LEGAL NOTICES

This chapter applies to the Medical Plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The U.S. Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans, including the Unisys Medical Plan, to cover reconstructive surgery and prostheses following mastectomies. The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient and is subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers, including the Unisys Medical Plan, generally may not, under Federal law, 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, a shorter stay may be paid if the attending provider (for example, the attending physician, nurse, midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours, if applicable).

Also, plans and health insurance issuers, including the Unisys Medical Plan, may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hours, if applicable) stay is treated less favorably to the mother or newborn than any earlier portion of the stay.

A plan also may not require a physician or other health care provider to obtain authorization for prescribing a stay of up to 48 hours (or 96 hours, if applicable). However, you may be required to precertify your care in order to use certain providers or facilities or to reduce your out-of-pocket costs.

CHOICE OF PROVIDER

Since the Plan allows you to designate a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider and for a list of participating primary care providers, call the claims administrator contact number on the back of your ID card. You may designate a pediatrician as the primary care provider for a child. If you designate a primary care provider, you do not need prior authorization from the claims administrator or from any other person (including, but not limited to, a primary care provider) to obtain access to obstetrical or gynecological care from a network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of

participating health care professionals who specialize in obstetrics or gynecology, call the claims administrator contact number on the back of your ID card.

COVERAGE HISTORY NOTICES

If your coverage terminates under the Medical Plan during 2015, you may have to demonstrate that you had creditable coverage under the Medical Plan.

To assist you in demonstrating that you had creditable coverage under the Medical Plan, the Plan Administrator or its designee will provide you with a written Coverage History Notice. To request a notice, contact the Unisys Benefits Service Center toll-free at **877-864-7972**. If your coverage under the Medical Plan terminates, a Coverage History Notice coverage will be provided to you in any of these instances:

- At the time of the Qualifying Event or other termination of coverage
- At the time your COBRA coverage ends
- Upon your request, provided that such a request is made within 24 months after your coverage ends

NOTE FOR NEW JERSEY RESIDENTS

The Health Care Quality Act, a New Jersey statute, requires that companies with health care plans such as the Consumer Health Plan notify you that this self-funded health option is not subject to New Jersey state consumer protection regulations. The law also requires that you be informed which state-mandated benefits are not covered under these plans.

If you are enrolled in, or elect to enroll in, the Consumer Health Plan through the Company, you will be enrolled in a self-funded health plan administered by an insurance company on behalf of the Company. A self-funded heath plan is an arrangement in which the employer provides benefits to associates with its own funds, rather than contracting with an insurance company to cover associates. This self-funded plan is known as an ERISA plan and is authorized under the ERISA. This Federal law provides rules and regulations regarding the conduct of the Plan.

This Plan is exempt from complying with New Jersey state law governing health insurance, including, but not limited to:

- State laws mandating coverage for specific health insurance benefits
- State laws granting individuals the right to appeal to an independent entity the final decisions by a managed-care organization to reduce or deny treatment for a covered health care service

Even though an insurance company's name may appear on your health care identification card or in correspondence about your coverage, you do not have the same legal rights as those covered by state-regulated health plans.

The following chart lists the services included in the state-mandated health insurance benefits and the coverage under the Unisys Medical Plan.

NEW JERSEY STATE-MANDATED BENEFITS	UNISYS MEDICAL PLAN
For certain treatments for Wilms' tumor	Covers treatments for this condition that are not deemed to be investigative or experimental
For certain treatments for cancer	Covers treatments for this condition that are not deemed to be investigative or experimental
For mammograms	Voluntarily covers these tests at least as frequently as mandated by the New Jersey law
For off-label uses of certain drugs	Does not cover drugs for treatments for which the drug has not been approved by the Federal Food and Drug Administration
For pharmacies	Voluntarily complies with the mandated requirements
For inpatient benefits following birth of child	Voluntarily complies with the mandated length of stay
For lead-poisoned children and childhood immunizations	Voluntarily complies with the mandated services
For health wellness promotion programs	Voluntarily complies with the mandated services
For treatment of diabetes	Voluntarily complies with the mandated services
For Pap smears	Voluntarily complies with the mandated services
For prostate cancer screening	Voluntarily complies with the mandated services
For reconstructive breast surgery following a mastectomy	Voluntarily complies with the mandated services
For inpatient benefits following a mastectomy	Voluntarily complies with the mandated services
For therapeutic treatment of inherited metabolic diseases	Voluntarily complies with the mandated services

NOTICE OF PRIVACY PRACTICES

This notice applies to the Unisys Medical, Dental and Vision Plans and describes how your health information may be used or disclosed. This notice is required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Effective April 14, 2003, protected health information that is created, received or maintained by the Unisys Medical Plan, the Unisys Post-Retirement and Extended Disability Medical Plan, the Unisys Dental Plan, the Unisys Vision Plan, the Unisys Flexible Spending Account (Health Care, including Limited Scope Health Care) and the Unisys Employee Assistance Program — collectively referred to as the “Plans” — are protected by Federal health privacy law. Protected health information is information that identifies you and relates to your physical or mental condition, to the provision of health services to you or to the payment for your health services. Protected health information is referred to as "health information" in this Notice.

