The U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan and The Roche Diagnostics Retiree Healthcare Plan Summary Plan Description effective January 1, 2023

The following Summary Plan Description (SPD) for the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan and the Roche Diagnostics Retiree Healthcare Plan (collectively the "Plan") has been updated to include all changes made to the Plan effective up to and including January 1, 2023.

This SPD is designed to provide general information about the Plan. The terms of your benefit plan are governed by legal documents. This SPD supersedes any other SPD and/or updates to other SPDs previously distributed.

The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"). This Plan is meant to be exempt from the market reform rules of the Patient Protection and Affordable Care Act (the "Affordable Care Act") as a retiree-only program. The Company maintains this Plan exclusively for the benefit of certain eligible retirees and their eligible family members. The preamble to "The Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act" (the "Grandfathered Regulations") provides that plans with less than two participants who are current Employees (commonly referred to as "retiree-only health plans") are exempt from the group market reform requirements of the Affordable Care Act. The preamble to the Grandfathered Regulations states, in relevant part, "Accordingly, the exceptions of ERISA section 732 and Code section 9831 for very small plans and certain retiree-only health plans, and for excepted benefits, remain in effect and, this ERISA section 715 and Code section 9815, as added by the Affordable Care Act, do not apply to such plans or excepted benefits." This Plan is intended to qualify as a "retiree-only health plan" under Section 9831 of the Internal Revenue Code, that is exempt from certain federal laws, including, but not limited to, the HIPAA portability requirements, the market reforms rules under the Patient Protection and Affordable Care Act, the Mental Health Parity and Addiction Equity Act and the Consolidated Appropriations Act, 2021.

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Table of Contents

The U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan and The Roche Diagnostics Retiree Healthcare Plan Summary Plan Description effective January 1, 2023

The Plan Sponsor and each participating Affiliate (the "**Company**") offer programs that provide healthcare coverage for eligible Participants (as defined in the Understanding Retiree Healthcare Plan Terms below) through the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan and the Roche Diagnostics Retiree Healthcare Plan (collectively the "**Plan**"). The Plan consists of two parts – healthcare coverage ("**Coverage**") and a subsidy to help defray the cost of Coverage (see "Medical Subsidy Programs" on page 15.

The Coverage options available under the Plan are:

- Medical and Prescription,
- Dental, and
- Vision

Coverage options available under the Plan are generally the same as those offered to active Employees. However, eligible Participants may only elect to participate in the Medical and Prescription, Dental or Vision coverage for which they were eligible under the Company's active Employee plan(s) immediately prior to retirement (see the Enrollment Rules section of this SPD).

Understanding Retiree Healthcare Plan Terms

You will see certain terms used throughout this section of the summary plan description ("**SPD**"). These terms are defined below It is important that you are familiar with their meanings:

Affiliate: means an entity which controls, is controlled by, under common control with, or in an affiliated service group with the Plan Sponsor, as determined under Code section 414.

Appeals Administrator: means the applicable insurance companies, HMO, administrative service organizations and other entities providing the fully insured Benefits; and the Plan Administrator, administrative service organizations and other entities administering the self-funded Benefits, except to the extent otherwise provided in the contracts or policies incorporated by reference as part of this Plan. The Appeals Administrator shall be neither the individual who made the initial determination nor the subordinate of such person.

Benefit: means the goods and/or services provided under one or more of the contracts or plans incorporated by reference.

COBRA: means Title 10 of the Consolidated Omnibus Budget Reconciliation Act of 1985, originally enacted as Pub. L. No. 99-272, and Code Sections 4980B(f) and (g) and part 6 of subtitle B of title I of ERISA, as added by COBRA (as amended).

Code: means the Internal Revenue Code of 1986, as amended. Any reference to a specific section of the Code herein will include such section, any valid regulation or IRS guidance promulgated thereunder, and any comparable provision of any future legislation amending, supplementing or superseding such section.

Company: means the Plan Sponsor and each Affiliate that participates in the Plan.

Eligible Domestic Partner: means a same or opposite sex domestic partner of a Retiree Participant, an LTD Participant, or a Severance Participant who has entered into one of the following prior to employment termination: (a) a domestic partnership affidavit as defined in the Statement of Domestic Partner Relationship form specified in the Employer's Intranet or Company's HR portal, (b) a registered domestic partnership, or (c) a civil union. The Plan Administrator reserves the right to discontinue or terminate coverage for Domestic Partners at any time if the affidavit in subsection (a) is not submitted pursuant to the affidavit rules, including recertification of the tax relationship. In addition, the Plan Administrator reserves the right to recoup any claims from the Retiree Participant, LTD Participant, or Severance Participant as well as their Domestic Partner, which were paid during any time period where the Domestic Partner's status was unsubstantiated. The Plan Administrator reserves all rights to determine a person's status as a Domestic Partner and their eligibility to participate in the Plan. The Retiree Participant, LTD Participant, or Severance Participant must immediately inform the Plan Administrator of the termination of the domestic partnership or civil union.

Eligible Dependent: Dependents of Retiree Participants, LTD Participants or Severance Participants are eligible for Coverage in the Plan (subject to the Plan's coverage eligibility rules on page 27) if they were either covered on your last day of work with the Employer or were eligible to be covered but were enrolled in another employer's group plan and, unless excluded below, they are:

- your Spouse as defined in this section;
- your Eligible Domestic Partner as defined in this section;
- your Dependent Child(ren) as defined below;
- your Eligible Domestic Partner's Dependent Child(ren);
- your disabled children as defined below; and
- any child an Employee is required to cover under a Qualified Medical Child Support Order provided the child otherwise meets the Plan's definition of Eligible Dependent.

Eligible Dependent Child(ren) up to age 26 (unless excluded below):

- your biological children,
- your stepchildren,
- your legally adopted children,
- children who have been placed with you for adoption,
- children for whom you, or you and your Spouse, have been appointed sole legal guardian(s), and
- biological, adopted, or legal ward children of an Eligible Domestic Partner.
- your disabled children age 26 and older, if certified as a disabled dependent by UHC or Kaiser in accordance with UHC or Kaiser's policy (as applicable) and if they were covered under another group plan immediately prior to age 26. Disabled children will continue to be eligible for the coverage they received prior to age 26. For example, if your disabled child had medical coverage, but not dental or vision coverage before age 26, then the disabled child may have only medical coverage after age 26. You must receive certification from UHC or Kaiser in order to receive coverage for your disabled dependent age 26 or older.
- The term Eligible Dependent does not include:
- Child(ren) age 26 and older, unless they meet the definition of a disabled Child above, or
- Parents and siblings

For simplicity, when possible, the term "*Spouse*" is used throughout this document to refer to both same and opposite sex legally married Spouses and same and opposite sex Eligible Domestic Partners.

All dependents must be approved thorough the Plan Administrator's dependent verification process to be considered an Eligibile Dependent.

Eligible Legacy Dependent: An eligible dependent as defined by the applicable Roche Legacy Program.

Eligible Survivors: A surviving Eligible Dependent of a deceased:

- Retiree Participant;
- LTD Participant;
- Severance Participant;
- active Employee who met the definition of Retiree on the date of their death; or
- active Employee who was eligible to participate in the Roche Post-Employment Healthcare Plan as of January 1, 2011 and had at least 5 years of service or was at least age 45 with at least one year of service on the date of their death.

Employee: A person who is classified and employed by a Participating Employer as a U.S. common-law employee and is being paid through the U.S. payroll system , and does not include anyone who is classified as a Post-Doctoral Fellow, Clinical Fellow, Term Assignment Employee, Intern, Consultant, Temporary Assignment Employee, Co-op, Contractor, Leased Employee, an employee of an employment agency or any entity other than the Employer, or a member of a collective bargaining unit unless Plan eligibility is specifically agreed to by a Participating Employer in a collective bargaining agreement and approved by the Plan Sponsor In addition individuals who are later reclassified as common law employees, but were not treated as common law employees of the Employer, will not be eligible for Benefits under the Plan for the period during which they were not considered a common law employee.

Employer: With respect to each Retiree Participant, LTD Participant, or Severance Participant, the entity that is part of the Company or an Affiliate that is or was the Participant's direct employer.

ERISA: means the Employee Retirement Income Security Act of 1974, as amended. Any reference to a specific section of ERISA herein will include such section, any valid regulation promulgated thereunder, and any comparable provision of any future legislation amending, supplementing or superseding such section.

Genentech Legacy Bridge to Medicare Program: A post-employment healthcare plan maintained by Genentech prior to January 1, 2011 for eligible Retirees whose employment terminated prior to January 1, 2011.

Group Health Benefit: means any Benefit that provides medical, including prescription drug, dental, and vision benefits.

HIPAA: means the Health Insurance Portability and Accountability Act of 1996, as amended. Any reference to a specific section of HIPAA herein will include such section, any valid regulation promulgated thereunder, and any comparable provision of any future legislation amending, supplementing or superseding such section.

IRS: means the Internal Revenue Service

Legally Adopted Child(ren): means a two-step judicial process resulting in a final judgment, decree, or order issued by a court of competent jurisdiction in conformance to state statutory provisions in which the legal obligations and rights of a child toward the biological parent(s) are terminated and new rights and obligations are created between the child and the adoptive parent(s). A child who has been placed for adoption with the Retiree Participant, LTD Participant, or Severance Participant is considered a Legally Adopted Child.

LTD Participant: An Employee (i) who has been approved to receive long-term disability benefits under the U.S. Roche Long-Term Disability Plan (the "**LTD Plan**"), (ii) who has been receiving such LTD Plan benefits for at least six (6) months, and (iii) whose employment with an Employer is terminated on or after January 1, 2011.

LTD Termination Date: the date on which an Employee's employment with the Employer is terminated after becoming eligible for LTD.

Medicare eligible: An individual will be deemed to be Medicare eligible under this Plan if (i) the individual attains age 65, (ii) the individual is under age 65 and has for more than twenty-four (24) months either (A) been entitled (or deemed to be entitled) to disability benefits under the Social Security Act or (B) been a disabled qualified beneficiary under the Railroad Retirement Act, or (iii) the individual meets the requirements of Medicare entitlement based on a diagnosis involving ESRD (i.e., the individual has an irreversible and permanent kidney impairment that requires regular dialysis or a kidney transplant).

Participant: A Retiree Participant, LTD Participant, Eligible Survivor, Eligible Dependent or a Severance Participant as defined in this SPD.

Participating Employer: an Employer listed as a "Participating Employer" in the Important Notice and Contact Information section of this SPD.

Plan: means the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan and the Roche Diagnostics Retiree Healthcare Plan, together with any and all amendments and supplements thereto and as amended from time to time.

Plan Administrator: means the Plan Sponsor or such other person, company or entity as may be designated from time to time by the Plan Sponsor except as otherwise provided in the Plan.

Plan Sponsor:

- Genentech, Inc., a Delaware corporation, and any successor by merger, consolidation or otherwise that assumes its obligations under the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, or
- Roche Diagnostics Corporation, an Indiana corporation, and any successor by merger, consolidation or otherwise that assumes its obligations under the for the Roche Diagnostics Retiree Healthcare Plan

Retiree: a former Employee who meets one of the following criteria on his last day of employment:

- First hired by the Company on or after January 1, 2011 and has completed at least 5 Years of Eligibility Service and had attained age 60; or
- Employed by Genentech prior to January 1, 2011 and
  - remained employed with the Company on and after January 1, 2011 and has completed at least 5 Years of Eligibility Service and has attained age 60[1]; or
  - terminated employment prior to January 1, 2011 and had completed at least 5 Years of Eligibility Service and had attained age 60[1] and remained eligible for coverage under the Genentech Legacy Bridge to Medicare Program; or

[111] In the case of an Employee of Genentech, Inc., Genentech, USA, Inc. or Genentech P.R., Inc. (collectively "Genentech") only who terminated before January 1, 2011, eligibility also includes the attainment of age 55 with 10 or more Years of Eligibility Service, provided your age plus your Years of Eligibility Service at Genentech equaled or exceeded 65 on January 1, 2004.

- An Eligible Retiree as defined in the Roche Post-Employment Healthcare Plan SPD who terminated employment on or after January 1, 2011 (excluding employees of Roche Colorado Corporation); or
- Employed by Roche Diagnostics Corporation or Roche Diagnostics Operations, Inc. (including Roche Diagnostics Systems ("RDS")) prior to January 1, 2011 and either
  - remained employed with the Company on and after January 1, 2011[2] and who has completed at least 10 Years of Eligibility Service and has attained age 55 at the time of employment termination, or
  - terminated employment prior to January 1, 2011 and had completed at least 10 Years of Eligibility Service and had attained age 55 and remained eligible for coverage under the Roche Diagnostics Retiree Healthcare Plan; or
- Employed by the Company prior to January 1, 2011, and remained employed with the Company on and after January 1, 2011, did not participate in a Company-sponsored post-employment healthcare plan prior to January 1, 2011, and has completed at least 5 Years of Eligibility Service and has attained age 60, or
- Anyone rehired by the Company on or after January 1, 2011 after a ninety (90) day break in service, except that rehired Retirees who were eligible to participate in the Coverage and retiree medical subsidy program upon their initial termination date will remain eligible for the Coverage and retiree medical subsidy program in which they were eligible to participate on their initial termination date, or
- Transferred from a non-Participating Employer on or after January 1, 2011, and has completed at least 5 Years of Eligibility Service and has attained age 60; as long as that Employee is not eligible to participate in any other Retiree Medical Program, or
- Transferred to a non-Participating Employer on or after January 1, 2011, has completed at least 5 Years of Eligibility Service, and has attained age 60; as long as that non-Participating Employer does not maintain a Retiree Medical Program and as long as the Employee is not eligible for a Roche Legacy Program.

Roche Legacy Program: A post-employment healthcare plan maintained by an Employer prior to January 1, 2011, including, but not limited to, the Roche Post-Employment Healthcare Plan and the Roche Diagnostics Retiree Healthcare Plan.

Retiree Medical Program: A program maintained by an Employer to provide for retiree medical benefits, including a Roche Legacy Program.

Retiree Participants: A former Employee who meets the definition of Retiree.

Severance Participant: A Severance Participant is an Employee who is terminated under a Severance Program and:

- meets all criteria to be eligible for the "Rule of 65" as that term is defined under a Severance Program and who was not otherwise eligible to participate in the Coverage of this Plan at the time of termination of employment; or

[2] Participants who transfer to a non-Participating Employer on and after January 1, 2011 but before they meet the definition of a Retiree, and transfer back to a Participating Employer prior to termination of employment, with no break in service, remain eligible for the Premium Contribution Percentage if they meet the definition of a Retiree.

- would have been eligible for participation under a Roche Legacy Program but did not meet the age and service requirements of that program, but had completed at least 5 Years of Eligibility Service and had attained age 60 by their termination date.

Severance Program: Any one of the following programs:

- Hoffmann-La Roche Inc. Transitions Special Severance Program;
- Roche Palo Alto LLC Transitions Special Severance Program;
- The Genentech/Roche Pharma U.S. Special Enhanced Severance Plan;
- Nutley Site Severance Plan;
- *U.S. Roche Transitional Benefits Plan (formerly known as the Genentech/Roche Pharma Transitional Benefits Plan);
- *U.S. Roche Officer Transitional Benefits Plan;
- Roche Diagnostics US Severance Plan.

*For Members eligible for the U.S. Roche Transitional Benefits Plan and the U.S. Roche Officer Transitional Benefits Plan only, if you do not meet eligibility for the Rule of 65 but your Termination Date is within 90 calendar days of the date on which you would otherwise have been eligible for benefits under the retiree healthcare program in which you participate on your termination date, you will be deemed to have met the eligibility requirement for the Rule of 65, but will not have met the definition of a Retiree (as defined in the retiree healthcare program in which you participate on your termination date).

Spouse: your same or opposite sex lawful husband or wife as determined in accordance with applicable federal law

Years of Credited Service: Applicable only to those participating in either the Healthcare Account or the Premium Contribution Percentage Program, a terminated Employee's Years of Credited Service includes any prior service with a Participating Employer as follows:

- Any prior service with a Participating Employer provided you were eligible to participate in a Participating Employer's Retiree Medical Program, but only to the extent your prior service was counted in the Participating Employer's Retiree Medical Program. Please refer to the chart below for eligibility dates for certain affiliates.
- All periods of absence due to an approved leave of absence with a Participating Employer prior to your date of termination.
- The break in service if you are rehired by a Participating Employer within ninety (90) days of your termination date after January 1, 2011 ("reinstatement"). In this case there will be no break in service and you will be treated as if you never left employment for purposes of calculating your Years of Credited Service.
- If you are rehired on or after January 1, 2011 and were not previously eligible under an Employer's Retiree Medical Program, then your Years of Credited Service will begin upon your first rehire date on or after January 1, 2011.
- If you transfer from a non-Participating U.S. Employer to a Participating Employer, or work for a non-Participating U.S. Employer that becomes a Participating Employer, your Years of Credited Service will begin upon the first day you work for a Participating Employer.
- If you transfer to a non-Participating U.S. employer, your Years of Credited Service will end upon the last day you work for a Participating Employer.

- If you transfer to a Participating Employer from a non-Participating Employer, and you previously worked for a Participating Employer that participated in a Retiree Medical Program, then your Years of Credited Service will include your prior service under that Participating Employer's Retiree Medical Program plus your new service from your transfer date to that Participating. Employer. Your time working for a non-Participating Employer does not count towards your Years of Credited Service.
- If you transfer to a Participating Employer from a non-Participating Employer on or after January 1, 2011, and never previously worked for a Participating Employer or were previously employed by a Participating Employer which did not have a Retiree Medical Program, then your Years of Credited Service will start from your transfer date to the Participating Employer.
- If you transfer to a non-Participating Employer from a Participating Employer but are eligible to elect coverage under this Plan because no retiree healthcare is available from the non-Participating Employer when your employment terminates, then your Years of Credited Service will include only your prior service with a Participating Employer during the time you participated in that Participating Employer's Retiree Medical Program.

You receive one month of Credited Service for each month of service worked for the Company, except as set forth below:

Healthcare Account Years of Credited Service Restrictions	
Roche Madison Inc.[1]	American Cyanamid[5]
NimbleGen[2]	Medi Physics Inc.[6]
Roche Sequencing Solutions[2]	Roche Professional Services Corp[7]
454 Life Sciences[2]	Cintichem[6]
Diesetronic (DUSA)[2]	Givaudan Roure[8]
Ventana, Inc.[2]	LabCorp[9]
Roche Vitamins, Inc.[3]	Memory Pharma[10]
Agri-Bio[4]	GenMark Diagnostics Inc[11]

[1] Only Years of Credited Service earned after October 1, 2008.

[2] Only Years of Credited Service earned after January 1, 2011.

[3] Only Years of Credited Service earned prior to September 30, 2003.

[4] Only Years of Credited Service earned between May 5, 1994 and May, 2000.

[5] Only Years of Credited Service earned between August 1, 1995 and May, 2000.

[6] Only Years of Credited Service earned before June 13, 1990.

[7] Only Years of Credited Service earned before January 1, 1993.

[8] Only Years of Credited Service earned before May 9, 2000.

[9] Only Years of Credited Service earned before April, 1995.

[10] Only Years of Credited Service earned between January 5, 2009 and August 31, 2009.

[11] Only Years of Credited Service earned after January 1, 2022.

Years of Eligibility Service: Applicable only to those participating in either the Healthcare Account or the Premium Contribution Percentage Program, a terminated Employee's Years of Eligibility Service includes the period of continuous employment with the Employer (this includes both Participating and non-Participating Employers, as well as U.S. and foreign Employers) as well as continuous employment with a company that becomes a Roche Affiliate until date of termination, adding together any pre-break and post-break service.

Your service is continuous as long as there is no interruption in your salary or wages, or you are absent for one of the following reasons:

- An authorized leave of absence for no more than 2 months due to personal need or emergency provided you return to work;
- An authorized leave of absence due to military service;
- An authorized leave to engage in an Employer's approved training or education program provided you return to work;
- Absent but qualified for temporary disability benefits unless your employment has been terminated and you become eligible for temporary disability benefits due to an illness or injury that began after your employment terminated; or
- Absent while entitled to long term disability benefits prior to your date of termination.

If you do not return to work immediately after an authorized leave, your service will be considered terminated on the day the leave ends.

Medical Subsidy Programs

The subsidy programs described in this section are:

- The Healthcare Account Program
- The Roche Diagnostics Premium Contribution Percentage Program

These subsidy programs are intended to help eligible Participants defray the cost of post-employment medical and prescription coverage. The portion of the cost of coverage that you pay depends on several factors, such as your hire and/or rehire date, your status at termination, and the coverage options you choose, as explained in detail in this section. Note that your contribution amounts are subject to change.

HEALTHCARE ACCOUNT

The Plan provides benefits for eligible Retiree Participants and Severance Participants to receive reimbursement for Eligible Healthcare Expenses (as defined below) incurred by them and/or their Eligible Dependents after they retire from the Employer by establishing a Healthcare Account on their behalf upon retirement. LTD Participants who are eligible for the Healthcare Account Program are not eligible to recieve their Healthcare Account until they meet the requirements for a Retiree Particpant.