This Notice is required by HIPAA and the regulations issued thereunder. This Notice informs you of how the Plans use and disclose your health information, explains the rights that you have with regard to your health information created, received or maintained by the Plans, and notifies you of the Plans’ legal duties with respect to your health information. The original Notice was effective April 14, 2003 and was subsequently updated. This revised Notice replaces the previous revised Notice and is effective Sept. 23, 2013. This revised Notice will remain in effect unless and until the Plans publish a further revised Notice.

INFORMATION SUBJECT TO THIS NOTICE

The Plans create, collect and maintain health information to help provide health benefits to you and your eligible dependents, as well as to fulfill legal requirements. The Plans collect this health information, which may identify you or your eligible dependents, from applications and other forms that you complete, through conversations you may have with the Plans’ administrative staff and health care providers, and from reports and data provided to the Plans by health care providers, insurance companies, or other third parties. The health information the Plans have about you includes, among other things, your name, address, phone number, birth date, Social Security number, employment information, and claims information. This is the information that is subject to the privacy practices described in this Notice.

Unisys Corporation (the “Company") helps the Plans perform many essential tasks, such as collecting Plan enrollment information, deciding Plan eligibility, and transmitting payment for premiums and claims. The information collected by the Company when it is performing these tasks **is not** health information and is not subject to the privacy practices described in this Notice.

THE PLANS’ USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The Plans are permitted under HIPAA to use and disclose your health information without your consent for the administration of the Plans and for processing claims. In unusual cases, the Plans may disclose your health information without your consent for other purposes as permitted by HIPAA, such as health and safety, law enforcement or emergency purposes. Generally, you must give your written consent for all other uses and disclosures of your health information.

The Uses and Disclosures that do not require your written consent are described below.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE

OPERATIONS

1. **For Treatment**. The Plans may use and disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you. For example, if the Medical Plan maintains information about interactions between your prescription medications, the Plan may disclose this information to your health care provider for your treatment purposes.
2. **For Payment**. The Plans may use and disclose your health information so that your claims for health care services can be paid according to Plan terms. For example, the Plans may use or disclose your health information to pay claims from physicians or hospitals that have treated you, to determine your eligibility for health benefits, or to coordinate your health benefits.
3. **For Health care Operations**. The Plans may use or disclose your health information so they can operate efficiently and in the best interests of its participants. For example, the Plans may disclose health information to their auditors to conduct an audit involving the accuracy of claim payments.

USES AND DISCLOSURES TO BUSINESS ASSOCIATES

The Plans may disclose your health information to third parties that assist the Plans in their operations. These third parties are referred to as "business associates" of the Plans. For example, the Plans may share your health information with the health claims administrators, the business associates responsible for processing claims for the Plans, to ensure your claims are paid properly. The Plans' business associates have the same obligation as the Plans to keep your health information confidential. The Plans must require that their business associates ensure that your health information is protected from unauthorized use or disclosure.

USES AND DISCLOSURES TO THE COMPANY

The Plans may disclose your health information, without your consent, to the Company for administration purposes, such as determining the amount of benefits you or your eligible dependent is entitled to under the Plans, determining or investigating facts that are relevant to a benefit claim, determining whether your benefits should be terminated or suspended, performing duties that relate to the establishment, maintenance, administration and/or amendment of the Plans, communicating with you about the status of a claim, recovering any overpayment or mistaken payments made to you, and handling issues related to subrogation and third party claims. The Company has designated certain associates as the associates who perform services for the Plans. These associates are the Health Plans Data Privacy Officer, the Health Plans HIPAA Compliance Officer, the Manager of Benefits Administration and the Benefits Representatives. Any health information that you discuss with these Company associates while they are performing duties that are related to the medical, dental, vision, post-retirement medical, flexible spending account (Health Care, including Limited Scope Health Care) and associate assistance benefits is subject to the privacy practices described in this Notice.

Only the Company associates described in the paragraph above are required to keep your health information confidential and subject to the privacy practices in this Notice, and only when they are performing duties that are related to the medical, dental, vision, post-retirement medical, flexible spending account (Health Care, including Limited Scope Health Care) and associate assistance benefits provided by the Plans. Please be aware of who you share your medical information with and do not assume that all Company associates have an obligation to keep your medical information confidential and subject to the privacy practices described in this Notice.

The Company may request your medical information for other reasons, including to determine

whether you are eligible for disability benefits, workers' compensation benefits, leave under the Family and Medical Leave or an accommodation under the Americans with Disabilities Act, or for drug testing. After April 14, 2003, you need to provide your written consent before the medical information needed for these purposes can be provided to the Company. The medical information that you provide to the Company under these circumstances is not subject to the privacy practices described in this Notice, although such information provided to the Company is subject to the protections described in the Unisys Global Privacy Policy on Personal Data (LEG8.1). In these cases, if you do not provide the Company with the necessary medical information, you will not receive the benefit for which the information is needed.

OTHER USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR WRITTEN CONSENT

HIPAA provides for specific uses or disclosures of your health information without your written consent.

1. **Required by Law**. The Plans may use and disclose your health information as required by Federal, state or local law. For example, the Plans may disclose your health information for judicial and administrative proceedings pursuant to legal process and authority, to report information related to victims of abuse, neglect, or domestic violence or to assist law enforcement officials in their law enforcement duties.
2. **Health and Safety**. Your health information may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease or disability, and meeting the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.
3. **Government Functions**. Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigation, licensure, and other oversight activities.
4. **Active Members of the Military and Veterans**. Your health information may be used or disclosed to comply with laws related to military service or veterans' affairs.
5. **Workers Compensation**. Your health information may be used or disclosed in order to comply with laws related to workers' compensation.
6. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.
7. **Others Involved In Your Care**. In limited instances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plans have verified are involved in your care or payment for your care. For example, if you are an eligible dependent, the Plans may send your Explanation of Benefit forms to the participant, or answer the participant's questions about the payment of a claim that involves your care. Also, the Plans may advise a family member or close personal friend about your condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.
8. **Personal Representatives**. Your health information may be disclosed to people you have authorized, or people who have the right, to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who hold Powers of Attorney for adults.

9. **Treatment and Health-Related Benefits Information**. The Plans and their business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services or medication.
10. **Research**. Under certain circumstances, the Plans may use or disclose your health information for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed.
11. **Organ and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.
12. **Deceased Individuals**. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

USES AND DISCLOSURES FOR FUNDRAISING PURPOSES

The Plans, or an authorized third party on the Plans' behalf, may contact you for fundraising purposes. If you are contacted for such purposes, you have the right to opt out of receiving such communication.

PROHIBITION ON THE USE AND DISCLOSURES OF GENETIC INFORMATION

The Plans are prohibited from using or disclosing your genetic information for underwriting purposes.

ANY OTHER USES AND DISCLOSURES

Most uses or disclosures of psychotherapy notes (where applicable), uses and disclosures ofprotected health information for marketing purposes and disclosures that constitute the sale of protected health information require an authorization. Uses and disclosures of your health information by the Plans other than those described above will be made only with your express written consent. Once your health information is disclosed with your express consent, the Federal privacy protections may no longer apply to that health information, and that information may be redisclosed by the recipient without your or the Plans’ knowledge or authorization.

If you do provide your written consent for a certain use or disclosure, you may subsequently revoke that written consent by notifying the Unisys Health Plans HIPAA Compliance Officer in writing (the address is in the “Your Rights” section that follows). If you do so, the Plans will not use or disclose the health information described in the written consent (unless the Plans have already acted in reliance on that written consent).

YOUR RIGHTS

You have the following rights regarding the health information that the Plans create, collect and maintain. Because your health information is typically used and retained by the Health Claims Administrator(s) for the Plan(s) in which you are enrolled, you should contact the Health Claims Administrator(s) directly to exercise your HIPAA rights described in this Notice (unless this Notice directs otherwise). This means that you should direct any questions and submit any required written requests to the appropriate Health Claims Administrator (but, you should contact the Health Claims Administrator before you submit any written requests to make sure you are following the Health Claims Administrator’s specific procedures). For your convenience, a list of the HIPAA contacts for the Health Claims Administrators and their contact information is attached.

If you are unsure of the appropriate Health Claims Administrator to contact, have a general request that covers more than one Plan, or if you are not satisfied with a response you receive from the Health Claims Administrator, please contact the following:

Unisys Health Plans HIPAA Compliance Officer
Unisys Corporation
801 Lakeview Drive
Suite 100
Blue Bell, PA 19422
E-mail: HIPAAComplianceOfficer@Unisys.com
Phone Number: **701-221-7530**

RIGHT TO INSPECT AND COPY HEALTH INFORMATION

Generally, you have the right to inspect and obtain a copy of your health information that is maintained by the Plans. This includes, among other things, health information about your eligibility, coverages, claim records and billing records.

To inspect and copy your health information, you must submit your request in writing. In certain limited circumstances, the Plans may deny your request to inspect and copy your health record and they will inform you of such a denial in writing. In certain instances, if you are denied access to your health information, you may request a review of the denial.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS, OR COMMUNICATIONS BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

You have the right to request that the Plans communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plans contact you only at work or by mail, or that the Plans provide you with access to your health information at a specific, reasonable location.

To request confidential communications by alternative means or at an alternative location, you must submit your request in writing. Your written request should state the reason(s) for your request and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of your health information by non-confidential communications could endanger you. The Plans will make their best effort to accommodate reasonable requests, and will respond to your request appropriately.

RIGHT TO REQUEST THAT YOUR HEALTH INFORMATION BE AMENDED

You have the right to request that the Plans amend your health information if you believe the information is incorrect or incomplete.