ELIGIBILITY FOR THE HEALTHCARE ACCOUNT

Employees eligible to participate in the Healthcare Account Program are those who are:

- First hired by the Company on or after January 1, 2011; or
- Employed by Genentech prior to January 1, 2011, and
  - remained employed with the Company on and after January 1, 2011; or
  - terminated employment prior to January 1, 2011 and remained eligible for coverage under the Genentech Legacy Bridge to Medicare Program; or
- Employed by a Participating Employer prior to January 1, 2011, remained employed with a Participating Employer, and did not participate in a Company-sponsored post-employment healthcare plan prior to January 1, 2011; or
- Rehired by a Participating Employer on or after January 1, 2011, after a ninety (90) day break in service except that Retirees who are rehired will remain eligible for the Coverage and retiree medical subsidy program in which they participated on their retirement date; or
- Transferred from a non-Participating Employer on/after January 1, 2011, if either (a) the Employee had never worked for a Participating Employer or (b) worked for a Participating Employer which did not have a Retiree Medical Program; or
- Transferred to a non-Participating Employer on or after January 1, 2011, as long as that non-Participating Employer does not maintain a Retiree Medical Program and as long as the Employee is not eligible for a Roche Legacy Program; or
- Terminated due to job elimination or reorganization and was eligible for participation under a Roche Legacy Program but did not meet the age and service requirements of that program, as long as they have completed at least 5 Years of Eligibility Service and have attained age 60 at the time of employment termination.

If you meet the above eligibility to participate, you must also meet the criteria to be considered a Retiree or Severance Participant at the time of your employment termination to be eligible for an Account.

However, those eligible for the Healthcare Account do not include those who have previously attained eligibility to participate in a Roche Legacy Program under the following conditions:

- Reinstatement - Employees who are rehired on or after January 1, 2011, prior to a ninety (90) day break in service who were eligible for a medical subsidy under a Roche Legacy Program prior to their rehire will be reinstated with eligibility for the previous medical subsidy programs, or
- Rehired Employees or Employees who transferred from a non-Participating Employer to a Participating Employer, who at the time of prior termination or transfer, were eligible to receive a medical subsidy under a Roche Legacy Program.

If you are eligible for the Healthcare Account because you met the Rule of 65 under a Severance Plan, both Healthcare Account and Coverage under this Plan become available to you on the first of the month following the latter of your 60th birthday or the end of your company paid health continuation coverage.

UNDERSTANDING THE HEALTHCARE ACCOUNT PROGRAM

Under this program, a Healthcare Account ("**Account**") will be established on behalf of each Retiree Participant and Severance Participant that can be used to "pay for" Eligible Healthcare Expenses as defined below, incurred by

the Participant and their Eligible Dependents after the Healthcare Account is established, including the cost of Coverage available to Participants and their Eligible Dependents under the Coverage options of this Plan.

HEALTHCARE ACCOUNT PROGRAM DESCRIPTION

The amount of benefits received under the Healthcare Account Program is based on your Years of Credited Service while actively employed by the Employer. If you complete a partial Year of Credited Service of at least six (6) months, the Company will round your length of service up to the next full Year of Credited Service. If you complete a partial Year of Credited Service of less than six (6) months, the Company will round your length of service down to the last full Year of Credited Service.

An Account will be established on your behalf only if you meet the eligibility for the Healthcare Account and you are either a Retiree Participant or Severance Participant as defined in this Plan on your date of termination. If you are eligible for the Healthcare Account because you met the Rule of 65 under a Severance Plan, both Healthcare Account and Coverage under this Plan become available to you on the first of the month following the latter of your 60th birthday or the end of your company paid health continuation coverage. If you leave the Employer before becoming a Retiree Participant or Severance Participant, you will not be eligible for the Healthcare Account Program. However, if you transfer to an Affiliate that does not participate in the Plan, special rules may apply.

CALCULATION OF HEALTHCARE ACCOUNT

If you become eligible for a Health Care Account, your Account will be equal to $1,000 multiplied by each Year of Credited Service.[3] For instance, if you retire with 15 Years of Credited Service, the value of your Account will be equal to $15,000 at retirement (see the definition of Years of Credited Service).

Once your Account is established, you will receive a statement reflecting the amount in your Account. Your Account also will be credited with 5% interest for the balance remaining in your Account as of each December 31, unless you become reemployed by an Employer (see below for information regarding how your reemployment by an Employer will impact your Account). You will receive an annual statement that will provide you with the amount, including interest, remaining in your Account.

HOW YOU CAN USE YOUR HEALTHCARE ACCOUNT

You may use the Account to pay for any Eligible Healthcare Expenses incurred by you and your Eligible Dependents.

Eligible Healthcare Expenses are:

- Medical expenses defined under Section 213 of the Internal Revenue Code ("**IRC**") as long as they neither have not been nor will be reimbursed by another healthcare plan or otherwise claimed as a deduction or credit on your or your Spouse's, if applicable, income tax return;
- Expenses or portions of expenses that are not paid for under any other healthcare plan(s) in which you participate (e.g., Copays and Deductibles or charges over Reasonable and Customary); and

[3] For those Employees of Genentech only, who were actively employed by Genentech on January 1, 2004, whose age plus Years of Eligibility Service equaled or exceeded 65 on January 1, 2004, the above amount is supplemented by $2,000 for each Genentech Year of Credited Service prior to January 1, 2004.

- Premiums paid to an insurance company, an employer (including a Spouse's employer, provided the premium was not paid on a pre-tax basis), a former employer for retiree coverage (including the Employer), or a government agency (including Medicare), for any type of healthcare plan (including medical, dental, HMO, vision, long-term care insurance up to the Internal Revenue Service annual limitations, etc.).

You may not use the Account to cover payments under a medical plan sponsored by another employer if you work for another company following your retirement from the Employer.

The Account will continue to be available until you (or your Eligible Dependents) have used your entire Account for Eligible Healthcare Expenses, unless you are reemployed by an Employer (either Participating or non-Participating) at which time, access to the Account is frozen and the Account may not be used to pay any Eligible Healthcare Expenses during the period of your reemployment with an Employer.

TAXATION OF YOUR HEALTHCARE ACCOUNT

The reimbursement of Eligible Healthcare Expenses by your Account and the 5% interest credited annually will be exempt from taxation under the IRC, provided your Eligible Dependents are considered tax-qualified dependents under IRC section 152 ("**tax-qualified dependent**"). Due to federal and state tax rules, if you use your Account to cover a Domestic Partner, a Domestic Partner's Child(ren) or any other non-tax-qualified dependent, you will incur imputed income for the value of the Account reimbursement.

Additionally, upon your death to receive favorable tax treatment your Eligible Survivors must be tax-qualified dependents. Otherwise, the reimbursements from the Account and annual interest will result in imputed income for the Eligible Survivor.

REIMBURSEMENT PROCEDURE

The Healthcare Account Program is administered by Alight's Smart-Choice. Smart-Choice is responsible for the administration of the Accounts and processing of reimbursement claims. In general, the Healthcare Account Program will not make payments directly to a healthcare plan or insurance provider.

After you or your Eligible Dependent has incurred an Eligible Healthcare Expense, you must submit a claim to Smart-Choice to request reimbursement from your Account. Smart-Choice will also send you a Smart-Choice debit card, which can be used to pay directly for Eligible Healthcare Expenses, without paying out of pocket or needing to submit a claim for reimbursement. Please note that the Smart-Choice debit card can not be used to pay for healthcre premiums, and some expenses will need to be validated (per federal regulations).

To view your account balance, submit claims, view claim status and validate eligible expenses you or your Eligible Spouse, if applicable, can access your Smart-Choice account at digital.alight.com/roche. Smart-Choice may also be contacted via phone at: 833-882-3585 or fax at: 855-673-6719. Claims must be submitted to Smart-Choice along with a copy of a third party receipt showing the name and address of the service provider, name of you or your Eligible Dependent who incurred the expense, amount of the expense, and proof of payment. Claims for reimbursement must be submitted to Smart-Choice within 12 months of the date of service or, in the case of reimbursement of premiums under a health plan, within 12 months of the date the premiums are due. Payment will not be made for expenses related to any claim submitted more than 12 months following the date the expense is incurred.

The provisions of the Healthcare Account Program are intended to comply with the requirements of Treas. Reg. Section 1.409A-3(i)(1)(iv). For the sake of clarity, the reimbursements under the program will be made on or before the last day of your taxable year following the taxable year in which the expense was incurred. The right to reimbursement under this program is not subject to liquidation or exchange for another benefit.

To the extent applicable, the foregoing provisions are intended to comply with the requirements of IRC Section 409A and any final regulations and official guidance promulgated thereunder ("**Section 409A**") so that none of the benefits to be provided hereunder will be subject to the additional tax imposed under Section 409A, and any ambiguities herein will be interpreted to so comply. The Company shall consider amendments to the Plan and to take such reasonable actions which are necessary, appropriate or desirable to avoid imposition of any additional tax or income recognition prior to actual payment to you under Section 409A.

LIFE EVENTS THAT WILL AFFECT YOUR ACCOUNT

Termination If you do not meet the criteria to be considered a Retiree Participant or a Severance Participant at termination of employment, no benefits are available to you under this Plan.

Rehire In the event that you terminate employment with the Employer, but are later reemployed by the Employer, your Account will be frozen and you will not be entitled to receive a benefit from this Plan. If you again become eligible for an Account, your benefit will be recalculated upon your new eligibility date using your new Years of Credited Service to calculate your benefit; provided however, that in no event, will your benefit exceed your Years of Credited Service calculation, less any previous benefits received while you were previously eligible. In the event that you terminate, but are later reemployed by the Employer within ninety (90) days of your initial termination, any break in service will be disregarded for eligibility purposes. During your reemployment, your Account will not earn the applicable 5% interest. In the event that you terminate, but are later reemployed by the Employer, your eligibility under this Plan will cease if you will be eligible to participate in the Employer's active medical, prescription, dental and visions plans. Otherwise, if you are not eligible to participate in the Employer's active medical, prescription, dental and visions plans, you will retain your eligibility under this Plan.

Death If you:

- are not a Retiree Participant, or
- are a Severance Participant who has not attained at least age 60 on the date of your death then no Healthcare Account benefits will be available to your Eligible Survivors under this Plan.

If you are eligible for the Healthcare Account on the date of your death and are survived by Eligible Survivors, your Eligible Survivors will have access to the Healthcare Account. After the date of your death, your Eligible Survivors may use any amounts remaining in your Account for reimbursement of any Eligible Healthcare Expenses incurred by them. Claims will be processed in the order they are received by the administrator. If you do not have any Eligible Survivors, any amounts remaining in your Account at the time of your death will be forfeited after ninety (90) days of your death.

If you are an Employee who is eligible for participation in the Plan under the Healthcare Account Program subsidy at the time of your death, and are survived by Eligible Survivors, your Eligible Survivors will have access to your Healthcare Account. After your date of your death, a Healthcare Account will be established and your Eligible Survivors may use the funds for reimbursement of any Eligible Healthcare Expenses incurred by them. Claims will be processed in the order they are received by the administrator. If you do not have any Eligible Survivors, and are an Employee on the date of your death, a Healthcare Account will not be established.

HOW YOU CAN LOSE YOUR ACCOUNT OR HAVE YOUR ACCOUNT SUSPENDED

- You and your Eligible Dependents, if applicable, are not eligible for the Healthcare Account Program or to receive reimbursement from your Account during any time period you are (i) covered under any Company health plan as an Employee, (ii) eligible to receive benefits under a Roche Legacy Program, or (iii) covered as a dependent of an Employee, Retiree Participant or Severance Participant.
- If you become eligible to participate in any non-participating Affiliate's Retiree Medical Program that takes into account all Years of Credited Service that have been credited to you under this Plan, your Account will be forfeited.

ROCHE DIAGNOSTICS PREMIUM CONTRIBUTION PERCENTAGE PROGRAM

The Roche Diagnostics Premium Contribution Percentage Program ("Premium Contribution Percentage") is a subsidy program available to Retirees eligible for coverage under the Roche Diagnostics Retiree Healthcare Plan last hired by Roche Diagnostics Corporation or Roche Diagnostics Operations, Inc. before January 1, 2011. It is intended to help eligible Plan Participants defray the cost of post-employment medical and prescription coverage. Under this program, Eligible Retired Diagnostic Participants pay a percentage of the cost of coverage based on your Years of Credited Service and the medical coverage option you choose. Because you pay a percentage of the cost, the amount you pay may fluctuate from year to year. You will be advised of any contribution change.

ELIGIBILITY

Participants are eligible for the Premium Contribution Percentage if they meet the eligibility requirements listed below, subject to the additional participation conditions listed below.

RETIRED DIAGNOSTICS PARTICIPANT

An Employee who (i) was last hired by Roche Diagnostics Corporation or Roche Diagnostics Operations before January 1, 2011[4], and (ii) is a Retiree who is eligible for the Premium Contribution Percentage Program.

UNDERSTANDING THE ROCHE DIAGNOSTICS PREMIUM CONTRIBUTION PERCENTAGE PROGRAM

Participation Conditions

Once you become eligible to participate in this Plan, your participation may change or terminate based on certain factors as described below.

[4] Participants who transfer to a non-Participating Employer on and after January 1, 2011 but before they meet the definiation of a Retiree, and transfer back to a Participating Employer prior to termination of employment , with no break in service, remain eligible for the Premium Contribution Percentage if they meet the definiation of a Retiree.

As a Retired Diagnostics Participant (as that term is defined above), your participation in the Plan is subject to the following conditions:

- If you were last hired before January 1, 2011[5] and you and your Spouse are under age 65, you will be eligible to elect medical, prescription, dental and vision coverage under the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, and you may use your Premium Contribution Percentage, to assist in payment for your medical/prescription coverage only[6], until you (or your Spouse) becomes Medicare-eligible. However, you will pay the entire cost of Coverage for your dental and/or vision coverage and for your Eligible Dependents' medical/prescription, dental and/or vision coverage, as there is no Premium Contribution Percentage for any Eligible Dependent coverage or for your dental or vision coverage.
- Upon reaching Medicare eligibility, or if you are Medicare eligible at the time of your retirement, you may apply the Premium Contribution Percentage to assist in payment of: -
  - a Medicare Supplemental (Medigap) plan and/or Medicare Part D (including Part D IRMAA) plan, or
  - a Medicare Advantage Plan of your choice for yourself only[4],

You may not apply your subsidy to pay for any other type of coverage including Medicare Part A or Medicare Part B premiums.

- If you become Medicare eligible after your employment termination and during your Coverage participation in the Plan, or if you die prior to your Spouse becoming Medicare eligible, your non-Medicare eligible Eligible Dependents will be eligible to continue Coverage participation in the Plan until your Spouse becomes Medicare eligible, by paying 100 percent of the cost of Coverage[4].
- If you are Medicare eligible at the time of your employment termination and your Spouse is not Medicare-eligible, then upon your termination your non-Medicare eligible Eligible Dependents may be eligible to elect Coverage participation in the Plan, until your Spouse becomes Medicare eligible, by paying 100 percent of the cost of Coverage[4].

[5] If you are a rehired Retired Diagnostic Participant and are rehired after January 1, 2011, you will remain eligible for the Coverage and retiree medical subsidy program in which you participated on your retirement date.

[6] If you are a former Roche Diagnostics Systems ("RDS") employee last hired prior to January 1, 1993 and transferred directly to Roche Diagnostics Corporation on January 1, 1999, you may use your Premium Contribution Percentage to assist in payment for medical/prescription coverage for yourself and your Eligible Dependents. This includes Eligible Dependent Child(ren) until you, and your Spouse (if applicable), become Medicare eligible. Upon your death, your Eligible Dependents will remain eligible for the Premium Contribution Percentage to assist in payment of medical/prescription coverage in this Plan or, upon your Spouse becoming Medicare eligible, for a Medicare Supplemental (Medigap) and/or Part D (including Part D IRMAA) or Advantage plan for your spouse.

PREMIUM CONTRIBUTION PERCENTAGE SCHEDULE

The table below shows the percentage of the cost of medical and prescription coverage that you will pay if you elect coverage in retirement. The percentage shown is based on your Years of Credited Service while actively employed by the Employer. If you complete a partial Year of Credited Service of at least six (6) months, the Company will round your length of service up to the next full Year of Credited Service. If you complete a partial Year of Credited Service of less than six (6) months, the Company will round your length of service down to the last full Year of Credited Service.

	Roche Diagnostics Corporation and Roche Diagnostics Operations, Inc. (including former RDS Employees hired on or after January 1, 1993*)		**For Former Roche Diagnostics Systems ("RDS") Employees last hired prior to January 1, 1993 and transferred directly to Roche Diagnostics Corp. ("RDC") on 1/1/1999**	
Medical/Rx **Retired Diagnostics Participant Premium Contribution Percentage**	Years of Credited Service at Retirement	Employer / Participant	Years of Credited Service at Retirement	Employer / Participant
	10-15	20%/80%	Less than 10	0%/100%
	16-19	30%/70%	10	35%/65%
	20-30	50%/50%	11	38%/62%
	31+	70%/30%	12	41%/59%
			13	44%/56%
			14	47%/53%
			15	50%/50%
			16	54%/46%
			17	58%/42%
			18	62%/38%
			19	66%/34%
			20	70%/30%
			21	74%/26%
			22	78%/22%
			23	82%/18%
			24	86%/14%
			25 and over	90%/10%
Eligible Dependent Medical/Rx Coverage		100%		Same as above
Dental and/or Vision	All eligible Retirees and Survivors	100%	All eligible Retirees and Survivors	100%

* Former Roche Diagnostics Systems ("RDS") employees hired on or after January 1, 1993 and transferred directly to Roche Diagnostics Corporation on January 1, 1999 will receive a Healthcare Account equal to the value of healthcare credits based on service accrued under the Roche Post-Employment Healthcare Plan prior to transfer to Roche Diagnostics Corporation, and will pay the Premium Contribution Percentage indicated above based on service accrued on and after January 1, 1999 under the Roche Diagnostics Retiree Healthcare Plan.

REIMBURSEMENT PROCEDURE

The Premium Contribution Percentage Program is administered by Alight's Smart-Choice. Smart-Choice is responsible for the processing of reimbursement claims. In general, the Premium Contribution Percentage Program will not make payments directly to a healthcare plan or insurance provider.

If you are not Medicare eligible and you participate in Coverage under this Plan, you will pay a percentage of the cost of medical and prescription coverage for yourself only based on your Years of Service and the medical coverage option you choose, as described in the chart above. Because you pay a percentage of the cost, the amount you pay may fluctuate from year to year. You will be advised of any contribution change. You will pay the entire cost of Coverage for your dental and/or vision coverage and for your Eligible Dependents' medical/prescription, dental and/or vision coverage as there is no Premium Contribution Percentage for Eligible Dependent coverage or for dental or vision coverage[1]. The Plan Administrator will bill you for the cost of Coverage under the Plan via monthly invoice.

If you are Medicare eligible, you may submit a request for reimbursement of premiums paid for a qualified Medicare Supplemental (Medigap) plan and/or Medicare Part D (including Part D IRMAA) plan or a Medicare Advantage Plan for yourself only[7]. You must submit a claim to Smart-Choice to request reimbursement.

To submit claims for reimbursement and view claim status access your Smart-Choice account at digital.alight.com/roche. Smart-Choice may also be contacted via phone at: 833-882-3585 or fax at: 855-673-6719. Claims must be submitted to Smart-Choice along with supporting documents (e.g., copy of the premium invoice) showing the name and address of the insurance provider, name of you or your Eligible Dependent[1] who incurred the expense, amount of the premiums paid, and proof of payment. Claims for reimbursement must be submitted to Smart-Choice within 12 months of the date the premiums are due. Payment will not be made for expenses related to any claim submitted more than 12 months following the date the premium was due.

The provisions of the Premium Contribution Percentage Program are intended to comply with the requirements of Treas. Reg. Section 1.409A-3(i)(1)(iv). For the sake of clarity, the reimbursements under the program will be made on or before the last day of your taxable year following the taxable year in which the expense was incurred. The right to reimbursement under this program is not subject to liquidation or exchange for another benefit.

To the extent applicable, the foregoing provisions are intended to comply with the requirements of IRC Section 409A and any final regulations and official guidance promulgated thereunder ("**Section 409A**") so that none of the benefits to be provided hereunder will be subject to the additional tax imposed under Section 409A, and any ambiguities herein will be interpreted to so comply. The Company shall consider amendments to the Plan and to take such reasonable actions which are necessary, appropriate or desirable to avoid imposition of any additional tax or income recognition prior to actual payment to you under Section 409A.

Coverage Eligibility

Individuals who are eligible for one of the Subsidy programs described above or eligible for a Roche Legacy Program may elect Coverage under the Plan, subject to the additional Coverage Participation Conditions described below.