To request an amendment, you must submit a detailed written request that provides the reason(s) that support your request. The Plans may deny your request if:

(i) you have asked to amend information that was not created by the Plans, unless the person or entity that created the information is no longer available to make the amendment;

(ii) the health information is not part of the health information maintained by or for the Plans;

(iii) the health information is not part of the health information you would be permitted to inspect and copy; or

(iv) the health information is accurate and complete.

The Plans will notify you in writing as to whether they accept or deny your request for the amendment. If the Plans deny your request, they will explain the reason(s) for the denial, and describe how you can continue to pursue the denied amendment.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to receive a written accounting of the disclosures of your health information by the Plans. The accounting is a list of disclosures of your health information by the Plans to others. Generally, the following disclosures are not part of an accounting:

(i) disclosures that occur before April 14, 2003;

(ii) disclosures for treatment, payment or health care operations;

(iii) disclosures made to you; and

(iv) disclosures for which you gave the Plans written consent.

An accounting includes the disclosures that have occurred during the six-year period before your request (but not before April 14, 2003).

To request an accounting of disclosures, you must submit your request in writing. If you want an accounting that covers a period of less than six years, please state that in your request. The first accounting that you request during a 12-month period is provided at no charge. For any additional accountings in the same 12-month period, the Plans may charge you for the cost of providing the accounting. In this case, the Plans will notify you of any cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request restrictions on the health information that the Plans use or disclose about you to carry out treatment, payment or health care operations. Also, you have the right to request restrictions on your health information that the Plans disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plans are not required to agree to your request for such restrictions, and the Plans may terminate any agreement to the restrictions you request.

To request restrictions, you must submit your request in writing, advise the Plans as to what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plans will notify you in writing as to whether they agree to your request.

RIGHT TO COMPLAIN

You have the right to complain to the Plans if you believe the Plans or the Health Claims Administrators have not complied with HIPAA in any way. To file a complaint with the Plans, you must submit your complaint in writing to the following:

Unisys Health Plans Data Privacy Officer
Unisys Corporation
801 Lakeview Drive
Suite 100
Blue Bell, PA 19422
E-mail: HIPAAComplianceOfficer@Unisys.com
Phone Number: **701-221-7530**

Alternatively, you may file a complaint with the U.S. Department of Health and Human Services. You will not be retaliated or discriminated against and no services, payment or privileges will be withheld from you because you file a complaint with the Plans or with the U.S. Department of Health and Human Services.

RIGHT TO RECEIVE BREACH NOTIFICATION

You have the right to, and will receive, notification if a breach of your unsecured protected health information requiring notification occurs.

CHANGES IN THE PLANS' PRIVACY PRACTICES

The Plans reserve the right to change their privacy practices, by action of the Plans' Data Privacy Officer, and to make the new practices effective for all health information that they create, collect and maintain, including your health information that is created, collected or received before the effective date of the change. If the Plans materially change any privacy practices, you will be notified of the change no later than 60 calendar days after the change is made, or, if the Plans post this Notice on the Company website, they shall: (1) prominently post the material change or the revised Notice on its website by the effective date of the material change to the Notice; and (2) provide the revised Notice, or information about the material change and how to obtain the revised Notice, during the next annual enrollment or at the beginning of the plan year if there is no annual enrollment process. Additional copies of the notification will be made available to you upon your written request.

DEFINITIONS

In this section, you will find definitions for the words and phrases used throughout the text of this document. These definitions are subject to change from time to time.

A

Accident — A sudden, unexpected and unforeseen identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under the Plan. The occurrence or event must be definite as to time and place. It must not be due to, or contributed to by, an illness or disease of any kind.

Aetna — Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with Aetna.

Ambulance — A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

B

Behavioral Health Provider/Practitioner — A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center — A freestanding facility that meets **all** of the following requirements:

- Meets licensing standards
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care
- Charges for its services
- Is directed by at least one physician who is a specialist in obstetrics and gynecology
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital
- Has at least two beds or two birthing rooms for use by patients while in labor and during delivery
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear
- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality that impairs function or threatens life.
- Accepts only patients with low-risk pregnancies

- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility
- Keeps a medical record on each patient and child

Body Mass Index — This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

C

Claims Administrator — The third-party vendor that administers the benefits offered by the Unisys Medical Plan and/or appeals related thereto. Aetna and HealthPartners are the claims administrators for medical benefits, and Express Scripts is the claims administrator for the Prescription Drug Program. The UBSC acts as a claims administrator for purposes of deciding appeals related to eligibility, enrollment and contributions. The Unisys Associate Benefits Administrative Committee acts as a claims administrator for purposes of making a final decision on second-level appeals of claims for medical benefits that have been denied by the third-party claims administrator.

Cosmetic — Services or supplies that alter, improve or enhance appearance.

Covered Expenses — Medical services and supplies shown as covered under this SPD.