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[7] If you are a former Roche Diagnostics Systems ("RDS") employee last hired prior to January 1, 1993 and transferred directly to Roche Diagnostics Corporation on January 1, 1999, you may use your Premium Contribution Percentage, to assist in payment for medical/prescription coverage for yourself and your Eligible Dependents. This includes Eligible Dependent Child(ren) until you, and your Spouse (if applicable), become Medicare eligible. Upon your death, or when you become Medicare eligible, your Eligible Spouse will remain eligible for the Premium Contribution Percentage to assist in payment of medical/prescription coverage in this Plan or, upon your spouse becoming Medicare eligible, for a Medicare Supplemental (Medigap) and/or Part D (including Part D IRMAA) or Advantage plan for your spouse.

Coverage Participation Conditions

Once you become eligible to participate in the Coverage of this Plan, your Coverage participation may begin, change or terminate based on certain factors as described below.

RETIREE PARTICIPANTS

As a Retiree Participant, your participation in the Coverage of the Plan is subject to the following conditions:

- If you become Medicare eligible and you are eligible to participate in the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, you and your Eligible Dependents' Coverage under this Plan will terminate. You will not be offered COBRA for Medical and prescription coverage, only for dental and/or vision coverage (if dental and/or vision were elected prior to becoming Medicare eligible). Your Eligible Dependents who are not Medicare eligible will be offered COBRA for all the types of coverage elected prior to you becoming Medicare eligible.
- If you are already Medicare eligible at the time your employment terminates and you are eligible to participate in the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, neither you nor your Eligible Dependents will be permitted to participate in the Coverage of this Plan.
- If your Eligible Dependent becomes Medicare eligible, your Eligible Dependent's Coverage under the Plan will terminate. You and any Eligible Dependents who are not Medicare eligible may continue Coverage under this Plan until you become Medicare eligible. Your Eligible Dependent who becomes Medicare eligible will not be offered COBRA for Medical and prescriptions benefits, only for dental and/or vision (if dental and/or vision were elected prior to becoming Medicare eligible).
- If either you or any one of your covered Eligible Legacy Dependents becomes Medicare eligible and you are eligible to participate in the Roche Post-Employment Healthcare Plan, you and your covered Eligible Legacy Dependents will be automatically transferred to the applicable Medical/Prescription and Dental coverage under the Roche Post-Employment Healthcare Plan. See the Roche Post-Employment Healthcare Plan SPD for more details. Please note that if you had Vision coverage in this Plan, then upon transfer to the Roche Post-Employment Healthcare Plan you and your covered Eligible Dependents may elect to continue Vision coverage under COBRA, since the Roche Post-Employment Healthcare Plan does not offer Vision coverage.
- if you become Medicare eligible and you are eligible to participate in the Roche Diagnostics Retiree Healthcare Plan, your Coverage under this Plan will terminate, but your non-Medicare eligible Eligible Dependents may continue coverage until the date your Eligible Spouse becomes Medicare eligible, at which time coverage for all Eligible Dependents will terminate.
- If you are already Medicare eligible at the time your employment terminates and you are eligible to participate in the Roche Diagnostics Retiree Healthcare Plan, you are not permitted to participate in the Coverage of this Plan, however, your non-Medicare Eligible Dependents may elect Coverage in the Plan and may continue Coverage until the date your Eligible Spouse becomes Medicare eligible, at which time coverage for all Eligible Dependents will terminate.

LTD PARTICIPANTS

As an LTD Participant, your participation in the Coverage of the Plan is subject to the following conditions:

- If you become Medicare eligible while you are an LTD Participant, you must notify the Company, and you and your Eligible Dependents' Medical and Prescription coverage under this Plan will terminate. Regardless of your Medicare eligibility, any Dental and Vision coverage under this Plan may continue while you are an LTD Participant.
- If you are already Medicare eligible at the time your employment terminates, neither you nor your Eligible Dependents will be permitted to participate in the Coverage of this Plan.
- If your Spouse becomes Medicare eligible while you are an LTD Participant or was already Medicare eligible at the time your employment terminated, you must notify the Company, and your Spouse's Medical and Prescription coverage will terminate. Regardless of your or your Spouse's Medicare eligibility, any Dental and Vision coverage under this Plan may continue while you are an LTD Participant.
- If you were eligible to participate in the Roche Post-Employment Healthcare Plan on your employment termination date, once you or any of your covered Eligible Dependents become Medicare-eligible, you and your Eligible Legacy Dependents will be transferred to the applicable coverage under the Roche Post-Employment Healthcare Plan as an Eligible Retiree (not an LTD Participant). See the Roche Post-Employment Healthcare Plan SPD for more details. Please note that if you had Vision coverage in this Plan, then upon transfer to the Roche Post-Employment Healthcare Plan, you and your covered Eligible Dependents may elect to continue Vision coverage under COBRA, since that plan does not offer Vision coverage.
- If you were eligible to participate in the Roche Diagnostics Retiree Healthcare Plan on your employment termination date, then upon your Medicare eligibility your Medical Coverage under this Plan will terminate but your Eligible Dependents may continue Medical Coverage after you become Medicare eligible until the date your Eligible Spouse becomes Medicare eligible, at which time Medical Coverage for all Eligible Dependents will terminate. You and your Eligible Dependents' Dental & Vison Coverage can continue until you are no longer an LTD Participant.

ELIGIBLE SURVIVORS

Eligible Survivors participation in the Coverage of the Plan is subject to the following conditions:

- If you die (i) as a Retiree Participant, (ii) as an active Employee who met the definition of Retiree at the time of your death, or (iii) as a Severance Participant, your non-Medicare eligible Eligible Survivors who are not enrolled in Coverage at the time of your death may elect Coverage in this Plan provided you were enrolled in or otherwise eligible for such coverage on your date of death. Your non-Medicare eligible Eligible Survivors must enroll in the Plan and provide any required proof of dependent status documents within **60 calendar days** of your date of death.
- If you die (i) as a Retiree Participant, or (ii) as a Severance Participant, then your Eligible Survivors who had Coverage at the time of your death will receive two months of Coverage at the Employer's cost.. After the two months they may choose between (A) COBRA, or (B) Continuing Coverage under this Plan until your Spouse becomes Medicare eligible, at which time your Eligible Survivor Child(ren) may continue their Coverage under COBRA, as long as your Eligible Survivor Child(ren) remain Eligible Dependents under this Plan. Eligible Survivors will be responsible for paying the required premium contributions, as described by your Retiree Medical Subsidy Program, after the two months of Employer paid Coverage.

- If you die (i) as a Retiree Participant, or (ii) as a Severance Participant, your non-Medicare eligible Eligible Survivors who are not enrolled in coverage at the time of your death may elect Coverage in this Plan. Eligible Survivors will be responsible for paying the required premium contributions, as described by your Retiree Medical Subsidy Program, and are not eligible for two months of Employer paid Coverage.
- If you were eligible to participate in the Roche Post-Employment Healthcare Plan at the time of your death, your Eligible Legacy Dependents (whether or not they had coverage at the time of your death) will be offered applicable coverage under the Roche Post-Employment Healthcare Plan instead of this Plan. See the Roche Post-Employment Healthcare Plan SPD for more details. Please note that if they had Vision coverage in this Plan, then upon transfer to the Roche Post-Employment Healthcare Plan your Eligible Survivors may elect to continue Vision coverage under COBRA, since that plan does not offer Vision coverage.

SEVERANCE PARTICIPANTS

As a Severance Participant, your participation in the Coverage of the Plan is subject to the following conditions:

- If you are a Severance Participant, then upon attaining age 60 or when your subsidized severance-related healthcare coverage ends (whichever is later), you will be eligible to participate in the Coverage of this Plan until you become Medicare eligible, at which time Coverage under this Plan will terminate for you and your Eligible Dependents.
- If you are already Medicare eligible at the time you attain age 60 or your subsidized severance-related healthcare coverage ends (whichever is later), neither you nor your Eligible Dependents will be permitted to participate in the Coverage of this Plan.
- If your Eligible Dependent becomes Medicare eligible, your Eligible Dependent's Coverage under the Plan will terminate. You and any Eligible Dependents who are not Medicare eligible may continue Coverage under this Plan until you become Medicare eligible.

However:

- if you are a Severance Participant and eligible to participate in the Roche Post-Employment Healthcare Plan, then upon attaining age 55 or when your subsidized severance-related healthcare coverage ends (whichever is later) you will be able to participate in the Coverage of this Plan until either you or any one of your covered Eligible Legacy Dependents becomes Medicare eligible, at which time you and your covered Eligible Legacy Dependents will be transferred to the applicable Medical/Prescription and Dental coverage under the Roche Post-Employment Healthcare Plan. See the Roche Post-Employment Healthcare Plan SPD for more details. Please note that if you had Vision coverage in this Plan, then upon transfer to the Roche Post-Employment Healthcare Plan you and your Eligible Dependents may elect to continue Vision coverage under COBRA, since that plan does not offer Vision coverage.
- If you are a Severance Participant and eligible to participate in the Roche Diagnostics Retiree Healthcare Plan, then upon attaining age 55 or when your subsidized severance-related healthcare coverage ends (whichever is later), you will be able to participate in this Plan until you become Medicare eligible. Coverage for any Eligible Dependents will end when your Eligible Spouse becomes Medical eligible. If any Eligible Dependent becomes Medicare eligible before you, that Eligible Dependents' Coverage under this Plan will terminate, and you and your other Eligible Dependents who are not Medicare eligible may continue Coverage under this Plan until you become Medicare eligible.

- If you are a Severance Participant and your Spouse is eligible for Retiree Participant Coverage as a Retiree under either this Plan or a Roche Legacy Program, your Spouse and Eligible Dependents may elect Coverage when your subsidized severance-related healthcare coverage ends. However, your Spouse and Eligible Dependents must elect Coverage within 31 calendar days from the loss of that subsidized coverage; otherwise, they will not be eligible to participate in this Plan or a Legacy Roche Program.

ELIGIBLE DEPENDENTS

Retiree Participants, LTD Participants and Severance Participants who enroll in Coverage in the Plan may also enroll their non-Medicare eligible Eligible Dependents or Eligible Legacy Dependents at that time. Only non-Medicare eligible Eligible Dependents who were eligible for coverage under the Company's Medical and Prescription, Dental or Vision Plans on your last day of work with the Employer prior to termination may be covered under this Plan. If they were covered under another employer's group healthcare plan they can be added to the Plan within 31 calendar days of losing that other group coverage (including COBRA coverage), as long as they were eligible for healthcare benefits under this Plan at the time of your termination with the Employer. Additionally, non-Medicare eligible Eligible Dependents may only enroll in the type of Coverage (Medical and Prescription, Dental, and/or Vision) which was lost. Please note that newly acquired dependents (i.e., due to a birth, adoption, marriage or court order) after your termination date are not eligible to participate in this Plan.

Special Notes Regarding Eligibility:

Spouses, Eligible Domestic Partners, stepchildren, and children of your Eligible Domestic Partners cease to be Eligible Dependents upon the earliest of: the date of your legal separation, the date of your divorce, or the date of termination of Domestic Partnership. Legal wards who otherwise meet eligibility requirements cease to be Eligible Dependents upon the date of the court order relinquishing legal ward status.

- If you and your Spouse are both employed by, or are a Retiree of, the Company, Eligible Dependent Children may be covered by either you or your Spouse, but not both. Also, Spouses who are both covered as Employee(s) and/or Retiree(s) cannot also cover each other as dependents. In other words, no participant can be covered more than once under a U.S. Roche benefit plan.
- All Participants must inform the applicable Plan Administrator (contact information listed in the Important Notice and Contact Information section of this SPD) of changes in their dependents' status. Failure to remove ineligible dependents may result in overpayment of your contributions, which are non-refundable, and/or required reimbursement of claims paid during the dependent's period of ineligibility.
- Misrepresentation or falsification of dependents, misstating dependents on a Benefit claim, or failure to notify the Plan Administrator of a family status change when a covered dependent is no longer an Eligible Dependent could result in the denial of payment of Benefits and the suspension of coverage in the Plan.

The Company reserves the right to conduct dependent eligibility verification on Eligible Dependents to ensure that all Participants meet the Plan's eligibility requirements. In addition, the Company reserves the right, in its sole discretion, to (i) remove dependents from coverage if such dependents are found to not be Eligible Dependents during the dependent eligibility verification, or if the Participant does not comply with the requests for information or verification requests; (ii) seek re-payment of premiums and claims incurred by or as a result of ineligible or non-compliant dependents; (iii) terminate the coverage of any Participant in cases of benefit eligibility fraud; and/or (iv) not offer COBRA continuation coverage to dependents who lose coverage because the dependent is found to be ineligible or non-compliant during the dependent eligibility verification.

Enrollment and Coverage Effective Dates

ENROLLMENT RULES

RETIREE PARTICIPANTS AND SEVERANCE PARTICIPANTS

Retiree Participants and Severance Participants may enroll in any Coverage option (i.e., medical/prescription, dental and/or vision) for which they were eligible on their last day of Active Work with the Employer provided they complete their enrollment in the Plan within 31 days after their termination date. Please note that the Plan rules do not permit anyone who is Medicare eligible to have coverage under the Plan.

As a Retiree Participant, if you were not enrolled in an active U.S. Employer plan(s) immediately prior to your last day of Active Work due to employment with a foreign Employer, or because you were enrolled in other employer group health plan coverage (for example, through your Spouse's employer), you may continue to waive coverage under this Plan until you terminate employment with the foreign Employer or lose that other coverage. However, you will not be able to enroll in this Plan at a later date, unless you enroll within **31** calendar days of the loss of that other employer group coverage (this includes COBRA coverage).

As a Severance Participant, you may enroll in the Coverage option (i.e., medical/prescription, dental and/or vision) in which you and your Eligible Dependents were participating on your last day of Active Work with the Employer at the later of the time your Employer-subsidized portion of your severance-related healthcare coverage under COBRA ends, or the date you attain the age at which you would have been eligible for coverage under the retiree healthcare plan in which you were participating prior to your termination date. However, you will not be able to enroll in this Plan at a later date, unless you enroll within **31** calendar days from the latest of the loss of that subsidized coverage, the loss of your COBRA coverage, or the loss of other employer group coverage. In addition, if your Spouse is eligible for Retiree Participant Coverage as a Retiree under this Plan or a Roche Legacy Program, your Spouse and Eligible Dependents may elect Coverage when your Employer-subsidized portion of your severance-related healthcare coverage under COBRA ends. However, if your Spouse and Eligible Dependents do not elect Coverage within **31** calendar days from the loss of that subsidized coverage or the loss of their COBRA coverage, they will not be eligible to participate in this Plan or a Legacy Roche Program.

Retiree Participants and Severance Participants who enroll in any Coverage option in the Plan may also enroll their Eligible Dependents at that time. If you do not enroll Eligible Dependents at the same time you enroll, you may only add them at a later date if they lose other employer group healthcare coverage and you apply for enrollment within 31 days of the loss of that coverage; you may only enroll them in the type of coverage they lost.

LTD PARTICIPANTS

If you have received benefits from the LTD Plan for at least six (6) months and your employment is terminated due to LTD, you may elect Coverage for yourself and your Eligible Dependents under this Plan provided the required contributions are made. You may continue this Coverage in this Plan until the earliest of: (i) the date you cease receiving LTD Plan benefits, (ii) 18 months after your LTD Termination Date, or (iii) the date you become Medicare eligible.

As an LTD Participant, you will have three options to elect Coverage in this Plan:

Option 1 — Retroactive coverage

If you were enrolled in the active Employee plan(s) immediately prior to your LTD Termination Date, you may elect to -enroll in the same Coverage option(s) under this Plan effective as of your LTD Termination Date. The Plan Administrator will bill you for your required retroactive and ongoing premium contributions. Your election must be made within **31** calendar days of the date LTD Plan benefits are approved.

If you do not make your election to enroll in this Plan within 31 calendar days of your LTD approval notice, you will have no coverage, and will not be able to enroll in this Plan unless you initially declined coverage because you had other employer group coverage (including COBRA coverage) and you subsequently enroll within **31** calendar days of the loss of that other coverage.

Option 2 — Coverage effective first of month following LTD approval

If you were enrolled in the active Employee plan(s) immediately prior to your LTD Termination Date, you may elect to enroll in the same Coverage option(s) under this Plan effective the first of the month following your notice of LTD approval, provided you were enrolled in other employer group coverage (including COBRA coverage) from your LTD Termination Date through the date your Company coverage is reinstated. You must make your election within **31** calendar days of the date of the approval notice. The Plan Administrator will bill you for your required premium contributions.

If you do not make your election to enroll in the Plan within **31** calendar days of your LTD approval notice, you will have no coverage and will not be able to enroll in this Plan unless you initially declined coverage because you had other employer group coverage and you subsequently enroll within **31** calendar days of the loss of that other coverage.

Option 3 — Enroll for coverage upon loss of other group employer coverage (including COBRA coverage)

If the reason you either were not enrolled in the active Employee plan(s) immediately prior to your LTD Termination Date or did not elect to continue your Company coverage was that you were enrolled in other employer group coverage (for example, through your Spouse's employer), you may continue to waive coverage under this Plan until you lose that other coverage. However, you must enroll within **31** calendar days of the loss of that other coverage (including COBRA coverage) and will not be able to enroll in this Plan at a later date.

RE-ENROLLMENT RULES

If you, your Eligible Dependents, or Eligible Survivors (collectively "you") do not enroll in this Plan at the time you first become eligible or you later waive coverage, you may not enroll or re-enroll at a later date unless you**:**

- were covered as an Eligible Dependent of a Spouse who is also covered under the active Company healthcare plans or this Plan, your Spouse predeceases you, and you elect coverage for yourself and your Eligible Dependent Child(ren) under this Plan within 60 calendar days of the loss of that coverage, or
- were covered as an Eligible Dependent of a Spouse who is also covered under the active Company healthcare plans or this Plan, your Spouse loses that coverage, and you enroll within 31 calendar days of the loss of that coverage, or

- were covered under another employer's group health plan (either as an employee or as your Spouse's dependent), and you enroll within 31 calendar days of the loss of that other coverage. If applicable, all required proof of dependent status documents must also be provided within 31 calendar days of the loss of that other coverage.

CHANGES TO COVERAGE OPTIONS

After initial enrollment in the PPO or HMO options, the following are the only allowable changes that Members may make at any time during the year:

- You may drop coverage for yourself and/or any Eligible Dependents. Please be sure to read the section titled "Re-enrollment Rules" for the restrictions on re-enrollment in the Plan.
- United Healthcare PPO Participants may switch options from:
  - Select to Health Choice
  - Health Choice to Select
- If you are enrolled in the PPO and live in a contracted Kaiser service area, you may elect the Kaiser HMO options at any time; however, you may not switch back again to the PPO.
- If you are enrolled in the Kaiser HMO options and you move out of a contracted Kaiser service area, you may elect the Select PPO or the Health Choice PPO.
- Dental Participants may switch from Premier to Basic
- Vision Participants may switch from Premier to Basic

The effective date of allowable mid-year changes is as follows:

- If change is elected before the 10th of any calendar month, the change will be effective the first of the month following the month in which change is elected
- If change is elected on/after the 10th of any calendar month, the change will be effective the first day of the second month following the month in which the change is elected

For example, a change elected on April 5th will be effective May 1st, while a change elected on April 10th will be effective June 1st

Participant Contributions for Coverage

The portion of the cost of Coverage that you must pay depends on the subsidy program for which you are eligible and the Coverage options in which you enroll. Your contribution amounts are subject to change.

For Retiree Participants, Eligible Survivors and Severance Participants: The portion of the cost that you must pay for any Coverage option in which you enroll depends on many factors, including whether you are eligible for the Healthcare Percentage Program, Healthcare Credits Program or Premium Contribution Percentage Program, as applicable under a Roche Legacy Program. If you are not eligible for any of the following programs, you must pay 100% of the cost of Coverage (i.e. premium costs).

- In the Healthcare Percentage Program, your contribution percentage ranges from 100% to 10% of the cost based on your eligible years of service at termination as defined by the Roche Post-Employment Healthcare Plan.

- In the Healthcare Credits Program, you pay 100% of cost of the Coverage you elect reduced by your Healthcare Credit allotment.
- In the Premium Contribution Percentage Program, your contribution percentage ranges from 80% to 30% of the cost based on your Years of Credited Service at termination.

For LTD Participants: The contributions you pay for any Coverage option in this Plan will be the same contribution as for the corresponding active Company plan. However, if you met the Retiree Participant eligibility requirements of this Plan prior to your termination, you will be considered to be a Retiree Participant at the earliest of: (i) the date you cease receiving LTD Plan benefits, (ii) 18 months after your LTD Termination Date, or (iii) the date you become Medicare eligible. The required monthly contributions will be deducted from your monthly LTD benefit.

Please note that due to federal and state tax rules if you cover an Eligible Domestic Partner, Domestic Partner Child(ren), or a child or stepchild who does not qualify as a tax dependent, you will have to pay a portion of the premium on an after-tax basis and will incur imputed income for the value of certain coverage for those dependents (note: healthcare coverage taxation laws vary by state.

SPECIAL NOTE ABOUT CONTRIBUTIONS

If your Spouse participates in the Company's Medical Plan as an active Employee or in this Plan as a Retiree Participant, LTD Participant or Severance Participant, you may be able to reduce the cost of medical coverage by becoming covered as the Eligible Dependent of your Spouse. If your Spouse participates in this Plan, and their contributions are less than yours as an active Employee, you may choose to participate in this Plan as an Eligible Dependent under your Spouse's coverage.

Coverage Tiers
You may elect one of the following four coverage tiers when you enroll: ***Employee Only*** ***Employee Plus Spouse*** ***Employee Plus Child(ren)*** ***Family*** Election of Employee plus Spouse, Employee plus Child(ren) or Family coverage does not mean that everyone in your family is automatically covered. The only family members that will be covered under the Plan are the Eligible Dependents who are indicated as covered under each individual plan section on the Company's HR Portal (if an LTD Participant) or with the third-party administrator (if a Retiree Participant or a Severance Participant). It is **your responsibility** to verify who is actually covered and determine if you need to add an Eligible Dependent to existing coverage during the applicable enrollment period.

State-Mandated Benefits

The U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan (with the exception of the Kaiser HMO component and the state-filed Hawaii plan which are fully insured) is self-funded by the Company (i.e., not insured through a contract with an insurance company). Self-funded medical/ prescription, dental, and vision plans are not

subject to state insurance laws, so state-mandated benefits do not apply to the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, with the exception of the Kaiser HMO options and the state-filed Hawaii plan of the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan. For more details about the UHC Hawaii PPO plan, please see *Addendum A*.

Federally-Mandated Benefits

The Plan complies with current federal laws and regulations including:

The Women's Health and Cancer Rights Act of 1998

The Plan provides coverage for the following services to an individual receiving Plan benefits in connection with a medically necessary mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan will determine the manner of coverage in consultation with the attending Physician and patient. Coverage for breast reconstruction and related services will be subject to Plan Deductibles and Coinsurance Amounts that are consistent with those that apply to other benefits under the Plan.

The 1996 Newborns' and Mothers' Health Protection Act (NMHPA)

The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal, non-cesarean, delivery, or less than 96 hours following a cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, a provider need not obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical and Prescription Coverage

COVERAGE OPTIONS

Within the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, Participants are given a choice of two medical/prescription coverage options (four options in California, Oregon and Washington):

2 Preferred Provider Organization (PPO) Options

- Select PPO
- Health Choice PPO with Health Savings Account

Each PPO option allows you to choose between In-Network and Out-Of-Network providers. Out-of-pocket costs are lower when In-Network providers are utilized. All of the PPO options are administered by UnitedHealthcare ("UHC") for medical coverage and OptumRx for prescription coverage. You will find a summary of the Medical and Prescription Plan PPO options beginning on page 52 of this Summary Plan Description ("SPD").

2 Health Maintenance Organization (HMO) Options (available in California, Oregon and Washington only if your home zip code is in the Kaiser HMO service area)

- Kaiser HMO
- Kaiser HMO Choice with Health Savings Account

Each HMO option provides coverage only when you use providers who contract with Kaiser HMO. You will find a summary of the Kaiser HMO options beginning on page 107 of this SPD.

Please note that state of Hawaii residents (and their Eligible Dependents) may only participate in a state-approved insured PPO plan, which is wrapped with a self-insured managed indemnity plan, due to state law restrictions. Please see "*Addendum A*" for additional details.

All options include prescription coverage. Participants enrolled in the PPO options of the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan (as well as the UHC Hawaii PPO plan) will automatically be covered under the prescription drug coverage administered by OptumRx. Those enrolled in the Kaiser HMO options have prescription coverage provided through the Kaiser HMO. You automatically receive prescription coverage through your medical plan enrollment. You do not need to make a separate election.

You will find more information on the prescription coverage on page 43 of this SPD.

UNDERSTANDING MEDICAL COVERAGE TERMS

You will see certain terms used throughout this section, as defined below. It is important that you are familiar with their meanings:

Adverse Benefit Determination means any of the following: a denial, reduction, rescission of, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, rescission, termination or failure to provide or make payments that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan, and including with respect to the Benefit, a denial, reduction, rescission of, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as the failure to cover an item or service for which

Benefits are otherwise provided, because it is determined to be an experimental treatment or not a Medical Necessity; provided, however, that a rescission attributable to a failure to provide or make payment will not be an "Adverse Benefit Determination".

Air Ambulance means medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

Ancillary Charge is a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge for the Prescription Drug Product, and the Prescription Drug Product Charge for the Chemically Equivalent Prescription Drug Product. For Prescription Drug Products from Non-Network Pharmacies, the Ancillary Charge is the difference between the out-of-network Reimbursement Rate for the Prescription Drug Product; and the out-of-network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

Ancillary Services are defined as items and services provided by out-of-network providers at a network facility that are: related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary; provided by such other specialty practitioners as determined by the Secretary; or provided by an out-of-network provider when no other network provider is available.

Brand-name **means** a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors. All products identified as a "brand name" by the manufacturer, pharmacy, or your physician may not be classified as Brand-name by UnitedHealthcare or OptumRx.

Chemically Equivalent means that a Prescription Drug Product contain the same active ingredient.

Claims Administrator are those entities that have the full discretion to determine claims and appeals. The claims administrator for the Preferred Provider Options are set forth in the Section titled "Medical PPO and Prescription Drug Claims and Appeals Procedures" and the claims administrator for the Health Maintenance Organization Option is set forth in the Section titled "HMO Claims Procedures."

Coinsurance is the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in the Eligible Expenses section and Prescription Drugs section. For example, if a service is covered at 80% of the Eligible Expense, your Coinsurance Amount will be the other 20% of the Eligible Expense not covered by the Medical and Prescription Plan (assuming you have satisfied any required Deductible).

Copayment (or ***Copay)*** is the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in the *What is Covered in the PPO Options* section, such as office visits or for some prescriptions. Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable.

Covered Expenses or ***Eligible Charges*** are those expenses or charges which are eligible for reimbursement. Covered Expenses may be subject to applicable Deductibles, Copays, Coinsurance Amounts, and specified maximums. In order to be eligible for coverage, all Eligible Charges must be medically necessary.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD.
- Provided to a covered person who meets the Plan's eligibility requirements, as described under Eligibility Requirements section of this SPD.
- Not otherwise excluded in this SPD.

Deductible is the amount of money you pay before a PPO option begins to pay Benefits for certain Covered Expenses, or the Recognized Amount when applicable. Once the Deductible has been paid, the Plan pays its benefit percentage and you pay the Coinsurance Amount, if applicable. Plan member Copays do not apply towards the deductible for medical services. Payments towards in-network Deductibles count toward out-of-network Deductibles, and vice versa.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Eligible Expenses section.

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

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

Emergency Health Services – with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an independent freestanding emergency department*)* that is within the capability of the emergency department of a Hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an independent freestanding emergency department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

    b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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

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

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in this SPD on page 71
- If you are not a participant in a qualifying Clinical Trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and Roche may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, the Claims Administrator and Roche must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Family Deductible for the Select PPO Option is the maximum amount a family pays toward the Deductible. If at least two of your family members' individual Deductibles add up to the Family Deductible in a given calendar year, then the individual Deductibles for the family will be considered satisfied for that calendar year. After any Eligible Dependent within your family satisfies their individual Deductible, the Plan will begin making payments for that person's Covered Expenses. Therefore, the most any one family member can contribute toward the Family Deductible is the amount of their individual Deductible.

Family Deductible for Health Choice PPO Plans is the maximum amount a family pays toward the Deductible. Unlike the Select PPO plan, the full family deductible must be met in any calendar year before the Plan pays benefits. The full family Deductible may be met by one family member or a combination of multiple family members. Once your family has collectively met the Family Deductible, benefits will be paid for all family members.

Gender Dysphoria – A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Generally Accepted Standards of Medical Practice means, for purposes of the UnitedHealthcare PPO options only, standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on physician- specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician-specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion. UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time) are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to physicians and other health care professionals on UHCprovider.com.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare or OptumRx identifies as a Generic product based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors. All products identified as a "generic" by the manufacturer, pharmacy or your physician may not be classified as a Generic by UnitedHealthcare.

Group Coverage means health plans offered to a group of individuals by an employer, association, union or other entity.

Health Maintenance Organization (HMO) means a plan in which you receive all of your care from participating (in-network) providers. You usually must obtain a referral from your Primary Care Physician (PCP) before you can see a specialist. The Kaiser plan is the only HMO option available in the Plan.

Intensive Outpatient Treatment – a structured outpatient treatment program.

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

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Medically Necessary (Medical Necessity) means

- for the purposes of the UnitedHealthcare PPO options, health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:
  - In accordance with Generally Accepted Standards of Medical Practice;
  - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms;
  - Not mainly for your convenience or that of your doctor or other health care provider;
  - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- for purposes of the Kaiser HMO options, a service if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standard of practice that are consistent with a standard of care in the medical community. For more information, see the Evidence of Coverage for Kaiser.

Medicare means the portion or portions of the United States Social Security Act of 1965, as amended, by which Benefits are provided for expenses incurred in connection with illness or injury.

Member means a person who is covered by the U.S. Roche Health and Welfare Benefits Retiree Healthcare ***Plan.***

Network Pharmacy is a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

Out-of-Network Reimbursement Rate is the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

Out-of-Pocket Maximum for the Select PPO Option -You and your Eligible Dependents have a maximum amount that you will pay "out-of-pocket" each year towards medical services received under the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan. The Out-of-Pocket includes your portion of Copayments, Deductibles, and Coinsurance for medical and prescription drug services, and once it is met, the Plan generally pays at 100% for the remainder of the calendar year. If the Out-of-Pocket maximum amounts of at least two covered family members total the family Out-of-Pocket maximum in a given calendar year, the Plan will reimburse medical Covered Expenses incurred by any covered individual at 100% of the negotiated rate or R&C for the remainder of that calendar year.

Out-of-Pocket Maximum for the Health Choice PPO Plan - You and your Eligible Dependents have a maximum amount that you will pay "out-of-pocket" each year towards medical services received under the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan. The Out-of-Pocket includes your portion of copayments, deductibles, and coinsurance for medical and prescription drug services, and once it is met, the plan generally pays at 100% for the remainder of the calendar year. If you are covering dependents, the full family Out-of-Pocket

maximum must be met by any combination of family members in any calendar year before the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan pays at 100% for the remainder of the calendar year. If the full family Out-of-Pocket maximum amount is reached in a given calendar year, the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan will reimburse Covered Expenses incurred by any individual at 100% of the negotiated or R&C for the remainder of that calendar year.

Post-Service Claim means a claim for a Benefit after obtaining the medical care services or treatment or the prescription drug, as applicable. A ***Post-Service Appeal*** is a request to change an Adverse Benefit Determination after obtaining medical care services or treatment or the prescription drug, as applicable.

Post-Tax Policy means the U.S. Roche Post-Tax Medical Policy, as amended from time to time.

Preferred Provider Organization (PPO) means a plan in which you have more flexibility in choosing physicians and other providers than in an HMO. You can see both participating and nonparticipating providers, but your out-of-pocket expenses will be lower when you see participating plan providers. The Plan has two general PPO options and the Hawaii state-filed plan wrapped around the managed indemnity medical plan.

Prescription Drug Charge **is** the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug Product is a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed **only according** to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is generally appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan**,** this definition includes**:**

- Inhalers (with spacers).
- Insulin.
- Certain injectable medications administered in a Network Pharmacy
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets.
  - Glucose meters including continuous glucose monitors.
- Vaccines/immunizations administered in a Network Pharmacy.

Prescription Order or Refill is the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Pre-Service Claim means a claim for a Benefit conditioned, in whole or in part, on approval of the Benefit in advance of obtaining medical care services or treatment or the prescription drug, as applicable. A ***Pre-Service Appeal*** is a request to change an Adverse Benefit Determination in advance of obtaining medical care services or treatment or the prescription drug, as applicable.

Primary Care Physician (PCP) is usually a family practice doctor, internist, obstetrician-gynecologist or pediatrician. They are your first point of contact with the health care system, particularly if you are in an HMO and you must select a participating provider and see them prior to seeking additional services.

Qualified Medical Child Support Order (QMCSO) means a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under the state law that creates or recognizes the right of a covered Employee's child to receive Benefits for which the covered Employee is entitled under the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan and which is determined by the Company to meet the requirements of a qualified medical child support order under Section 609 of ERISA and satisfies the following requirements:

1. the order specifies your name and last known address and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the time period and each applicable plan to which it applies.

The QMCSO may not require the Plan to provide coverage for any type or form of Benefit or option not otherwise provided under the Plan. You must provide the Company with a copy of the QMCSO.

Reasonable and Customary (R&C) means

- for the purposes of the UnitedHealthcare Select and Health Choice PPO options, the maximum amount of reimbursement that the Plan will allow for services and supplies covered under the UnitedHealthcare PPO options, which reflects the normal and ordinary charges or fees for a particular health care service. Reasonable and Customary is determined by UnitedHealthcare using a formula that incorporates a variety of factors, including actual provider charges in a geographic area, relative value scales, and average wholesale prices. UnitedHealthcare uses national databases to determine what is Reasonable and Customary.
- for purposes of the Kaiser HMO options, the range of usual fees for comparable services charged by a provider in a geographic area.
- ***Recognized Amount*** is the amount which Copayment, Coinsurance and applicable deductible is based on for Covered Health Services when provided by non-Network providers for non-Network Emergency Health Services, or non-Emergency Covered Health Services received at certain Network facilities by non-Network physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

  The amount is based on either applicable state law, an All Payer Model Agreement if adopted, or the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility. The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

  Note: Covered health care services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

Secretary – as that term is applied in the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).

Specialty Prescription Drug Products are Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. You may access a complete list of Specialty Prescription Drug Products through at www.medicare.gov/ or by calling the telephone number on your ID card.

Telehealth is a modality of care defined as "the interactive, electronic exchange of information for the purpose of diagnosis, consultation, treatment, intervention, education, or ongoing care management between a patient and health care providers situated remotely." Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician or physician-to-physician.

Telemedicine/Virtual Visits are general terms used to describe clinical services provided to patients via electronic communications through a vendor that provides telephone and online video consultations with a physician.

Unproven Services means, ***for the purpose of the UnitedHealthcare PPO options only,*** health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined not to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please Note: If you have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and Plan Sponsor may, at its discretion, consider an otherwise Unproven Service to be a Covered Expense for that sickness or condition. Prior to such consideration, UnitedHealthcare and Plan Sponsor must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

Urgent Care Claim means a claim for medical care or treatment or prescription drugs if the time period for making non-urgent care determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The determination of whether a claim involves urgent care is to be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If a physician with knowledge of the claimant's medical condition determines a claim involves urgent care, the Plan shall treat that claim as one involving urgent care. An ***Urgent Appeal*** is always clinical and is a request to change an Adverse Benefit Determination of an Urgent Care Claim, as applicable.

Usual and Customary Charge is the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

HEALTH SAVINGS ACCOUNT (HSA)

(available with the Health Choice PPO and the Kaiser HMO Choice options)

Two of the Medical and Prescription Plan PPO options are the Health Choice PPO and the Kaiser HMO Choice, each allowing contributions to a Health Savings Account (HSA). The Health Choice PPO and the Kaiser HMO Choice are just like the Select PPO option or the Kaiser HMO option, respectively, except they have a higher deductible that must be met before claims will be paid (except for preventive care services), and you pay a coinsurance instead of a copay for most services. A HSA is a custodial account in your name into which you (if eligible) may deposit tax-free[8] contributions, up to annual IRS limits, to use for qualified healthcare expenses. Unused amounts can be carried forward into later years when your medical needs may be greater.

A Health Saving Account ("HSA") is a tax-advantaged savings account for federal, and in some cases state, tax that allows you to pay for current or future qualified medical expenses. You must be an eligible individual to qualify for contributions to a HSA.

IRS rules do not allow you to make or receive HSA contributions if any of the following is true:

- You are enrolled in Medicare Part A or Part B
- You are covered under a non-high deductible health plan (e.g., the Select PPO, Kaiser HMO, or your spouse's non-high deductible health plan, etc.)
- You or your spouse are enrolled in a full- purpose health care FSA program (also referred to as a "general purpose" health care FSA program), such as through your spouse's employer
- You are claimed as a dependent on someone else's tax return
- You are receiving benefits from TRICARE
- You have received Veterans Administration (VA) benefits within the past three months (with certain exceptions)

You are responsible for contributing to and maintaining your own HSA. Additional information, including HSA eligible healthcare expenses and annual contribution limits can be found at www.irs.gov.

[8] Contributions to your HSA are exempt from federal income tax and state income in most states (California, New Jersey, New Hampshire and Tennessee do not treat HSA contributions and/or earnings as tax-advantaged).

The Preferred Provider Organization (PPO) Options

The PPO options are administered by UnitedHealthcare and generally include two choices (with the exception of employees who are residents of the state of Hawaii – see below*):

- the Select PPO, and
- the Health Choice PPO with a Health Savings Account (HSA)

MEDICAL COVERAGE

If you enroll in a PPO option you may choose between having health care provided by either "in-network" or "out-of-network" providers or facilities. Your out-of-pocket costs will be lower when you use in-network providers or facilities. There is no need to select a primary care physician and no referrals are necessary, although certain pre-notifications are required for in-patient care.

* Notwithstanding, Participants who are residents of the state of Hawaii (and their eligible dependents) shall only be eligible to elect to participate in the UnitedHealthcare state-filed insurance plan wrapped around the managed indemnity medical plan and prescription plans (and cannot elect to participate in the Select PPO option) due to state law restrictions. Please see "Addendum A" for additional details.

PRESCRIPTION COVERAGE

The Medical and Prescription Plan covers drugs available only by prescription according to state or federal law (including insulin and other eligible diabetic supplies except for diabetic pumps) and that have a valid National Drug Code (NDC) number.

For Participants in the UHC PPO options or the UHC Hawaii PPO plan:

If you enroll in the Select PPO, Health Choice PPO, or the UHC Hawaii PPO plan, you and any Eligible Dependents that you enroll will automatically receive prescription coverage. Anyone not enrolled in the Select PPO, Health Choice PPO or the UHC Hawaii PPO plan will not receive prescription coverage.

OptumRx administers the prescription portion of the Medical and Prescription Plan. Shortly after you enroll you will receive a United Healthcare identification card that contains prescription drug coverage information. When you present this card at a participating pharmacy, prescription drugs, including refills, are covered in full after you pay the appropriate Copay, Deductible, or Coinsurance. Generally, certain Genentech/Roche pharmaceuticals and diagnostic products manufactured, marketed, or co-marketed by Genentech/Roche are covered at 100 percent with no co-pay under the Select PPO option. They are covered at 100 percent under the Health Choice PPO option after the Deductible is met. The amount of your Copay, Deductible or Coinsurance will be determined by the PPO option in which you are enrolled and the drug category of your prescription medication, as described in the below PPO benefit summaries. To find an in-network pharmacy you should access the OptumRx website at www.myuhc.com.

If you go to an out-of-network pharmacy, or if you forget to bring your ID[9] card to an in-network pharmacy, you must pay for the entire cost of your prescription and then complete and mail in a claim form to OptumRx for reimbursement. The amount you will be reimbursed is based on the OptumRx Usual and Customary Charge for the prescription drug,

[9] If you return to most in-network pharmacies with your ID card within 7 days, the pharmacy will reprocess your claim as in-network.

which means you will be responsible for the Copay, Deductible or Coinsurance, plus, for an out-of-network pharmacy, the difference between the pharmacy's billed rate and the OptumRx Usual and Customary Charge.

Certain preventive medications are covered at 100%, and not subject to the Deductible, Copay or Coinsurance provisions. Please see www.myUHC.com for a list of these preventive medications.

NETWORK PROVIDERS

The Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, the Claims Administrator will send you a directory of Network providers free of charge.

Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call the Claims Administrator at the number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Roche or the Claims Administrator.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator. A directory of providers is available online at www.myuhc.com or by calling the telephone number on your ID card to request a copy. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the Claims Administrator at the telephone number on your ID card.

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

USING IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS AND PHARMACIES

Each PPO option allows you to choose between In-Network and Out-of-Network providers and utilizes the same UHC provider network and OptumRx pharmacy network.

In-Network

You pay less when services are performed by in-network providers or you obtain prescriptions from an in-network pharmacy. Also, what you pay is based on the negotiated rates that UHC has with the in-network provider, or the negotiated rates OptumRx has with the pharmacy. If you forget to bring your ID[10] card to an in-network pharmacy, you must pay for the entire cost of your prescription up front and then complete and mail in a claim form to OptumRx for reimbursement. The amount you will be reimbursed is based on the OptumRx network-discounted rate for the prescription, which means you will be responsible for the Copay, Deductible or Coinsurance, plus, for an out-of-network pharmacy, the difference between the pharmacy's billed rate and the OptumRx network-discounted rate. If you return to most in-network pharmacies with your ID card within 7 days, the pharmacy will reprocess your claim as in-network.

Finding an In-Network Provider

For assistance in finding an in-network Medical provider or information on negotiated rates, you can call UnitedHealthcare customer service at the toll-free number indicated on your identification card or visit UnitedHealthcare's Website at www.myuhc.com.