Creditable Coverage — A person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis
- Medicare
- Medicaid
- Health care for members of the uniformed services
- A program of the Indian Health Service
- A state health benefits risk pool
- The Federal Employees' Health Benefit Plan (FEHBP)
- A public health plan (any plan established by a state, the government of the United States, or any subdivision of a state or of the government of the United States, or a foreign country)
- Any health benefit plan under Section 5(e) of the Peace Corps Act
- The State Children's Health Insurance Program (S-Chip)

Custodial Care — Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy

- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

D

Day Care Treatment — A partial confinement treatment program to provide treatment for you during the day. The hospital, psychiatric hospital or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least four hours, but not more than 12 hours in any 24-hour period.

Deductible — The part of your covered expenses you pay before the Plan starts to pay benefits.

Dentist — A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Designated Transplant Center (DTC) — A hospital or other facility that has contracted with HealthPartners to give services or supplies to a DTC patient in connection with specific transplants and procedures at a negotiated charge. A facility is a DTC facility only for those types of transplants or procedures for which it has signed a contract.

Detoxification — The process by which an alcohol-intoxicated or drug-intoxicated, or an alcohol-dependent or drug-dependent, person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors, or
- Alcohol in combination with drugs

as determined by a physician. The process must keep the physiological risk to the patient at a minimum and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory — A listing of all network providers for the Plan. Network provider information is also available through Aetna's online provider directory, DocFind® and HealthPartner's website **www.healthpartners.com**.

Durable Medical and Surgical Equipment (DME) — Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of an **illness** or **injury**,

- Suited for use in the home,
- Not normally of use to people who do not have an **illness** or **injury**,
- Not for use in altering air quality or temperature, and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

Emergency Care — This means the treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency Medical Condition — A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy
- Serious impairment to bodily function
- Serious dysfunction of a body part or organ
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Experimental or Investigational — Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be experimental or investigational if (as determined by the applicable claims administrator in its sole discretion) if:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical society or regulatory agency has determined, in writing, that it is experimental or investigational or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and U.S. Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment (including, but not limited to, the written informed consent used by the treating facility or another facility studying the same drug, device, procedure, or treatment), states that it is experimental or investigational, or for research purposes.

G

Generic Prescription Drug — Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical or within an acceptable bioequivalent range to corresponding Preferred or Non-Preferred versions. The color or flavor of a generic medicine may be different,

but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.

H

Health Savings Account — A personal health care bank account funded by you and, with respect to eligible associates, your employer's tax-free contributions (for Federal income tax purposes) to pay for qualified medical expenses. You must be enrolled in the Consumer Health Plan to open an HSA. Funds contributed to an HSA automatically roll over from year to year if you do not spend them, and the account is portable, meaning if you change jobs your account goes with you.

Homebound — This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered homebound include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair-accessible transportation.

Home Health Care Agency — An agency that meets all of the following requirements:

- Mainly provides skilled nursing and other therapeutic services
- Is associated with a professional group (of at least one **physician** and one **R.N.**) that makes policy
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person
- Has an administrator
- Meets licensing standards

Home Health Care Plan — This is a plan that provides for continued care and treatment of an illness or injury. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a hospital or **skilled nursing facility** stay.

Hospice Care — This is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency — An agency or organization that meets all of the following requirements:

- Has hospice care available 24 hours a day
- Meets any licensing or certification standards established by the jurisdiction where it is located
- Provides:
  - Skilled nursing services**,**
  - Medical social services, and

  - Psychological and dietary counseling

- Provides, or arranges for, other services which include:
  - Physician services,
  - Physical and occupational therapy,
  - Part-time home health aide services which mainly consist of caring for terminally ill people, and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One physician
  - One R.N., and
  - One licensed or certified social worker employed by the agency
- Establishes policies about how **hospice care** is provided
- Assesses the patient's medical and social needs
- Develops a hospice care program to meet those needs
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency
- Permits all area medical personnel to utilize its services for their patients
- Keeps a medical record on each patient
- Uses volunteers trained in providing services for non-medical needs
- Has a full-time administrator

Hospice Care Program — This is a written plan of hospice care that:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

Hospice Facility — A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons
- Charges patients for its services
- Meets any licensing or certification standards established by the jurisdiction where it is located
- Keeps a medical record on each patient
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility
- Is run by a staff of physicians. At least one staff physician must be on call at all times
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator

Hospital — An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services
- Is supervised by a staff of physicians
- Provides 24-hour-a-day R.N. service
- Charges patients for its services
- Is operating in accordance with the laws of the jurisdiction in which it is located, and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Health care Organizations.

In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

Hospitalization — A continuous confinement as an inpatient in a hospital for which a room and board charge is made.

I

Illness — A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings that set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or **Infertility** — The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is under 35 years of age*: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older*: six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

Injury — An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person; or
- An act or event that is definite as to time and place.

In-network — In-network providers are doctors, hospitals and other providers that contract with your health care network provider to provide health care services at discounted rates.