Out-Of-Network

When treatment is received from out-of-network providers, the Plan will pay a lower percentage on Covered Expenses billed by out-of-network providers than Covered Expenses billed by in-network providers. The PPO options will also base their out-of-network payment on Reasonable and Customary (R&C) and, therefore, you will be responsible for any charges above Reasonable and Customary (R&C). If you go to an out-of-network pharmacy, or if you forget to bring your ID card to an in-network pharmacy, you must pay for the entire cost of your prescription up front and then complete and mail in a claim form to OptumRx for reimbursement. The amount you will be reimbursed is based on the OptumRx network-discounted rate for the prescription, which means you will be responsible for the Copay or Coinsurance, plus, for an out-of-network pharmacy, the difference between the pharmacy's billed rate and the OptumRx Usual and Customary Charge for the prescription drug, which means you will be responsible for the Copay, Deductible or Coinsurance, plus, for an out-of-network pharmacy, the difference between the pharmacy's billed rate and the Usual and Customary Charge.

Do not assume that all in-network providers use in-network facilities, or that all providers who render services in an in-network facility are in-network providers. For each provider and facility that you will be using, you should check whether in-network coverage will apply.

[10] If you return to most in-network pharmacies with your ID card within 7 days, the pharmacy will reprocess your claim as in-network.

DEDUCTIBLES*

You and your Eligible Dependents must each satisfy a calendar year Individual Deductible, or your family must satisfy the calendar year Family Deductible, for many services before the Plan will begin to pay for some Benefits at the percentages indicated in the Coverage Chart below. See page 52 for more information on what services apply towards the deductible. For the Select PPO option the deductible generally applies to medical expenses only. However, for the Health Choice PPO option the deductible applies to medical and prescription drug expenses.

	Select PPO In-Network **	Select PPO Out-of-Network **	Health Choice PPO In-Network ***	Health Choice PPO Out-of-Network ***
Employee Only Coverage Calendar Year Deductible	**$750**	**$1,500**	**$1,500**	**$3,000**
Employee + Eligible Adult, Employee + Child(ren), or Family Coverage Calendar Year Deductible	**Individual $750 Family Maximum $1,500**	**Individual $1,500 Family Maximum $3,000**	**$3,000**	**$6,000**

*** Combined Deductible** – All Deductible amounts are added together to satisfy both the in-network and out-of-network Deductibles.

**** Family Deductible for the Select PPO –** If the Deductibles of at least two covered family members total the Family Deductible in a given calendar year, the Plan will reimburse medical Covered Expenses incurred by any covered family member at the applicable Coinsurance (as shown below starting on page 47 for the remainder of that calendar year).

***** Family Deductibles for Health Choice PPO –** If you are covering dependents, the full family deductible must be met in any calendar year before the Plan pays benefits. The full Family Deductible may be met by one family member or a combination of multiple family members. A Deductible applies to medical and prescription drug services. Once your family has collectively met the Family Deductible, the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan will reimburse medical Covered Expenses incurred by any covered family member at the applicable Coinsurance (as shown below starting on page 47 for the remainder of that calendar year).

The following expenses will not count toward the satisfaction of the Deductible:

- expenses that are covered by a Copayment
- expenses which are not Covered Expenses;
- expenses which exceed R&C; and
- prescription drug costs (except that prescription drug costs will count toward the deductible in the Health Choice PPO; though the cost difference between a brand drug and its generic equivalent will not count toward the combined medical/prescription deductible and out-of-pocket maximum, and the difference between the pharmacy's billed rate and the OptumRx Usual and Customary Charge will not count).

COINSURANCE

After the Deductible is satisfied, the Plan pays a percentage of your expenses, which is called Coinsurance. See the charts starting on page 52 for information on when Coinsurance applies and the Coinsurance level. Generally, the Plan pays more if you seek care from an in-network provider.

OUT-OF-POCKET MAXIMUM*

You and your Eligible Dependents have a maximum amount that you will pay "out-of-pocket" each year towards medical services received under the Medical and Prescription Plan. The Out-of-Pocket includes your portion of Copayments, Deductibles, and Coinsurance for medical and prescription drug services.

These Out-of-Pocket maximums are shown in the table below:

	Select PPO In-Network **	Select PPO Out-of-Network **	Health Choice PPO In-Network ***	Health Choice PPO Out-of-Network ***
Employee Only Coverage **Calendar Year Out-of-Pocket Maximum**	**$2,500**	**$5,000**	**$4,000**	**$6,000**
Employee + Eligible Adult, **Employee + Child(ren), or** **Family Coverage** **Calendar Year Out-of-Pocket Maximum**	**Individual $2,500** **Family Maximum $5,000**	**Individual $5,000** **Family Maximum $10,000**	**$6,850**	**$12,000**

*** Combined Out-of-Pocket Maximums** – All medical and prescription drug Out-of-Pocket amounts are added together to satisfy both the in-network and out-of-network maximums.

**** Family Out-Of-Pocket Maximum for the Select PPO –** If the medical and prescription drug out-of-pocket amounts of at least two covered family members total the family out of pocket maximum in a given calendar year, the Plan will reimburse medical Covered Expenses incurred by an individual at 100% of the negotiated rate or R&C, for the remainder of that calendar year.

*****Family Out-of-Pocket Maximum for Health Choice PPO** – If you are covering dependents, the full Family Out-of-Pocket Maximum must be met in a given calendar year before the Medical and Prescription plan begins paying benefits at 100% for any family member. One family member or a combination of multiple family members may meet the full Family Out-of-Pocket Maximum. Once your family has collectively met the Family Out-of-Pocket Maximum in a given calendar year, the Medical and Prescription Plan will reimburse Covered Expenses incurred by any covered family member at 100% of the negotiated rate or R&C for the remainder of that calendar year.

The following expenses will not count toward the satisfaction of the out-of-pocket maximums:

- expenses which are not Covered Expenses;
- expenses which exceed R&C;
- cost difference between brand and generic equivalent prescription drugs; and
- difference between the pharmacy's billed rate and the OptumRx Usual and Customary Charge.

COMBINED LIFETIME AND ANNUAL BENEFIT MAXIMUM FOR CERTAIN SERVICES

The Lifetime Maximum benefit amount is unlimited, meaning there is no lifetime cap on benefits.

However, there are certain lifetime and annual benefit maximums for certain services:

- The PPO options have a combined lifetime maximum of two SMART Cycles* for fertility services and treatment (excluding prescription drugs).
- The PPO options have a combined annual benefit maximum of 30 visits per covered person for chiropractic, 30 visits per covered person for acupuncture, 120 visits per covered person for home health care, and 120 visits per confinement for skilled nursing.
- The PPO options have a combined benefit maximum of $6,000 every 36 months per covered person for hearing aids.
- The PPO options have a combined 60 visit per diagnosis per individual maximum for physical therapy. After the 60 visit threshold has been reached, subsequent visits are subject to a review. If the subsequent visits are deemed to be medically necessary, additional visits per individual per diagnosis will be approved.
- The PPO options cover preventive exams, screenings and other services. In addition to the preventive care services recommended by the U.S. Preventive Services Task Force, Preventive Care exams are covered as follows:
  - **Well Baby Care (under age 4):** up to 7 visits during the first 12 months, up to 3 visits during months 13 to 24, and up to 3 visits in months 25 to 36.
  - **Routine Physical Exams (age 4 and over):** up to 1 preventive exam per calendar year.
  - **Annual OB/GYN Exams:** up to 1 preventive exam per calendar year.

*SMART Cycles refer to the fertility program provided by Progyny. See page 71 for details about fertility coverage.

Any expenses you incur that apply against the lifetime or annual benefit maximums described above will continue to apply against these maximums if you change your coverage option under the Medical and Prescription Plan.

ELIGIBLE EXPENSES

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

Eligible Expenses are the amount UnitedHealthcare determines that the Medical and Prescription Plan will pay for Benefits. For Network Benefits, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.

For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.

For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.

For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in this SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

For Emergency ground ambulance transportation provided by a non-Network provider, the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expense are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the

conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expense and how it was determined. Please call UnitedHealthcare at the number on the back of your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment.

WHAT IS COVERED UNDER THE PPO OPTIONS

The following charts outline the deductible, coinsurance, out-of-pocket maximum and other coverage provisions for Covered Expenses under the PPO options.

2023 UHC Health Choice PPO

Medical Plan

	In-network	Out-of-network[1]
Calendar year deductible *(includes combined medical and prescription expenses)*		
Employee only	$1,500	$3,000
Employee + eligible adult, Employee + child(ren), or Family	$3,000	$6,000
Calendar year out-of-pocket maximum *(includes combined medical and prescription deductibles, co-insurance, and co-pays)*		
Employee only	$4,000	$6,000
Employee + eligible adult, Employee + child(ren), or Family	$6,850	$12,000
Preventive care	100%, no deductible	
Well-baby care *(including immunizations)*	Under age 4: Up to 7 visits in the first 12 months; up to 3 visits in months 13–24; up to 3 visits in months 25–36	
Routine annual physical exam *(age 4 and over)*	Limited to 1 preventive exam per calendar year	
Annual OB/GYN exams *(including Pap smears)*	Limited to 1 preventive exam per calendar year	
Mammograms	100%, no deductible	
Colonoscopies	100%, no deductible	
Lung cancer screening *(ages 50–80)* 3	100%, no deductible	
Office visits		
PCP	100% after deductible	70% after deductible
Specialist	90% after deductible	
Urgent care	90% after deductible	
Virtual/Telehealth visits		
PCP	100%, no deductible	70% after deductible
Specialist	90%, no deductible	
Urgent care	90%, no deductible	
Emergency room		
Emergency	90% after deductible	
Non-emergency	70% after deductible	
Ambulance		
True emergency/medically necessary	90% after deductible	
Non-emergency/not medically necessary	Not covered	

2023 UHC Health Choice PPO

	In-network	Out-of-network[1]
Hospital		
Inpatient precertification	Precertification required	
Inpatient semi-private room	90% after deductible	70% after deductible
Outpatient services	90% after deductible	70% after deductible
Doctor visits	90% after deductible	70% after deductible
Surgery		
Inpatient precertification	Precertification required	
Inpatient	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
X-ray/lab	90% after deductible	70% after deductible
Fertility treatments[2]		
Inpatient	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Office visits	100% after deductible for PCP visit; 90% after deductible for Specialist visit	70% after deductible
Lifetime maximum	2 Progyny SMART Cycles	
Mental health		
Inpatient precertification	Precertification required	
Inpatient	90% after deductible	70% after deductible
Outpatient and office visits	90% after deductible	70% after deductible
Virtual/Telehealth visits	90%, no deductible	70% after deductible
Substance abuse		
Inpatient precertification	Precertification required	
Inpatient	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Transitional residential recovery services	90% after deductible	70% after deductible
Other medical care		
Physical therapy	90% after deductible Up to 60 visits/diagnosis then subject to preauthorization	70% after deductible
Chiropractic	90% after deductible Limited to 30 visits each year	70% after deductible
Acupuncture	90% after deductible	70% after deductible

2023 UHC Health Choice PPO

	In-network	Out-of-network[1]
	Limited to 30 visits each year (services must be provided by a licensed acupuncturist)	
Hearing aids	90% after deductible	70% after deductible
	Limited to $6,000 every 36 months	

1. Benefits for out-of-network care are based on the Reasonable and Customary (R&C) charge. You are responsible for any amount that exceeds R&C. R&C charges are not included in the deductible or calendar year out-of-pocket maximum.
2. Participation in Progyny Fertility Benefits program is required.
3. In accordance with ACS and USPSTF, recommendations for a yearly LDCT scan for people ages 50–80 who meet certain criteria.

Prescription drug plan

	Network retail pharmacy or Optum Rx Specialty Pharmacy *(30-day supply)*	OptumRx home delivery3 *(90-day supply)*
Generic	$10 co-pay after deductible	$20 co-pay after deductible
Brand without generic equivalent	You pay 20% after deductible subject to the minimums and maximums below: • $15 minimum; $25 maximum for a maintenance1 medication • $25 minimum; $50 maximum for a non-maintenance medication	You pay 20% after deductible subject to the minimums and maximums below: • $30 minimum; $50 maximum for a maintenance1 medication • $50 minimum; $100 maximum for a non-maintenance medication
Brand with generic equivalent	$10 co-pay after deductible plus cost difference between brand drug and generic equivalent2	$20 co-pay after deductible plus cost difference between brand drug and generic equivalent2

1. Maintenance categories include drugs for asthma, diabetes, and osteoporosis; statins, lipid-lowering, and cardiovascular drugs. Some preventive maintenance drugs may be covered at 100 percent and are not subject to the deductible. Visit **YourLifeYourRewards.com** for a complete list.

2. Cost difference between brand drug and generic equivalent does not count toward the combined medical/prescription deductible and out-of-pocket maximum.

3. 90-day supply available at retail pharmacies with payment of three 30-day supply co-pays (e.g., $30 for generic drugs).

Note: Prior authorization and quantity limits apply for certain types of drugs. There is no coverage for certain drugs that are available over the counter or non-FDA approved drugs.

2023 UHC Select PPO

Medical Plan

	In-network	Out-of-network[1]
Calendar year deductible		
Individual	$750	$1,500
Family	$1,500	$3,000
Calendar year out-of-pocket maximum *(includes combined medical and prescription deductibles, co-insurance, and co-pays)*		
Individual	$2,500	$5,000
Family	$5,000	$10,000
Preventive care	100%, no deductible	
Well-baby care *(including immunizations)*	Under age 4: Up to 7 visits in the first 12 months; up to 3 visits in months 13–24; up to 3 visits in months 25–36	
Routine annual physical exam *(age 4 and over)*	Limited to 1 preventive exam per calendar year	
Annual OB/GYN exams *(including Pap smears)*	Limited to 1 preventive exam per calendar year	
Mammograms	100%, no deductible	
Colonoscopies	100%, no deductible	
Lung cancer screening *(ages 50–80)*[3]	100%, no deductible	
Office, virtual, or telehealth visits		
PCP	100% after $20 co-pay	70% after deductible
Specialist	100% after $35 co-pay	
Urgent care	100% after $20 co-pay	
Emergency room		
Emergency	100% after $150 co-pay; waived if admitted	
Non-emergency	70% after deductible	
Ambulance		
True emergency/medically necessary	90%, no deductible	
Non-emergency/not medically necessary	Not covered	
Hospital		
Inpatient precertification	Precertification required	
Inpatient semi-private room	90% after deductible	70% after deductible
Outpatient services	90% after deductible	70% after deductible
Doctor visits	90% after deductible	70% after deductible

2023 UHC Select PPO

	In-network	Out-of-network[1]
Surgery		
Inpatient precertification	Precertification required	
Inpatient	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
X-ray/lab	90% after deductible	70% after deductible
Fertility treatments[2]		
Inpatient	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Office visits	100% after $20 PCP co-pay; 100% after $35 Specialist co-pay	70% after deductible
Lifetime maximum	2 Progyny SMART Cycles	
Mental health		
Inpatient precertification	Precertification required	
Inpatient	90% after deductible	70% after deductible
Outpatient, virtual, or telehealth visits	100% after $20 PCP co-pay	70% after deductible
Substance abuse		
Inpatient precertification	Precertification required	
Inpatient	90% after deductible	70% after deductible
Outpatient	100% after $20 PCP co-pay	70% after deductible
Transitional residential recovery services	90% after deductible	70% after deductible
Other medical care		
Physical therapy	100% after $35 co-pay	70% after deductible
	Up to 60 visits/diagnosis then subject to preauthorization	
Chiropractic	100% after $35 co-pay	70% after deductible
	Limited to 30 visits each year	
Acupuncture	90% after deductible	70% after deductible
	Limited to 30 visits each year (services must be provided by a licensed acupuncturist)	
Hearing aids	90% after deductible	70% after deductible
	Limited to $6,000 every 36 months	

1. Benefits for out-of-network care are based on the Reasonable and Customary (R&C) charge. You are responsible for any amount that exceeds R&C. R&C charges are not included in the deductible or calendar year out-of-pocket maximum.
2. Participation in Progyny Fertility Benefits program is required.
3. In accordance with ACS and USPSTF, recommendations for a yearly LDCT scan for people ages 50–80 who meet certain criteria.

Prescription drug plan

	Network retail pharmacy or Optum Rx Specialty Pharmacy *(30-day supply)*	OptumRx home delivery[3] *(90-day supply)*
Generic	$10 co-pay	$20 co-pay
Brand without generic equivalent	You pay 20% subject to the minimums and maximums below: • $15 minimum; $25 maximum for a maintenance[1] medication • $25 minimum; $50 maximum for a non-maintenance medication	You pay 20% subject to the minimums and maximums below: • $30 minimum; $50 maximum for a maintenance[1] medication • $50 minimum; $100 maximum for a non-maintenance medication
Brand with generic equivalent	$10 co-pay after deductible plus cost difference between brand drug and generic equivalent[2]	$20 co-pay after deductible plus cost difference between brand drug and generic equivalent[2]

1. Maintenance categories include drugs for asthma, diabetes, and osteoporosis; statins, lipid-lowering, and cardiovascular drugs. Some preventive maintenance drugs may be covered at 100 percent and are not subject to the deductible. Visit **YourLifeYourRewards.com** for a complete list.
2. Cost difference between brand drug and generic equivalent does not count toward the combined medical/prescription deductible and out-of-pocket maximum.
3. 90-day supply available at retail pharmacies with payment of three 30-day supply co-pays (e.g., $30 for generic drugs).

Note: Prior authorization and quantity limits apply for certain types of drugs. There is no coverage for certain drugs that are available over the counter or non-FDA approved drugs.

PRIOR AUTHORIZATION OF CERTAIN COVERED EXPENSES

In order to receive Medical and Prescription Plan Benefits, you or your treating physician must obtain prior authorization from UnitedHealthcare or OptumRx, as applicable, for certain services, supplies, and prescription medications prior to the dates of service when you have an upcoming treatment or service involving hospitalizations and certain other services or prescription medications. If you or your provider do not obtain prior authorization, you bear the risk of services not being covered. Failure to obtain prior authorization will result in no benefits being payable for the services or treatments deemed not to be Medically Necessary.

Health Services Requiring Prior Authorization

Network providers are responsible for obtaining prior authorization before services are rendered. However, there are also some services where you are responsible for obtaining prior authorization, particularly if your services are provided by an out-of-network provider.

You or your provider must contact UnitedHealthcare or OptumRx to obtain prior authorization before you or a covered dependent obtain any of the following services, supplies or prescription medications:

- All hospital inpatient stays, including
  - mental health/substance use and addictive disorders, residential and Intensive outpatient (IOP)
  - Rehabilitation center
  - Skilled nursing facility,
  - Hospice care
  - Maternity, if expected to exceed 48 hours for normal deliveries and 96 hours for Cesarean sections,
- Ambulance (non-emergent air)
- Clinical trials
- Congenital heart disease
- Diabetes Treatment: Insulin pump >$1,000
- Durable Medical Equipment >$1,000
- Gender Dysphoria
- Home health care—private-duty nursing
- Obesity surgery
- Orthognathic surgery
- Prosthetic Devices >$1,000
- Reconstructive procedures
- Sleep apnea procedures and surgery
- Sleep studies: lab, X-ray and diagnostics
- Therapeutics (outpatient)—dialysis, IV infusion, intensity modulated radiation therapy, MR-guided focused ultrasound
- Transplantation services
- Outpatient services related to the treatment of:
- Electro-convulsive treatment

- Intensive Behavioral Therapy (IBT) including Applied Behavior Analysis (ABA) therapy for autism spectrum disorders
- Psychological testing
- Partial hospitalization/Day treatment
- Transcranial magnetic stimulation
- Any physical therapy visits after the 60th visit per individual for each diagnosis, and
- Prescription drugs. The patient must ask their prescriber to contact OptumRx for prior authorization before coverage by the plan will be allowed for certain medications, including but not limited to:
  - Hair Growth Stimulants and Depigmenting Agents
  - Compound medications with a charge over $300
  - Specialty cholesterol lowering drugs called PCSK9 Inhibitors (e.g., Repatha or Praluent)
  - Dupixent
  - Testosterones
  - Oral fentanyl
  - Entire class of narcolepsy drugs
  - Opioids/painkillers
  - Certain hyper-inflated dermatological drugs such as Diclofenac 3% (Soloraze) gel and Fluocinonide 0.1%
  - Injectable migraine drugs
  - Epidiolex
  - Doxepin 5% cream

Note: If you are admitted to a hospital or other facility as a result of an Emergency, you must notify the Claims Administrator within two business days after the admission or as soon as reasonably possible.

How To Notify UnitedHealthcare or OptumRx

For medical services and/or prescription drugs that require prior authorization, you must call the toll-free number listed on the UnitedHealthcare identification card to request authorization. Medical professionals, in cooperation with your physician, will review treatment to help ensure that it is medically necessary, appropriate and effective. \

IMPORTANT

Either you, your physician, or your family member may make required calls. However, you are ultimately responsible for satisfying the Medical and Prescription Plan's notification requirements.

Preventive Care Benefits for Breast Pumps

Preventive care Benefits defined under the Health Resources and Services Administration requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. If more than one type of breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

- which pump is the most cost effective;

- whether the pump should be purchased or rented;
- duration of a rental; and
- timing of an acquisition;

Benefits are only available if breast pumps are obtained from a participating or authorized durable medical equipment ("DME") provider or Physician.

For questions about your preventive care Benefits under the Medical and Prescription Plan call the number on the back of your ID card.

UNITED HEALTHCARE PERSONAL HEALTH SUPPORT

Care Management

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

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Personal Health Support nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted. After leaving the hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse

will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access health care information
- Support by a nurse to help you make more informed decisions in your treatment and care
- Expectations of treatment
- Information on providers and programs

Conditions for which this program is available include:

- Back pain
- Knee & hip replacement
- Prostate disease
- Prostate cancer
- Benign uterine conditions
- Breast cancer
- Coronary disease
- Bariatric surgery

Disease and Condition Management Services

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive

free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

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

Complex Medical Conditions Programs and Services

Cancer Resource Services (CRS) Program

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

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

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

Travel and Lodging assistance may also be available. Refer to the *Travel and Lodging Benefits on page 65*.

Congenital Heart Disease (CHD) Resource Services

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

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on the Plan's terms, exclusions, limitations and conditions, including eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries contact CHD Resource Services prior to surgery to enroll in the program.

Travel and Lodging assistance may also be available. Refer to the Travel and Lodging Benefits on page 65

Comprehensive Kidney Solution (CKS) program

For Participants diagnosed with Kidney Disease, UnitedHealthcare offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

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

Kidney Resource Services (KRS) program

End-Stage Renal Disease (ESRD)

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

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

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

Transplant Resource Services (TRS) Program

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

To learn more about Transplant Resource Services, call the number on your ID card.

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

The U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan also provides Travel and Lodging assistance. Refer to the *Travel and Lodging Benefits below for* more information

Travel and Lodging Assistance Program

The Plan may provide you with Travel and Lodging Assistance Program benefits for you or your eligible family member if you meet the qualifications for the benefit. Travel and Lodging (T&L) benefits are available for the patient and one traveling companion when the patient is receiving care at a UHC in-network facility/provider (or a non-network facility/provider when there is no Network provider who is reasonably accessible or available to provide Covered Health Services and a gap exception to utilize the provider has been approved) and lives more than 50 miles from the closest UHC in-network facility or provider that is able to treat the condition(s). If the patient is a minor child, T&L expenses for two traveling companions will be covered. Benefits are paid for transportation of the patient and one companion (two companions if the patient is a minor child) who are traveling on the same day(s) to and/or from the site of the medical care, and for transportation for parents/guardians traveling to the site of care of a dependent child confined as an inpatient at a covered facility. Benefits are paid at a daily rate for lodging near the facility where medical care is provided, up to $150 for one person and up to $200 for two people. (T&L benefits for the patient are not paid when the patient is confined to the treatment facility.)

Please note that reimbursement for certain lodging expenses that exceeds the per diem rate allowed by the IRS or is for more than one person accompanying a minor child is considered taxable income that is reportable on a Form W-2. Taxes on such excess reimbursement will be withheld through payroll taxes at the end of the tax year and will be reported to the IRS..

All T&L benefits associated with a patient's care at a UHC in-network facility/provider are paid up to a lifetime maximum of $10,000 for all expenses. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts. Claims are processed subject to the deductible and coinsurance for the Health Choice PPO, and processed at 100% for the Select PPO.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding the Travel and Lodging benefits, please call the Health Team at UHC at 1-888-264-0749.

WELLNESS PROGRAMS

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse

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

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card. As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services (NRS)

NRS is a program that provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program, call the HealthTeam at the number on your ID card or call NRS directly at 1-866-534-7209.

Benefits for Covered Health Services are described in this SPD, unless the service is excluded as stated in this SPD.

MENTAL HEALTH SERVICES AND SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES

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

Benefits include the following levels of care:

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

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

Services include the following:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator by calling the Health Team at UHC at 1-888-264-0749 for assistance in locating a provider and coordination of care.

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility, you must provide pre-service notification and obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission (including Emergency admissions).

In addition, for Non-Network Benefits you must provide pre-service notification and obtain prior authorization before the following services are received:

- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment programs;
- outpatient electro-convulsive treatment;
- psychological testing;
- transcranial magnetic stimulation;

Defined terms:

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator – the organization or individual designated by Roche who provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Medical and Prescription Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)* (see below for additional details about ABA Therapy coverage) that are the following:

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

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

Benefits include the following levels of care:

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

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

Services include the following:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY

The Medical and Prescription Plan offers an Applied Behavior Analysis (ABA) therapy benefit for Participants diagnosed with Autism Spectrum Disorder. To access this benefit, call 1-888-264-0749, enter your date of birth and ID number as requested. When prompted for the reason you are calling say "Benefits" and at the next prompt say "Mental Health". You will be connected to the United Behavioral Health (UBH) Call Team. Tell the UBH Call Team representative you are calling about Roche's ABA therapy benefit. When you call, the UBH Intake Call Team will collect some additional information and make a referral to a specialized Autism Care Advocate who will assist you with starting the approval process and a Transition of Care plan, if applicable.

Your Autism Care Advocate can help identify qualified and credentialed providers within the network and help determine whether non-network providers comply with UBH's provider requirements and coverage determination guidelines. Out-of-network benefits are available, but at a reduced level of coverage and/or reimbursement. Contact UBH for the out-of-network coverage and reimbursement levels.

UBH requires all providers to comply with UBH provider requirements and coverage determination guidelines before UBH can pay any claims for ABA therapy – even out-of-network providers. Transitional authorizations (for out-of-network providers who meet UBH requirements) for ABA therapy services may be available for a maximum of 90 days from the date the Participant is first enrolled for coverage in this Plan.

To request a Transition of Care period, call (888) 264-0749, enter your date of birth and ID number as requested. When prompted for the reason you are calling say "Benefits" and at the next prompt say "Mental Health". You will be connected to the UBH Call Team. Tell the UBH Call Team representative you are calling about Roche's ABA therapy benefit and you want to participate in the Transition of Care Period. The UBH representative will explain the process and any necessary next steps.

Due to the required special handling, ABA claims must be faxed to UBH in order to be processed. In-network providers will fax the claims on the employee's behalf. For out of network providers, it is the employee's responsibility to fax the claims and associated paperwork, although in some instances the out-of-network provider may agree to complete on behalf of the employee. To obtain the ABA Autism fax number please contact the Health Team at UHC at (888) 264-0749. The ABA Autism Care Advocate will review this process with employees and providers during the prior-authorization process.

BARIATRIC RESOURCE SERVICES (BRS)

The Plan offers a Bariatric Resource Services (BRS) program. If you are considering bariatric surgery, you must participate in the BRS program. Failure to do so may result in uncovered procedures.

The BRS program provides you with;

- specialized clinical consulting services to educate on obesity treatment options
- access to specialized Network facilities and Physicians for obesity surgery services.

Centers of Excellence (CoE)

The BRS program provides access to top-performing, quality bariatric surgery hospitals and surgeons that deliver improved clinical and economic outcomes. Centers of Excellence perform more successful bariatric procedures than other facilities nearby. They also have fewer complications and readmissions, and they could significantly reduce or eliminate your out-of-pocket medical costs.

Coverage requirements

Participation in the BRS program is required to receive benefits coverage for expenses related to bariatric surgery. You must access the Bariatric Resource Services programs by calling the number on the back of your ID card. While having your surgery at a CoE facility is not required, you may receive enhanced benefits that could reduce your out of pocket costs if you have surgery at a CoE, as follows:

- 100 percent with no deductible if you are enrolled in the Select PPO, or
- 100 percent after the deductible if you are enrolled in the Health Choice PPO.
- Travel and lodging expenses covered if you live more than 50 miles from the CoE where your surgery is performed. Refer to the *Travel and Lodging Assistance Program on page 65 for details.*

In order to qualify for bariatric surgery, you must also meet certain eligibility criteria, which includes (but are not limited to):

- You have enrolled in the Bariatric Resource Services program
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

ORTHOPEDIC HEALTH SUPPORT PROGRAM

Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond.

This program offers:

- Early intervention and appropriate care.
- Coaching to support behavior change.
- Shared decision-making.
- Pre-surgical and post-surgical counseling.
- Support in choosing treatment options.
- Education on back-related information and self-care strategies.
- Long-term support.
- Access to Designated Providers for certain inpatient and outpatient orthopedic surgeries.

Participation in the program is voluntary and without extra charge, however you may receive enhanced benefits that could reduce your out of pocket costs for your hospital stay if you participate in the program and have surgery at a Center of Excellence (CoE), as follows:

- 100 percent coverage with no deductible if you are enrolled in the Select PPO, or
- 100 percent coverage after a reduced deductible if you are enrolled in the Health Choice PPO.

Important: To receive enhanced benefits, you must contact an Orthopedic Nurse Case Manager to register for the program and have your surgery at an approved CoE. If no CoE is available within 50 miles of your geographic area, you may still elect to participate in the program and travel to a CoE in another location. Refer to the *Travel and Lodging Benefits on page 65 for details*.

To learn more about the Orthopedic Health Support program or to enroll, contact the Health Team at UHC at the number on the back of your ID card.

CLINICAL TRIALS

For purposes of the UnitedHealthcare PPO options only, Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

- Covered Expenses for which Benefits are typically provided absent a Clinical Trial.
- Covered Expenses required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Expenses needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

FERTILITY BENEFITS PROGRAM WITH PROGYNY

Progyny is a Fertility Benefits program for participants in the UnitedHealthcare plans. This program supports families going through fertility issues by providing access to high quality care and expanded services. Progyny Patient Care Advocates will guide you through the fertility process.

The fertility benefit through Progyny offers two SMART Cycles per lifetime. SMART Cycles offer a combination of services, so you can work with your doctor to pick the services that best fit your situation. Benefits for fertility services are covered by, and paid through, the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan subject to your deductible, co-insurance and co-pay (if applicable). **Participating in the program and working with a Patient Care Advocate is required to receive benefits for fertility treatment.**

Progyny Overview

Progyny provides comprehensive fertility and family planning solutions. This includes cutting-edge fertility treatments, a national network of fertility clinics, fertility preservation counseling, and a dedicated Patient Care Advocate (PCA) to provide education, support, and coordinated care for all family building needs.

PCAs provide pre-treatment counseling, advice, and logistical support, including:

- Coordination of initial and follow-up appointments.
- Assistance in selecting a provider, including a review of clinic success rates and outcomes.
- Education regarding what to expect at the initial consultation.
- Emotional support from a Patient Care Advocate who understands family building challenges.
- Review of the various treatment options and technologies that increase treatment success, while decreasing the risk of multiple births (twins).
- Information about Egg Freezing.
- Curated educational content related to treatments, as well as consultative services for people interested in donor services.
- Family building strategies for same sex couples.
- Drug administration advice.

The Progyny SMART Cycle benefit may be used to receive coverage for the following treatments and procedures:

- **Two (2) Consultations per calendar year.** Consultations are an opportunity to discuss and explore the possible reasons why one may be struggling to conceive. Consultations outline potential diagnostic testing protocol and possible treatment options.
- **Diagnostic testing -** Diagnostic testing is performed to assess reproductive organ functionality to determine the root cause of the inability to conceive. Fertility specialists are able to make a treatment recommendation following the assessment of the diagnostic testing results.
- **Transvaginal Ultrasounds** - a type of pelvic ultrasound used by doctors to visually examine female reproductive organs. This includes the uterus, fallopian tubes, ovaries, cervix, and vagina.
- **IVF (In-Vitro Fertilization) –** Includes cycle management via in-cycle monitoring, office visits, blood work, ultrasounds, oocyte (egg) retrieval and identification, fertilization, embryo assessment via Pre-implantation Genetic Screening (PGS) testing followed by the embryo transfer (if/when applicable)
- **IUI (Intrauterine Insemination) -** a procedure in which semen is placed into the uterus directly through the use of a catheter. Also referred to as artificial insemination.
- **ICSI (Intracytoplasmic Sperm Injection) –** a procedure that is performed to increase fertilization.
- **PGS (pre-implantation genetic screening**) – a genetic screening to ensure embryo viability. PGS ensures that the embryo chosen for transfer has the correct number of chromosomes.

- **PGD (pre-implantation genetic diagnosis) -** a screening used to identify a specific heritable disease causing genetic defect within an embryo. This test prevents the transfer of an embryo that may contain certain diseases or disorders from being passed on to the child.
- **Embryo assessment and transfer -** analyzes early embryo development to aid in the selection and transfer of the most viable embryo for transfer.
- **Fertility Preservation via egg, embryo, or sperm freezing.**
  - Includes oncofertility preservation due to cancer or medical treatments.
- **Up to 10 years of storage (egg, embryo, sperm) with annual renewal and eligibility verification.**
  - Member can self-pay for additional years of storage or use of ¼ SMART Cycle per renewal

Purchase of Donor Tissue (Sperm, Eggs)

- **Previously Frozen tissue:** The purchase of donor sperm and purchase of donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member. You are required to pay out of pocket for purchase and submit eligible charges to Progyny for reimbursement.
  - 1 Egg Cohort Purchase = 1 SMART Cycle
  - Donor Sperm purchase = ¼ SMART Cycle
- **Fresh Donor Recipient Cycle:** Egg donor will undergo an egg retrieval at an in-network Progyny provider that will allow for a fresh embryo transfer into a covered female. Treatment must occur at an in-network Progyny network provider. If in-network provider is not contracted for fresh donor recipient cycle, Progyny will pursue a special case agreement, if special case agreement request is denied, you will need to pay for the donor services out of pocket and submit eligible charges to Progyny for reimbursement.
  - Fresh Donor Recipient Cycle = 1.5 SMART Cycles

Fertility Benefit

The Progyny Benefit allows for:

2 Smart Cycles per lifetime subject to all applicable plan copay, coinsurance, and deductible requirements.

A 3rd Smart Cycle per lifetime may be granted should the initial Smart Cycles not result in a live birth.

You must contact Progyny to activate the benefit and confirm eligibility in order to locate an in-network provider to utilize the benefit.

To begin please contact Progyny at 844-399-6008.

Fertility Benefit Exclusions

- **See "What the PPO Options Do Not Cover" section of this SPD**

Fertility Pharmacy Benefit

Progyny Rx

Some benefits provided under this fertility benefits program may be taxable, such as egg storage over 1 year. Please check with your tax adviser for more information.

For more information about the program, including coverage and treatment options, contact Progyny at (844) 399-6008 or info@progyny.com.

GENDER REASSIGNMENT SURGERY SERVICES

Members should contact the HealthTeam at UHC directly at 1-888-264-0749 with any questions related to this specific coverage, or to confirm coverage of specific services.

Eligibility Criteria

All Members, including non-binary members, are eligible for Gender reassignment surgery when criteria (aside from desire to be the opposite sex) is met. Members should not be denied coverage for Gender Dysphoria services, based solely on identifying as non-binary, if otherwise eligible for coverage. Gender reassignment surgery (GRS) is considered medically necessary when *all* of the following criteria are met:

1. The individual has been diagnosed with Gender Dysphoria, Gender Identity Disorder (GID), or Transsexualism, including all of the following:
    a. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
    b. The disorder is not a symptom of another mental disorder or a chromosomal abnormality; and/or
    c. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
2. For those individuals without a medical contraindication, the individual has undergone continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and
3. The individual has completed a minimum of 12 months of successful continuous full time real-life experience in their desired gender, with no returning to their original gender, including one or more of the following:
    a. Maintain part- or full-time employment; or
    b. Function as a student in an academic setting; or
    c. Function in a community-based volunteer activity; and
4. Demonstrable knowledge of the required length of hospitalizations, likely complications, and post-surgical rehabilitation requirements of various surgical approaches; and
5. Demonstrable progress in consolidating one's gender identity, including demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance); and
6. Two referrals from qualified mental health professionals who have independently assessed the individual are needed for genital surgery; one referral from a qualified mental health professional is needed for breast/chest surgery. The referrals should document the following:
    a. The individual's general identifying characteristics;
    b. Results of the individual’s psychosocial assessment, including and diagnoses;
    c. The duration of their professional relationship with the individual including the type of evaluation and therapy or counseling to date;

d. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the individual's request for surgery;
e. A statement about the fact that informed consent has been obtained from the individual;
f. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

7. The treatment plan must conform to identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence based professional society guidance.

Covered Procedures (exclusion from this list does not indicate lack of coverage if procedure is diagnosed as clinically indicated/ medically necessary):

- Orchiectomy/ Saginectomy/ Hysterectomy
- Salpingo-oopherectomy
- Breast augmentation / breast removal / chest reconstruction
- Sexual Reassignment Surgery (vaginoplasty/ labiaplasty/ phalloplasty/ metoidioplasty)
- Construction of artificial vagina
- Vaginectomy; colpectomy; clitoroplasty for intersex state
- Mastectomy
- Mastopexy
- Mammaplasty, augmentation
- Nipple/areola reconstruction
- Urethroplasty; urethromeatoplasty
- Amputation of penis; complete
- Orchiectomy, with or without testicular prosthesis, scrotal or inguinal approach
- Insertion of testicular prosthesis (separate procedure)
- Laparoscopic, surgical; orchiectomy
- Scrotoplasty; complicated
- Intersex surgery; male to female [a series of staged procedures that includes male genitalia removal, penile dissection, urethral transposition, creation of vagina and labia with stent placement]; female to male [a series of staged procedures that include penis and scrotum formation by graft, and prostheses placement]
- Vulvectomy simple; complete
- Plastic repair of introitus
- Perineoplasty, repair of perineum, non-obstetrical (separate procedure)
- Coloproctostomy (low pelvic anastomosis)
- Facial Feminization Surgery/ Facial Masculinization Surgery: for example:
  - Rhinoplasty
  - Facial bone reduction/remodeling (for facial feminizatgion)

- Rhytidectomy (i.e., face lift)
- Blepharoplasty

- Suction-assisted lipoplasty of the waist
- Abdominoplasty, modified as part of phalloplasty
- Electrolysis or laser hair removal; services must be performed by a licensed professional (drugs for purpose of hair removal may be covered in the Prescription coverage portion of the Medical and Prescription Plan)
- Hair transplantation or prosthesis
- Voice modification surgery
- Voice therapy/lessons
- Pre-transition banking of reproductive materials (subject to the Medical and Prescription Plan coverage details and limitations on Fertility services)
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Reimbursement of travel/ lodging costs for specialist services obtained in geographically remote areas, if there is not a qualified physician in the members area. Reimbursement is subject to certain limitations and must be approved/authorized by United Healthcare. Refer to the *Travel and Lodging Assistance Program on page 65 for more information.*

Notes: Procedures (e.g..: electrolysis) not regularly performed by medical professionals should be performed by qualified personnel (e.g..: licensed electrologists) in order for coverage and reimbursement.

The procedures/services are derived from the World Professional Association for Transgender Health (WPATH) and Standard of Care for Gender Identity Disorders.

WHAT THE PPO OPTIONS DO NOT COVER

Items excluded from coverage under the Medical PPO options include but are not limited to the items listed below. There may be other exclusions. You should always check with UnitedHealthcare, the Claims Administrator for medical coverage, to determine whether or not a service is covered.

- Charges for a service or supply furnished by an in network or out-of-network provider in excess of the negotiated/ Reasonable and Customary charge.
- Charges submitted for services that are not rendered, or are rendered to a person not eligible for coverage under the Plan.
- Charges for a service or supply not submitted within 24 months (12 months for prescription drug charges) of the date the services are rendered or supplies are received.
- Services:
  - Performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
  - Performed by a provider on himself or herself;
  - Performed by a provider with your same legal residence;
  - Ordered or delivered by a Christian Science practitioner;

- Performed by an unlicensed hospital, physician or other provider, or a provider who is operating outside of the scope of their license;
- Provided at a diagnostic facility (hospital or free-standing) without a written order from a Provider;
- Which are self-directed to a free-standing or hospital-based diagnostic facility;
- Ordered by a Provider affiliated with a diagnostic facility (hospital or free-standing), when that provider is not actively involved in your medical care prior to ordering the service or after the service is received;
- Custodial Care or maintenance care services provided by a personal care assistant; Custodial Care is defined as services that do not require special skills or training and that: a) Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating); b)Do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or c)Do not require continued administration by trained medical personnel in order to be delivered safely and effectively;
- Domiciliary Care;
- Multi-disciplinary pain management programs provided on an inpatient basis;
- Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which benefits are provided;
- Rest cures;
- Services of personal care attendants; and
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

- Contraceptive supplies -- over the counter contraceptive supplies that are not FDA approved and prescribed by a healthcare provider (certain exceptions may apply; please check with OptumRx for coverage information).
- 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 (except that this exclusion does not apply to services covered for Gender Dysphoria. Please see Gender Reassignment Surgery section in this SPD for coverage information) including:
  - Face lifts, body lifts, tummy tucks, liposuctions or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple, removal of excess skin, removal or reduction of non-malignant moles (except biopsy), 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;
  - Pharmacological regimens;
  - Nutritional procedures or treatments;

- 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 Mmedically necessary;
- Removal of tattoos or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures) (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
- Hair removal or replacement by any means; treatments for skin wrinkles or any treatment to improve the appearance of the skin; treatment for spider veins; skin abrasion procedures performed as a treatment for acne; treatments for hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic;
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct gynecomastia;
- Breast augmentation and reduction surgery, except for breast surgery as required by the Women's Health and Cancer Rights Act of 1998 and breast reduction surgery that is medically necessary;
- Otoplasty;
- Replacement of an existing intact breast implant if the earlier breast implant was performed as a cosmetic procedure;
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation;
- Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; and
- Wigs or other scalp-hair prosthesis, regardless of the reason for the hair loss, except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury. Wigs will be covered for alopecia or hair loss due to injury or disease. Any combination of in-network and out-of-network benefits is limited to two wigs or other scalp-hair prosthesis per calendar year.