Institute of Excellence (IOE) — A hospital or other facility that has contracted with Aetna to give services or supplies to an IOE patient in connection with specific transplants and procedures at a negotiated charge. A facility is an IOE facility only for those types of transplants or procedures for which it has signed a contract.

J

Jaw Joint Disorder — This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or

- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L

L.P.N. — A licensed practical or vocational nurse.

M

Mail Order Pharmacy — An establishment where prescription drugs are legally given out by mail or other carrier.

Maintenance Care — Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Are given in a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically Necessary or Medical Necessity — These are health care or dental services and supplies or prescription drugs (as determined by the applicable claims administrator in its sole discretion) that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an illness;
  - an injury; or
  - a disease; or
  - its symptoms.

The provision of the service, supply or prescription drug must be:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, injury or disease; and
- Not mostly for the convenience of the patient, physician, other health care or dental provider; and
- Not costing more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with physician or dental specialty society recommendations. They must be consistent with the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Mental Disorder — An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a mental disorder under this Plan:

- Anorexia/Bulimia Nervosa
- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Pervasive developmental disorder (including Autism)
- Psychotic disorders/Delusional disorder
- Schizo-affective disorder
- Schizophrenia

Also included is any other mental condition which requires Medically Necessary treatment.

Morbid Obesity — This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including, but not limited to: hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

N

Negotiated Charge — The maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network Provider — A health care provider who has contracted to furnish services or supplies for this Plan; but only if the provider is, with the claims administrator 's consent, included in the directory as a network provider for:

- The service or supply involved; and
- The class of associates to which you belong.

Network Service(s) or Supply(ies) — Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Night Care Treatment — A partial confinement treatment program provided when you need to be confined during the night. A room charge is made by the hospital, psychiatric hospital or residential treatment facility. Such treatment must be available at least:

- Eight hours in a row a night; and
- Five nights a week.

Non-Occupational Illness — A non-occupational illness is an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Preferred Brand Drug — Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.

Non-Occupational Injury — A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Specialist — A physician who is not a specialist.

Non-Urgent Admission — An inpatient admission that is not an emergency admission or an urgent admission.

O

Occupational Injury or Occupational Illness — An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence — This means a period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment, services, or supplies, for a disease or injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or injury.

Orthodontic Treatment — This is any:

- Medical service or supply, or
- Dental service or supply

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth,
- Of the bite; or
- Of the jaws or jaw joint relationship

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer, or
- A surgical procedure to correct malocclusion

Out-of-Network — Out-of-network providers are doctors, hospitals and other providers that are not contracted with your health care network. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-pocket Maximum — Also known as an out-of-pocket limit. The most you pay during a given time period (usually a 12-month calendar period) before your Medical Plan begins to pay 100% of the allowed amount. This limit does not include your contributions, charges beyond the Reasonable and Customary Charge, or health care the Plan does not cover. Check with your

health care network provider to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter Medications — Medications typically made available without a prescription.

P

Partial Confinement Treatment — A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or mental disorders. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital or residential treatment facility on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who reviews and evaluates its effect weekly.

Day care treatment and night care treatment are considered partial confinement treatment.

Payment Percentage — Both the percentage of covered expenses that the Plan pays and the percentage of covered expenses that you pay. The percentage that the Plan pays is referred to as the “Plan payment percentage” and varies by the type of expense.

Pharmacy — An establishment where prescription drugs are legally dispensed. Pharmacy includes a retail pharmacy, mail order pharmacy and specialty pharmacy.

Physician — A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices, and
- Provides medical services which are within the scope of his or her license or certificate

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices
- Provides medical services which are within the scope of his or her license or certificate
- Under applicable insurance law is considered a "physician" for purposes of this coverage
- Has the medical training and clinical expertise suitable to treat your condition
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder,and
- Is not you or related to you

Precertification or Precertify — A process where the claims administrator is contacted before certain services are provided, such as hospitalization or outpatient surgery, to determine whether the services being recommended are considered covered expenses under the Plan. It is not a guarantee that benefits will be payable.

Preferred Brand Drugs — Brand-name drugs on your provider’s list of approved drugs. You can check online with your provider to see this list.

Prescriber — Any physician or dentist, acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

Prescription — An order for the dispensing of a prescription drug by a prescriber. If it is an oral

order, it must be put in writing promptly by the pharmacy.

Prescription Drug — A drug, biological, or compounded prescription which, by state and Federal law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid health care professional. Covered injectable drugs include injectable insulin.

Preventive Drugs — Prescription drugs that can help keep you from developing a health condition are called preventive prescription drugs. They can help you maintain your quality of life and avoid expensive treatment, helping to reduce your overall health care costs.

Primary Care Physician (PCP) — This is the network provider who:

- Is selected by a person from the list of primary care physicians in the directory;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown in the claims administrator records as the person's PCP.

Psychiatric Hospital — This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or mental disorders
- Is not mainly a school or a custodial, recreational or training institution
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly
- Is staffed by psychiatric physicians involved in care and treatment
- Has a psychiatric physician present during the whole treatment day
- Provides, at all times, psychiatric social work and nursing services
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges
- Meets licensing standards

Psychiatric Physician — This is a physician who:

- Specializes in psychiatry, or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse, or mental disorders**.**

R

Reasonable and Customary (R&C) Charge — Also known as an eligible expense or the Usual and Customary (U&C) Charge. For Aetna, the R&C charge is defined as the amount your health care network provider will pay for a medical service in a geographic region based on what providers in the area usually charge for the same or similar medical service. For HealthPartners,

the U&C charge is defined as the maximum amount allowed that the Plan considers in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region. You must pay any charges above the U&C charge and that amount does not apply to the out-of-pocket limit. HealthPartners' U&C fee schedules are determined using the Medicare Fee Schedule.

Rehabilitation Facility — A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services — The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

Residential Treatment Facility (Mental Disorders) — This is an institution that meets all of the following requirements:

- On-site licensed behavioral health provider 24 hours per day/7 days per week
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission)
- Is admitted by a physician
- Has access to necessary medical services 24 hours per day/7 days a week
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs
- Offers group therapy sessions with at least an R.N. or Masters-level health professional
- Has the ability to involve family/support systems in therapy (required for children and adolescents, encouraged for adults)
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy
- Has peer-oriented activities
- Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet the claims administrator's credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director)
- Has individualized active treatment plans directed toward the alleviation of the impairments that caused the admissions
- Provides a level of skilled intervention consistent with patient risk
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located
- Is not a wilderness treatment program or any such related or similar program, school and/or education service

Residential Treatment Facility (Substance Abuse) — This is an institution that meets all of the following requirements:

- On-site licensed behavioral health provider 24 hours per day/7 days per week
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission)
- Is admitted by a physician
- Has access to necessary medical services 24 hours per day/7 days a week

- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending physician
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs
- Offers group therapy sessions with at least an R.N. or Masters-level health professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents, encouraged for adults)
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy
- Has peer-oriented activities
- Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet the claims administrator's credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director)
- Has individualized active treatment plans directed toward the alleviation of the impairments that caused the admissions
- Provides a level of skilled intervention consistent with patient risk
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located
- Is not a wilderness treatment program or any such related or similar program, school and/or education service
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on-site or externally
- Has 24-hours-per-day/7-days-a-week supervision by a physician with evidence of close and frequent observation
- Has on-site, licensed behavioral health provider, medical or substance abuse professionals 24 hours per day/7 days a week

R.N. — A registered nurse.

Room and Board — Charges made by an institution for room and board and other medically necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Semi-Private Room Rate — **The room and board charge** that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, the claims administrator will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area — This is the geographic area, as determined by the claims administrator, in which network providers for this Plan are located.

Skilled Nursing Facility — An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:

- Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N.; and
- Physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by**:**
  - The Joint Commission on Accreditation of Health Care Organizations,
  - The Bureau of Hospitals of the American Osteopathic Association, or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g., acute) and portions of a hospital designated for skilled nursing or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care
  - Custodial care services
  - Ambulatory care, or
  - Part-time care services
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

Skilled Nursing Services — Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist — A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care — Health care services or supplies that require the **services of a specialist.**

Stay — A full-time inpatient confinement for which a room and board charge is made.

Substance Abuse — This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical

Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); or an addiction to nicotine products, food or caffeine intoxication.

Surgery Center — A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards
- Is set up, equipped and run to provide general surgery
- Charges for its services
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital, and
  - Dentists who perform oral surgery
- Has at least two operating rooms and one recovery room
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery
- Does not have a place for patients to stay overnight
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions

Must have all of the following:

- A physician trained in cardiopulmonary resuscitation
- A defibrillator
- A tracheotomy set
- A blood volume expander
- A written agreement with a hospital in the area for immediate emergency transfer of patients
- Written procedures for such a transfer must be displayed and the staff must be aware of them
- An ongoing quality assurance program, including reviews by physicians who do not own or direct the facility
- Medical records on each patient

T

Terminally Ill (Hospice Care) — Terminally ill means a medical prognosis of six months or less to live.

U

Urgent Admission — A hospital admission by a physician due to:

- The onset of or change in an illness,
- The diagnosis of an illness, or
- An injury.

The condition, while not needing an emergency admission, must be severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider — This is:

- A freestanding medical facility that meets all of the following requirements:
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available
  - Routinely provides ongoing unscheduled medical services for more than eight consecutive hours
  - Makes charges
  - Is licensed and certified as required by any state or Federal law or regulation
  - Keeps a medical record on each patient
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility
  - Is run by a staff of physicians. At least one physician must be on call at all times
  - Has a full-time administrator who is a licensed physician
- A **physician**'s office, but only one that:
  - Has contracted with the claims administrator to provide urgent care; and
  - Is, with the claims administrator's consent, included in the directory as a network urgent care provider.