- Court ordered services: Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when related to judicial or administrative proceedings or orders (except court ordered family therapy, which is a covered benefit).
- Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery, and restorative treatment are excluded.
- 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:
  - Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration and replacement of teeth; medical or surgical treatment of dental conditions; services to improve dental clinical outcomes. (This exclusion does not apply to accident-related dental services when accident-related dental services are covered in accordance with UHC standard coverage guidelines for repair or replacement of sound natural or restored teeth due to injury. You must contact a doctor or dentist within 72 hours of the accident, treatment must start within 3

months of the accident or 3 months from the time you are covered on the plan, and treatment must be completed within 12 months of the accident or 12 months from the time you are covered on the plan);

- Services of dentists, oral surgeons, dental hygienists, and orthodontists including 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, bone grafts, and other implant-related procedures, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth;
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment;
- Dental braces (orthodontics);
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan; and
- Treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned, or super numerary (extra) teeth, even if part of a congenital anomaly.

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

- Devices, appliances, and prosthetics:
  - Devices used specifically as safety items to affect performance in sports-related activities;
  - Orthotic appliances and devices that straighten or re-shape a body part, except if covered under Durable Medical Equipment provisions of the Plan (this exclusion does not apply to cranial molding helmets and cranial banding);
  - The following items are excluded, even if prescribed by a physician: blood pressure cuff / monitor, enuresis alarm, testing equipment, non-wearable external defibrillator, trusses, and ultrasonic nebulizers;
  - The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;
  - The replacement of lost or stolen prosthetic devices;
  - Powered and non-powered exoskeleton devices;
  - Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices; and
  - Oral appliances for snoring.
- Drugs, medications and supplies (note: The exclusions listed below apply to the medical portion of the Plan only. Coverage may be available under the Prescription Drug portion of the Plan administered by OptumRx):
  - Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician’s office.

- Self-administered or self-infused medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting). This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.);
- Hormone therapy (unless it is a Roche/Genentech medication);
- Prescription drug products for outpatient use that are filled by prescription order or refill (these may be covered by the prescription coverage of the Plan);
- Over-the-counter drugs and treatments, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins; and
- Injectable drugs if an alternative oral drug is available.

- 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.
- Examinations:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - Required by any law of a government, or professional or other licenses, and
  - Any special medical reports not directly related to treatment except when provided as part of a covered service.
- Experimental or investigational services, drugs, devices, treatments or procedures or unproven services, as defined in this SPD . This exclusion applies even if experimental, investigational, or unproven services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to covered health services provided during a clinical trial for which Benefits are provided.
- 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; or
  - Spas.
- Food items of any kind, including nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items. Foods that are not covered include:
  - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless:
    - they are the only/sole source of nutrition; or
    - they are required due to the covered person's medical condition; or
    - they are specifically created to treat inborn errors of metabolism, such as phenylketonuria (PKU).

Infant formula available over the counter is always excluded.

- Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
- Oral vitamins and minerals;
- Meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- Other dietary and electrolyte supplements.

- Foot Care:
  - Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for diabetics;
  - Nail trimming, cutting, or debriding (removal of dead skin or underlying tissue);
  - Hygienic and preventive maintenance foot care. Examples include:
    - Cleaning and soaking the feet;
    - Applying skin creams in order to maintain skin tone;

  This exclusion does not apply to preventive foot care for covered persons who are at risk of neurological or vascular disease arising from disease such as diabetes;
  - Treatment of flat feet;
  - Treatment of subluxation of the foot.
- Growth/Height: any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, devices to stimulate growth, and growth hormones.
- Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.
- Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.
- Health services for transplants involving animal organs;
- Home and mobility: any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, including:
  - Bathroom equipment such as bathtub seats, benches, rails, and lifts;
  - 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, massage devices or over-bed tables;
  - Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, 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, or 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; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alternations to any vehicle or transportation device.

- Intracellular micronutrient testing.
- Medical supplies, equipment, and appliances
  - Prescribed and non-prescribed medical supplies and supplies including ace bandages, gauze and dressings, and syringes (except as covered for diabetic supplies);
  - Tubings, nasal cannulas, connectors and masks except when used with durable medical equipment;
  - The repair and replacement of durable medical equipment when damaged due to misuse, malicious breakage or gross neglect;
  - The replacement of lost or stolen durable medical equipment; and
  - Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under ostomy supplies;
  - Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes, except for Roche and Genentech products which are covered.
- Medicare: payment for that portion of the charge for which Medicare or another party is the primary payer.
- Mental health and substance use disorders:
  - Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or Diagnostic and Statistical Manual of the American Psychiatric Association;
  - Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
  - Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
  - Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorder and paraphilic disorders;
  - Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes;
  - Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act;
  - Transitional living services. For purposes of this exclusion, Transitional Living Services means:
    - Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision , including those defined in the American Society of Addiction Medicine (ASAM) criteria, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

  Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery;

- Non-Medical 24-Hour Withdrawal Management (follows the American Society of Addiction Medicine (ASAM)
- High Intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment

- Miscellaneous charges for services or supplies including:
  - 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 (to the extent exclusion is permitted by law) including:
    - 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; or
    - 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.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy.
- Nutritional counseling (individual or group), including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
  - nutritional education is required for a disease in which patient self-management is an important component of treatment; and
  - there exists a knowledge deficit regarding the disease which requires intervention of a trained health professional.

- Personal comfort and convenience items: any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services, housekeeping, cooking, cleaning, shopping, monitoring, security or other home services, travel, transportation, or living expenses, rest cures, recreational or diversional therapy, supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, purifiers and filters;
  - Batteries and battery chargers;
  - Dehumidifiers and humidifiers;
  - Ergonomically correct chairs; non-hospital beds, comfort beds, and motorized beds and mattresses;
  - Breast pumps; This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement as described in the Eligible Expenses section of this SPD.
  - Car seats;
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners;
  - Exercise equipment and treadmills;
  - Hot tubs, Jacuzzis, saunas and whirlpools;
  - Medical alert systems;
  - Music devices;
  - Personal computers;
  - Pillows;
  - Power-operated vehicles;
  - Radios;
  - Strollers;
  - Safety equipment;
  - Vehicle modifications such as van lifts;
  - Video players; and
  - Home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).
  - Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Private duty nursing during your stay in a hospital.
- Procedures or surgeries to remove fatty tissue or hanging skin such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.
- Rehabilitation services and manipulative treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

- Reproduction services including:
  - The following Infertility treatment-related services:
    - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services;
    - Long-term storage (greater than ten years) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue;
    - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees;
    - Ovulation predictor kits;
    - The following services related to Gestational Carrier or Surrogate:
    - Fees for the use of a Gestational Carrier or Surrogate;
    - Insemination costs of Surrogate or transfer embryo to Gestational Carrier;
    - IVF for a traditional Surrogate;
    - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person;
  - In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility;
  - Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes;
  - The reversal of voluntary sterilization;
  - Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
  - Infertility treatment following unsuccessful reversal of voluntary sterilization;
  - Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy);Home ovulations prediction kits;
  - Services provided by a doula (labor aide); and
  - Parenting, pre-natal or birthing classes.
- Sclerotherapy treatment of veins.
- Services provided by another plan:
  - Services for which coverage is available:
    - Under another plan, except for Covered Expenses payable as described under Coordination of Benefits (COB);
    - Under workers' compensation, or similar legislation if you could elect it, or could have it elected it, while on active military duty; and
    - For treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably accessible;
    - Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.:
- Services provided by a Spouse, parent, child, stepchild, brother, sister, in-law or any household member.
- Services of a resident physician or intern rendered in that capacity.
- Services or prescription drugs that require prior authorization if the prior authorization is not received.
- Services and supplies provided in connection with treatment or care that is not covered under the Plan.

- Strength and performance: services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
  - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
  - Drugs or preparations to enhance strength, performance, or endurance; and
  - Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.
- Therapies and tests: any of the following treatments or procedures:
  - Acupressure;
  - Aromatherapy;
  - Art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatments as defined by the National Center of Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health
  - Biofeedback;
  - Chelation therapy (except for heavy metal poisoning);
  - Educational therapy;
  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
  - Massage therapy;
  - Megavitamin therapy; and
  - Rolfing;
  - Wilderness, adventure, camping, outdoor, or other similar programs.
- Temporomandibular Joint (TMJ) Services: the following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ) are excluded: surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.
- Transplant: the transplant coverage does not include charges for services and supplies furnished to a donor when recipient is not a covered person.
- Unauthorized services, including any service obtained by or on behalf of a covered person without prior authorization by UnitedHealthcare when required. This exclusion does not apply in a medical emergency or in an Urgent Care situation.
- Vision-related services and supplies. The Plan does not cover:
  - Routine vision examinations, including refractive examinations to determine the need for vision correction;
  - Implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
  - Purchase cost and associated fitting and testing for eyeglasses or contact lenses;
  - Eye exams for contact lenses or their fitting;
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  - Replacement of lenses or frames that are lost or stolen or broken;

- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures; and
- 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 morbid obesity, regardless of the existence of comorbid conditions; except as provided by the Plan, including but not limited to:
  - Liposuction, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Counseling (except if associated with an approved plan of treatment), or when nutritional counseling is prescribed by a physician for an a medically appropriate diagnosis and provided by appropriately licensed or registered health care professionals), coaching, training, hypnosis or other forms of therapy; and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.
- Wigs or other scalp-hair prosthesis regardless of the reason for the hair loss, except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury. Wigs will be covered for alopecia or hair loss due to injury or disease. Any combination of in-network and out-of-network benefits is limited to two wigs or other scalp hair prosthesis per calendar year.
- Work related: any illness or injury related to employment or self-employment including any injuries that arise 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.
- Other Exclusions:
  - Autopsies and other coroner services and transportation services for a corpse;
  - Charges for:
    - missed appointments;
    - room or facility reservations;
    - completion of claims forms;
    - record processing; or
    - charges that are prohibited by federal anti-kickback or self-referral statutes.
  - Diagnostic tests that are:
    - delivered in other than a physician's office or health care facility; and
    - self-administered home diagnostic tests, including, but not limited to, HIV and pregnancy tests;
  - Expenses for health services and supplies:
    - that do not meet the definition of Covered Expenses, Eligible Charges or Covered Health Services;

- that are received as a result of war or any act of war, whether declared or undeclared, while you are part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians and injured or otherwise affected by war, any act of war, or terrorism in a non-war zone;
- that are received after date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
- for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this benefit Plan;
- that exceed Covered Expenses, Eligible Charges, or any specified limitation; or
- for which a provider waives the Copay (if applicable), Annual Deductible or Coinsurance amounts.

- Long term (more than 30 days) storage of blood, umbilical cord or other material, except for storage of egg, embryo, or sperm as covered under the fertility benefit of the Plan;
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments as a result of incarceration or related to judicial or administrative proceedings or orders;
- Foreign language and sign language services;
- Health services related to a non-covered health service: when a service is not covered under the Medical and Prescription Plan, all services related to that service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be covered health services if they are to treat complications that arise from the non-covered health service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a cosmetic procedure, that require hospitalization.
- Health services related to a non-covered health service: when a service is not covered under the Plan, all services related to that service are also excluded, which also includes any services, items or drugs which are illegal under the laws of the applicable jurisdiction. This exclusion does not apply to services the Plan would otherwise determine to be covered health services if they are to treat complications that arise from the non-covered health service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a cosmetic procedure, that require hospitalization.

There may be other excluded items. Contact UHC to determine whether a specific service is covered under the PPO.

PRESCRIPTION EXPENSES THAT ARE NOT COVERED UNDER THE PRESCRIPTION COVERAGE OF THE PPO OPTIONS

- All drugs obtained without a valid prescription.
- Drugs, compounds, and other medications that are not approved by the Food and Drug Administration (FDA).
  - Any charges for prescriptions submitted without a valid **National Drug Code (NDC) number.**
  - Charges related to an injury for which Workers' Compensation benefits are payable.
  - Charges covered under any other group insurance.

- All over-the-counter (OTC) medications, unless accompanied by a prescription and covered under the Affordable Care Act or otherwise required by law.
- Prescription drugs that have over-the-counter equivalents (Proton Pump Inhibitors, Non-Steroidal Anti-Inflammatory drugs, and Nasal Steroids).
- Compound pharmacy exclusions
  - Select bulk ingredients and costly bases used in compounds
  - Products already available as over-the-counter or that have FDA-approved solutions
  - Charges for prescription drugs not submitted within 12 months of the date received.
- Medications for which Benefits are provided in the medical portion of the Medical and Prescription Plan.
- Medications for which Benefits are provided in the medical portion of the Plan.
- Charges for therapeutic devices or appliances such as hypodermic needles and syringes (unless in connection with diabetes), support garments, and other non-medical substances.
- Diabetic pumps (however, the pumps may be covered under the PPO options).
- Charges for administration of a prescription drug or insulin.
- Charges for prescription drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit, or which is less than the minimum supply limit.
- Charges for prescription refills in excess of the number specified by the physician.
- Prescription drugs as a replacement for a previously dispensed prescription drug that was lost, stolen, broken or destroyed.
- Serum supplied by a physician (may be covered under the medical portion of the Plan's PPO options,).
- Any drug labeled "Caution: Limited By Federal Law To Investigational Use" or experimental drugs.
- Diaphragms, contraceptive jellies, ointments or foams, unless accompanied by a prescription.
- Hair removal agents.
- Anti-wrinkle agents.
- Dietary supplements.
- Diagnostic kits and products including associated services.
- Vaccines, except those that are accompanied by a prescription and only those recommended for routine use in children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) on the CDC Immunization Schedules. These recommended vaccines differ by member age.
- Respiratory therapy supplies.
- Health services related to a non-covered health service: when a service is not covered under the Plan, all services related to that service are also excluded, which also includes any services, items or drugs which are illegal under the laws of the applicable jurisdiction.

There may be other excluded drugs and items. Contact UnitedHealthcare and OptumRx at the number listed on your ID card to determine whether a specific service or prescription drug is covered under the PPOs.

How to Apply for Coverage of an Excluded Drug

If an excluded drug is prescribed for a specific medical condition and you have attempted to use at least one alternative drug that's deemed as a therapeutic equivalent drug, you may qualify for coverage of the excluded drug. To request coverage, submit an appeal to UHC from your doctor stating the medical condition that requires the non-covered drug and the length of projected use. Depending on the medication and OptumRx's review, the period of time you will be allowed coverage for your medication will vary. If your appeal is approved, you will receive a letter notifying you of the length of time your coverage is approved, and you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable copay or coinsurance amount.

PRESCRIPTION EXPENSES THAT REQUIRE PRIOR AUTHORIZATION UNDER THE PRESCRIPTION COVERAGE OF THE PPO OPTIONS

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare/OptumRx or its designee. The reason for obtaining prior authorization from UnitedHealthcare/OptumRx or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service.

The Plan may also require you to obtain prior authorization from UnitedHealthcare/OptumRx or its designee so it can be determined whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization: When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from UnitedHealthcare.

Non-Network Pharmacy Prior Authorization: When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician, are responsible for obtaining prior authorization from UnitedHealthcare as required.

If you do not obtain prior authorization before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. You can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. The Prescription Drug Products requiring prior authorization are subject to UnitedHealthcare's periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Examples of medications that require prior authorization before coverage by the Medical and Prescription Plan will be allowed, include but are not limited to:

- Hair Growth Stimulants and Depigmenting Agents
- Compound medications with a charge over $300
- Specialty cholesterol lowering drugs called PCSK9 Inhibitors (e.g., Repatha or Praluent)
- Dupixent
- Testosterones

- Oral fentanyl
- Entire class of narcolepsy drugs (except Brand and Generic Provigil and Nuvigil)
- Opioids/painkillers
- Certain hyper-inflated dermatological drugs such as Diclofenac 3% (Soloraze) gel and Fluocinonide 0.1%
- Injectable migraine drugs
- Epidiolex
- Doxepin 5% cream

PRESCRIPTION EXPENSES THAT HAVE QUANTITY LIMITS UNDER THE PRESCRIPTION COVERAGE OF THE PPO OPTIONS

- The following medications have quantity limits:
  - Medications to treat erectile dysfunction are limited to 20 tablets or doses per 30-day supply.

For more information on the above restrictions, contact UnitedHealthcare or OptumRx.

HOW TO OBTAIN MEDICAL COVERAGE BENEFITS UNDER THE PPO OPTIONS

In-Network:

If you or your Eligible Dependents use a UnitedHealthcare PPO in-network hospital or provider, there are no claim forms or other paperwork to file. Just present your identification card, and the hospital or provider will submit the claim directly to UnitedHealthcare for claim processing. Payment will be made directly to the hospital or provider. Your expenses will be lower because you will benefit from UnitedHealthcare's negotiated rates, and you will not be responsible for any amounts above the negotiated rate. UnitedHealthcare will send you an Explanation of Benefits (EOB) statement showing the amount of the expense that is your responsibility. The hospital or provider may directly bill you for any Copayments, Coinsurance Amounts, required Deductibles and amounts in excess of certain Plan maximums you are required to pay. For example, if a service is covered at 80%, the provider will bill you for the other 20% not covered by the Medical and Prescription Plan.

Out-Of-Network:

If you or your Eligible Dependents use an out-of-network hospital or provider, you may be asked to pay for services at the time they are rendered or after, or you may be billed for the balance once UnitedHealthcare has made payment. In most cases, the hospital or provider will not bill UnitedHealthcare directly; and you will have to file a claim form for your expenses to UnitedHealthcare at the address listed on your identification card within 24 months of the date of service. You can access a UnitedHealthcare claim form at http://roche.welcometouhc.com/home. UnitedHealthcare will reimburse you or your provider, depending on payment assignment, for amounts payable by the Plan. As with in-network, you will receive an Explanation of Benefits from UnitedHealthcare explaining how payment was calculated. Please note that in addition to the Deductible and Coinsurance amount, an out-of-network provider may also bill you for amounts that are not covered by the plan (such as amounts above R&C).

Foreign Claims:

If you or your Eligible Dependents use a hospital or provider outside of the United States due to a medical emergency while in a foreign country, the claim will be treated as in-network. However, if you or your Eligible Dependents use a hospital or provider outside of the United States for any non-emergency care while in a foreign

country, the claim will be treated as out-of-network. In most cases, you may be asked to pay for services at the time they are rendered since the foreign hospital or provider will not bill UnitedHealthcare directly. You will have to file a claim form for your expenses to UnitedHealthcare at the address listed on your identification card within 24 months of the date of service. UnitedHealthcare will reimburse you or the provider, depending on payment assignment, for amounts payable by the Plan.

HOW TO OBTAIN PRESCRIPTION COVERAGE BENEFITS UNDER THE PPO

Retail Pharmacies:

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Medical and Prescription Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You may obtain information about Network Pharmacies by contacting UnitedHealthcare at the number listed on your identification card or by logging onto www.myuhc.com.

Benefits are also provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with UnitedHealthcare. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay and/or Coinsurance.

The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay and/or Coinsurance that applies will reflect the number of days dispensed

IDENTIFICATION CARD (ID CARD) – NETWORK PHARMACY

Either you must show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours. If you do not show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the full Usual and Customary Charge for the Prescription Drug at the pharmacy. If you return to most in-network pharmacies with your ID card within 7 days, the pharmacy will reprocess your claim as in-network. You may also seek reimbursement from the Medical and Prescription Plan; however, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Deductible, Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Submit your claim to:
Optum Rx
PO Box 29077
Hot Spring, AR 71903

Prescription Mail Order Program

This component of the prescription coverage provides a convenient and cost-savings option if you wish to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home. Up to a 90-day supply of medication is covered in full after you pay the applicable Copay, Deductible or Coinsurance (or $0 Copay for certain Roche/Genentech pharmaceuticals and diagnostic products manufactured, marketed, or co-marketed by Roche/Genentech in the Select plan; and $0 cost in the Health Choice plan after the Deductible is met). You can find additional information on the Mail Order Program and obtain a Mail Order drug form from www.myUHC.com. To get started:

- By ePrescribe
  - Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can be ordered only by ePrescribe.
- Go online
  - Visit myuhc.com
  - Click on “Manage Claims”, “Prescriptions”, “Manage Prescriptions’< then click “My Medicine Cabinet” and choose the appropriate option to refill or transfer to home delivery.
- By phone
  - Call the HealthTeam at 1-888-264-0749, which is listed on your ID card.