It is not the emergency room or outpatient department of a hospital.

Urgent Condition — This means a sudden illness, injury, or condition that meets all of the following requirements:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your **physician** becomes reasonably available.

W

Walk-in Clinic — A walk-in clinics is a free-standing health care facility. It is an alternative to a physician's office visit for treatment of:

- Unscheduled, non-emergency illnesses and injuries
- The administration of certain immunizations, and
- Individual screening and counseling services

It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither:

- An emergency room, nor
- The outpatient department of a hospital

shall be considered a walk-in clinic.

CONTACTS

If you have benefits questions, reach out to the Unisys Benefit Service Center or any of the Claims Administrators for answers, but the provisions of the Plan will govern in all cases.

WHO TO CALL:	HOW TO REACH THEM:
Biometric Screenings Quest Diagnostics	**Toll-free 866-908-9440** Call Center hours: Mon. – Fri., (except holidays) 8 a.m. – 9:30 p.m., Sat., (except holidays) 8:30 a.m. – 5 p.m. Eastern Time **https://my.blueprintforwellness.com** Registration Key: Unisys
Medical Aetna	**Toll-free 800-223-3580** Call Center hours: Mon. – Fri., (except holidays) 8 a.m. – 6 p.m. Eastern Time **www.aetna.com** Hearing impaired: 800-628-3323 Group #: 655530
HealthPartners	**Toll-free 800-883-2177** Call Center hours: Mon. – Fri., (except holidays) 8 a.m. – 8 p.m. Eastern Time **www.healthpartners.com** Hearing impaired: 888-850-4762 Group #: 3493
Kaiser **Medical/Rx**	**Toll-free 808-432-5955** (Oahu) **800-966-5955** (neighbor islands) Call Center hours: Mon. – Fri., 8 a.m. to 8 p.m., Sat. 8 a.m. – noon HST **kp.org** Hearing impaired: **877-447-5990** Group #: 15615
Rx Pharmacy Express Scripts (Aetna and HealthPartners)	**Toll-free 800-903-4734** Call Center hours: 24/7, excluding Dec. 25 **www.express-scripts.com** Group #: 24617
HealthAdvocate™	**Toll-free 866-695-8622** Call Center hours: 24/7 **www.healthadvocate.com**
Teladoc Aetna and HealthPartners members	**Toll-free 855-Teladoc (855-835-2362)** Call Center hours: 24/7/365 **www.Teladoc.com/Unisys**

WHO TO CALL:	HOW TO REACH THEM:
Health Savings Account PayFlex/Aetna	**Toll-free 888-678-8242** Call Center hours: Mon. – Fri., 8 a.m. – 8 p.m., Sat. 10 a.m. – 3 p.m. Eastern Time **www.aetna.com**
Unisys Benefits Service Center (UBSC)	**Toll-free 877-864-7972** Call Center hours: Mon. – Fri., (except holidays) 9 a.m. – 5 p.m. Eastern Time **http://resources.hewitt.com/unisys**

Please note:

- HSAs under the Medical Plan are offered by Aetna and HealthPartners and managed by PayFlex. The Company's sole involvement is to offer the option for eligible associates to make payroll contributions, to make certain employer contributions on behalf of certain eligible associates, and to pay certain HSA fees. HSAs are outside the Unisys Flexible Benefits Program and are not part of an employer-sponsored welfare benefit plan for the purposes of the U.S. Employee Retirement Income Security Act of 1974, as amended (ERISA).
- The tools and resources offered by the health care network providers contain a lot of information and are intended to assist you as you do your benefit planning. However, you are strongly urged to consult your own sources, based on your own personal facts, circumstances and preferences. Unisys makes no representation about these tools and resources.
- In addition to the Federal income tax aspects of the Consumer Health Plan, there may also be state, local and/or international tax aspects of the Plan, which will vary based on each associate's particular facts and circumstances. Because Unisys cannot give legal, financial or tax advice, you are strongly urged to consult your own personal legal, financial and tax advisors before you take any action under the Plan.

APPENDIX 1

KAISER HMO

The SPD for the Kaiser HMO is incorporated into this plan document by reference and may be requested by contacting the Unisys Benefits Service Center (UBSC) toll-free at **877-864-7972.**

APPENDIX 2

AETNA GLOBAL BENEFITS (AGB) PROGRAM

You may request a hard copy of SPDs, free of charge, through any one of the following methods:

- Submit your request to “Ask HR”
- Email the HR Service Center at ~HRSC or **HRSC@unisys.com**
- Call the HR Service Center at 888-560-1782, Monday through Friday (except holidays), 9 a.m. to 6 p.m. Eastern Time
- Mail your request to: Unisys Corporation, 1133 College Drive, Bismarck, ND 58501

This document is the plan document for the Unisys Medical, Dental and Vision Plans and the Summary Plan Description (SPD) of the Unisys Medical Plan for eligible associates and their eligible dependents.