Note: To maximize your Benefit, ask your physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay and/or Coinsurance for any prescription order or refill if you use the mail order service, regardless of the number of day’s supply that is written on the order or refill. Be sure your physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

You can find additional information on the Mail Order Program and obtain a Mail Order drug form from www.myUHC.com, by calling 1-888-264-0749.

Optum Specialty Pharmacy Program

To receive any benefit under the prescription coverage for specialty/biotech medications, you must obtain them through the Optum Specialty Pharmacy Program. The program is specifically designed to meet the needs of plan participants with rare and/or complex chronic disorders. Medications handled by a specialty pharmacy may be taken orally, inhaled, injected or infused, high-cost, and/or have special delivery and storage requirements, such as refrigeration. Some examples of the specialty drug categories covered through the program are:

- Alpha 1-Antitrypsin Deficiency, or Genetic Emphysema
- Cystic Fibrosis
- Growth Hormone Deficiencies
- Hemophilia/Von Willebrand Disease
- Immune Disorders
- Hepatitis C
- Rheumatoid Arthritis
- Respiratory Syncytial Virus (RSV)
- Psoriasis
- Cancer
- Multiple Sclerosis
- Transplant Recipients
- Pulmonary Arterial Hypertension
- Infertility
- Crohn’s

When obtaining specialty/biotech medications through Optum Specialty Pharmacy to be administered by your physician, medication administration charges from your physician are covered under the medical plan, subject to deductibles and co-insurance. Additionally, specialty/biotech medications obtained through your physician's office (e.g., infused chemotherapy) are excluded from this Specialty Pharmacy requirement and will continue to be covered under the medical plan, subject to deductibles and co-insurance. Please call the UnitedHealthcare customer service number on the back of your ID card with any questions about coverage under the medical plan.

Optum Specialty Pharmacy services can be reached toll-free at (800) 237-2767. For a full list of specialty/biotech medications, visit www.cvsspecialty.com and choose the Drugs and Conditions link.

Features of the Optum Specialty Pharmacy

The Optum Specialty Pharmacy program provides convenient delivery of your specialty medication and offers a broad array of services to help you take your medication properly and stay as healthy as possible. Some of services include:

- 24/7 access to a pharmacist or patient care coordinator that provides condition-specific education, medication administration instruction and expert advice to help you manage your therapy.
- Claims assistance to help determine your individual coverage and file the necessary paperwork.
- Easy ordering with a dedicated toll-free number, and refill reminders.
- Timely delivery in confidential packaging

Special note for participants in Medicare Parts A & B:

Primary coverage for some specialty medications is provided through Medicare Parts A and B. For Plan Participants for whom Medicare is primary to the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, coverage for some specialty medications will be provided under Medicare A and/or B instead of the Plan. If Medicare Parts A and/or B cover these drugs, claims must be submitted to Medicare first and may then be submitted to the Medical and Prescription Plan for available secondary coverage. Medicare claims will not be coordinated withOptumRx. If you are uncertain if a particular drug is covered under your primary Medicare plan, please contact your Medicare insurance provider for coverage information.

Filing a Medical or Prescription Claim under the PPO Options

You can obtain a UnitedHealthcare or OptumRx claim form at www.myUHC.com. A claim form must be accompanied by an itemized bill each time one is submitted for reimbursement. Separate claim forms must be submitted for each Eligible Dependent for whom a claim is being made. If one family member is submitting more than one bill at a time, only one claim form is necessary. If bills are submitted without a claim form, UnitedHealthcare or OptumRx will be unable to process your claim.

The bill must be an original if the Plan is the primary payer; a copy is acceptable if the Plan is the secondary payer.

All bills must include:

- the name and address of the Participant,
- the Participant's complete UnitedHealthcare identification number,
- the name of the patient, if other than the Participant,
- the diagnosis (if a medical claim), and
- the date, charge, and nature of services rendered.

Payment cannot be made without all of this information. Cancelled checks are not acceptable in place of bills.

If you receive further treatment and have additional bills after the first claims submission, you should file them periodically along with new claim forms. Prompt filing of fully completed claim forms with all required itemized bills will result in faster processing of your claim. All claims to UnitedHealthcare must be submitted to the claims administrator within 24 months of the date the services are rendered. If you need to contact UnitedHealthcare regarding a claim you have submitted, be sure to have your identification number ready when you call. Your identification number must also be on every claim form you submit, otherwise, UnitedHealthcare will not be able to process your claim. All claims to OptumRx must be submitted to the claims administrator within 12 months of the date the services are rendered. You must complete the OptumRx claim form and mail it with your receipt confirming that the expense was incurred.

Please note that for an out-of-network hospital confinement, it is best to provide the claim form to the hospital at the time of your admission if possible. Providing the form, along with your identification card, will make your admission easier and may result in the waiver of any cash deposit required because the hospital will know exactly where to send the bill for services received by you or your Eligible Dependents.

If you or an Eligible Dependent is covered by another plan or Medicare, the other plan's Explanation of Benefits (EOB) must also accompany each claim. Likewise, if the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan is secondary to another group plan, the other plan's EOB must also accompany your claim.

MEDICAL PPO AND PRESCRIPTION DRUG CLAIMS AND APPEALS PROCEDURES

You may file claims for PPO and Hawaii Medical and Prescription Plan benefits, and appeal adverse claim decisions, either yourself or through an Authorized Representative using the Claims and Appeals Procedures set forth below.

An "Authorized Representative" means a person you authorize, in writing, to act on your behalf. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your Authorized Representative. Your Authorized Representative will be required to produce evidence of his or her authority to act on your behalf, and the Plan may require you to execute a form relating to the representative's authority before that person will be given access to your protected health information ("PHI") or allowed to take any action for you. (A mere assignment of your benefits does not constitute a designation of an authorized representative). Such a designation must be clearly stated in a form acceptable to the Plan. This authority may be proved by one of the following:

a. A power of attorney for health care or health care benefits purposes, notarized by a notary public;
b. A court order of appointment of the person as the conservator or guardian of the individual;
c. An individual who is the parent of an non-emancipated minor child; or
d. A form acceptable to the Plan that (i) identifies the Member, ID number, claim number, dates of service, provider number and billed amount, (ii) clearly indicates that the representative is appealing a claim denial under the Plan on your behalf, (iii) includes a signed and dated acknowledgement that you are appointing the individual as your Authorized Representative for purposes of ERISA, and (iv) is notarized by a notary public.

The Plan retains discretion to deny access to your PHI to an authorized representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

General questions or casual inquiries about your eligibility or about Plan coverage of particular benefits are not considered "claims" and are not subject to the procedures outlined below. If you want your question to be considered a "claim" you must follow the procedures outlined below.

Your claims will be reviewed by UnitedHealthcare or OptumRx, as applicable, and decided in accordance with their reasonable claims procedures, as required by Section 503 of ERISA. If your claim is denied in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial. You will have an opportunity to appeal in accordance with their reasonable appeals procedures, as required by Section 503 of ERISA. UnitedHealthcare and OptumRx provide for an independent outside appeal right under certain circumstances. Such independent outside appeal will comply with applicable claim procedure regulations as required by Section 503 of ERISA.

If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

When will UnitedHealthcare or OptumRx make a determination on an initial claim?

- Urgent Care Claims
  - As soon as possible, but not later than 72 hours after receipt of the claim by UnitedHealthcare or OptumRx, unless you fail to provide sufficient information to decide the claim. In that case, UnitedHealthcare or OptumRx will notify you as soon as possible, but not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. You will receive a reasonable

period of time to provide information, but not less than 48 hours. UnitedHealthcare or OptumRx will notify you of the determination as soon as possible, but within 48 hours of the earlier of (a) the receipt of the requested information, or (b) the end of the period you had to provide information.

- Pre-Service/Concurrent Claims
  - Within a reasonable time, but not later than 15 days after receipt; however they may extend the determination period once for up to 15 days if an extension is necessary due to matters beyond their control respectively and they notify you prior to the expiration of the initial 15-day period of the circumstances requiring the extension and the date a decision is expected. If the need for an extension is due to your failure to submit necessary information, the notice will also describe the required information and you will have at least 45 days to provide such requested information. The extension period will be tolled until you respond to the request for additional information.
- Post-Service Claims
  - Within a reasonable time, but not later than 30 days after receipt; however they may extend the determination period once for up to 30 days if an extension is necessary due to matters beyond their control respectively and they notify you prior to the expiration of the initial 30-day period of the circumstances requiring the extension and the date a decision is expected. If the need for an extension is due to your failure to submit necessary information, the notice will also describe the required information and you will have at least 45 days to provide such requested information. The extension period will be tolled until you respond to the request for additional information.

Payment of Benefits

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

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

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

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

Any such payment to a provider:

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

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

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

How to file an appeal for medical benefits with UnitedHealthcare, if your initial claim is denied

If your claim is denied, you or your authorized representative will have 180 days following receipt of the denial to appeal the decision directly to UnitedHealthcare. You may submit written comments, documents, records and other information relative to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that UnitedHealthcare provide you, free of charge, copies of all documents, records and other information relevant to the claim. Any review and notice issued by UnitedHealthcare will be completed in accordance with by Section 503 of ERISA.

- Urgent Care Claims
  - You will receive notice from UnitedHealthcare of its decision on your first appeal no later than 72 hours after UnitedHealthcare receives your request for review.
  - There is no second level of appeal for urgent care claims.
  - You may make a voluntary request for external review to an independent outside party if your claim involves a clinical appeal or a rescission of coverage. Please contact UnitedHealthcare for further information if you wish to have your claim reviewed by an independent outside party. If you make a voluntary request for external review, you will receive notice of the decision no later than 72 hours after the independent review organization's receipt of your request for an external review.
  - Your external review will be conducted in compliance with the applicable claims procedure regulations as required by Section 503 of ERISA.
- Pre-Service/Concurrent Claims
  - You will receive notice from UnitedHealthcare of its decision on your first appeal within 15 days after UnitedHealthcare receives your request.

- You may make a second level appeal to UnitedHealthcare directly or, if your claim involves a clinical appeal or a rescission of coverage, to an independent outside party. Please contact UnitedHealthcare for further information if you wish to have your second level appeal reviewed by an independent outside party. If you make a second level appeal to UnitedHealthcare, you will receive notice from UnitedHealthcare of its decision within 30 days after UnitedHealthcare receives your request for a second level appeal.
- If you or your authorized representatives make a second level appeal to UnitedHealthcare and your appeal is denied, you may still request an external review by an independent outside party. Your external review will be conducted in compliance with the applicable claims procedure regulations as required by Section 503 of ERISA.

- Post-Service Claims
  - You will receive notice from UnitedHealthcare of its decision on your first appeal within 30 days after UnitedHealthcare receives your request.
  - You may make your second level appeal to UnitedHealthcare only. Once you make a second level appeal to UnitedHealthcare, you will receive notice from UnitedHealthcare of its decision within 30 days after UnitedHealthcare receives your request for a second level appeal.
  - If the second level appeal of your Post-Service Claim is denied by UnitedHealthcare, you may request an external review of the claim by an independent outside party if it involves a clinical appeal or a rescission of coverage. Your external review will be conducted in compliance with the applicable claims procedure regulations as required by Section 503 of ERISA.

Any appeal filed with UnitedHealthcare should be sent to the following address:

National Appeals:
UnitedHealthcare Appeals
National Appeals Center
ASO
P.O. Box 30432
Salt Lake City, UT 84130-0432

Required Time Periods for Review of Clinical Appeals

A Clinical Appeal requires health care professional interpretation to determine the status of the Claim:

Type of Appeal	First Level Appeal with UnitedHealthcare	Second Level Appeal with UnitedHealthcare	External Review	Roche Review (Final Appeal)
Urgent	72 hours to resolve*	Unavailable, due to urgency of claim	Voluntary Request	Voluntary Request
Pre-Service/ Concurrent	15 days to resolve*	30 days to resolve*	Voluntary Request	Voluntary Request
Post-Service	30 days to resolve*	30 days to resolve*	Voluntary Request	Voluntary Request

Required Time Periods for Review of Administrative Appeals

An Administrative Appeal requires review of the Plan and internal reimbursement policies to determine the status of the Claim:

Type of Appeal	First Level Appeal with UnitedHealthcare	Second Level Appeal with UnitedHealthcare	External Review	Roche Review (Final Appeal)
Urgent	72 hours to resolve*	Unavailable, due to urgency of claim	Unavailable	Voluntary Request
Pre-Service/ Concurrent	15 days to resolve*	30 days to resolve*	Unavailable	Voluntary Request
Post-Service	30 days to resolve*	30 days to resolve*	Unavailable	Voluntary Request

*** Mandatory -** Appeals level is mandatory and must be processed before you may bring your Claim to the next level of appeal.

How to file an appeal for prescription benefits with OptumRx, if your initial claim is denied

If you are a Participant in the prescription drug plan through OptumRx, you have the right to appeal a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a request for a prescription benefit. You may appeal denials based on either clinical or non-clinical determinations. Clinical determinations are based on medical criteria and determinations, while non-clinical determinations relate to eligibility determinations, Copay issues, and explicit exclusions under the Plan.

You may appeal your Adverse Benefit Determination in writing to OptumRx within 180 days following receipt of the denial. You may submit written comments, documents, records and other information relative to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that OptumRx provide you, free of charge, copies of all documents, records and other information relevant to the claim. Any review and notice issued will be completed in accordance with Section 503 of ERISA.

- Urgent Care Claims
  - If you have an Urgent Care Claim, you or your attending physician can appeal the determination by faxing your request to 801-994-1058 or calling OptumRx at the number on the back of your ID card
  - You will receive notice from OptumRx of its decision on review no later than 72 hours after OptumRx receives your request for review.
  - Any review and notice issued by OptumRx will be completed in accordance with by Section 503 of ERISA.
  - You may make a voluntary request for external review by an independent outside party if your claim involves a clinical appeal or a rescission of coverage. Please contact OptumRx for further information if you wish to have your claim reviewed by an independent outside party. If you make a voluntary request for external review, you will receive notice of the decision no later than 72 hours after the independent review organization's receipt of your request for an external review.
- Pre-Service Claims
  - You will receive notice from OptumRx of its decision on review of your first appeal within 15 days after OptumRx receives your request.

- If your appeal is denied, you will have 180 days following receipt of the denial to request a second level appeal. You will receive notice of the decision on your second level appeal within 15 days after OptumRx receives your request.
- If your claim involves a clinical appeal or a rescission of coverage, you may make a voluntary request for external review by an independent outside party. Please contact OptumRx for further information if you wish to have your claim reviewed by an independent outside party.

- Post-Service Claims
  - You will receive notice from OptumRx of its decision on review of your first appeal within 15 days after OptumRx receives your request.
  - If your appeal is denied, you will have 180 days following receipt of the denial to request a second level appeal. You will receive notice of the decision on your second level appeal within 60 days after OptumRx receives your request.
  - If your claim involves a clinical appeal or a rescission of coverage, you may make a voluntary request for external review by an independent outside party. Please contact OptumRx for further information if you wish to have your claim reviewed by an independent outside party.

Any appeal and supporting documentation should be mailed to OptumRx to the following address:

National Appeals:

UnitedHealthcare Appeals
National Appeals Center

ASO

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

Your physician may submit an appeal for an Urgent Care Claim by calling the physician-only toll-free number: (866) 442-1183.

How to apply for Prior Authorization with OptumRx

Certain medications require the patient to have their prescriber contact OptumRx for prior authorization before coverage by the Plan will be allowed. To begin the prior authorization process, you can:

- Let your doctor know that a prior authorization is required for your medication.
- Call UnitedHealthcare at the toll free number on your ID card.

How to file an appeal for Brand Copay Reconsideration with OptumRx

You can request a benefit reconsideration of the brand Copay in situations where your prescribing physician provides a well-documented and established medical reason for a brand-name drug to be prescribed when there is a generic alternative. There will be a strong presumption in each case that the generic drug involved is equivalent to a brand name drug and is, therefore, an appropriate treatment. However, if the benefit reconsideration is approved, you will pay the brand name Copay only.

The Brand Co-pay Benefit Reconsideration Process can be found on **www.myUHC.com**. To begin the prior authorization process you can:

- Let your doctor know that a prior authorization is required for your medication.

- Call UnitedHealthcare at the toll free number on your ID card.

Here is a summary of the process:

- The prescribing physician must complete the Brand Co-pay prior authorization through OptumRx
- The OptumRx review timeframe is within 14 days; however, once the request has been submitted and received, it may take only up to 24 hours to process, especially if your physician submits the request electronically. If your prior authorization request needs additional review, it may take longer. . Determination letters will be sent to both you and the prescribing physician.
- There are two benefit reconsideration levels with OptumRx.

The first level can be pre- or post-fill.

A second level reconsideration is available if the first level was denied and if a prescribing physician can provide additional information in support of clinical justification for the medical need for the brand name drug. The second level reconsideration must be submitted to OptumRx within 180 days of the date of the initial reconsideration denial letter.

How to file a Claim that does not involve a request for benefits reimbursement (eligibility claim)

You or your authorized representative may file any other claims under the Plan which are not urgent or pre-service claims and which do not involve a request for benefits reimbursement within one year after the date the claim arises. Roche has directed Alight's Claims and Appeals Management (CAM) to review claims concerning enrollment and eligibility for the Plan. CAM will notify you of the decision not later than 30 days after receipt of the claim. This time period may be extended up to an additional 15 days due to circumstances outside CAM's control. In that case, you will be notified of the extension before the end of the initial period. If the extension is necessary because you have not submitted sufficient information, 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. When CAM requests additional information, the 30 day review period pauses. Once the information is returned, the 30 day review period starts again. For example, if CAM requests additional information on day 10 after the claim was received, the CAM timing pauses until the information is returned (within the 45 day period provided). Once the requested information is returned the CAM clock starts again, giving CAM 20 days (in this example) to complete the claim. If you do not provide any additional information, your claim will be decided based on the original information provided.

If your claim is denied by CAM, you or your authorized representative will have 180 days following receipt of the denial to appeal the decision directly to the U.S. Roche Benefits Appeals Committee (the "Committee"). You may submit written comments, documents, records and other information relative to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim, to the address listed below. You may also request that the Committee provide you, free of charge, copies of all documents, records and other information relevant to the claim. You will be notified of the Committee's decision not later than 60 days after the appeal is received.

To file an eligibility claim, you or your Authorized Representative must send a written notice via:

Fax:

1-224-.333-2333
Attention: Roche Claims and Appeals Management

Mail:

Roche Claims and Appeals Management
Dept 03406
P.O. Box 1407
Lincolnshire, IL 60069-1407

How to File a Proof of Eligibile Dependent Claim

Roche has directed Alight's Dependent Verification Service (DVS) to verify if dependents are Eligible Dependents, as defined by the Plan. If it is determined by DVS that your dependent is not an Eligible Dependent, you or your Authorized Representative may file a Claim to DVS Claims and Appeals Management (CAM) within 120 days of the denial. DVS CAM will notify you of the decision no later than 30 days after receipt of the claim.

To file a claim to DVS CAM, you or your Authorized Representative must send a written notice via:

Claims and Appeals Management (DVS)
P.O. Box 1434
Lincolnshire, IL 60069-1434
CAM Fax: 855-769-5781

How to file a voluntary appeal with U.S. Roche Benefits

The PPO options of the Plan have a voluntary appeal process or certain denials of claims. Prior to proceeding with any voluntary appeal, you must first pursue all applicable appeals with UnitedHealthcare or OptumRx. If you still disagree with the determination made by UnitedHealthcare or OptumRx after all such appeals are completed, you or your authorized representative will have 180 days following receipt of the denial to file a voluntary appeal with the U.S. Roche Benefits Appeals Committee (the "Committee").

To file a voluntary appeal, you must address and send a written notice of appeal to:

U.S. Roche Benefits Appeals Committee
Dept 03406
P.O. Box 1407
Lincolnshire, IL 60069-1407

Your notice must include any written comments to the Committee, any information, documents and/or records that you believe to be relevant to the appeal, and all correspondence between yourself and UnitedHealthcare or OptumRx, including a copy of your original claim and all Explanations of Benefits. The Committee must receive this appeal and supporting materials within 180 days of the date on which you received notice of the final Adverse Benefit Determination (i.e., the final denial of your last mandatory appeal) from UnitedHealthcare or OptumRx.

If you or your authorized representative decides to pursue a voluntary appeal, you or your authorized representative should know that:

- A decision to participate in this voluntary appeal process will have no effect on your rights to any other benefits under the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan.
- You do not have to elect this voluntary appeal process. You may, instead, elect to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).
- The Plan will not assert a failure to exhaust administrative remedies if you elect to pursue a claim in court rather than through the voluntary level of appeal.

- The Plan agrees that any statute of limitations applicable to pursuing your claim in court will be suspended during the period of the voluntary appeal process.
- No fees or costs will be imposed on you or your authorized representative as part of the voluntary appeal process.
- The Company reserves the right to verify that you have asked an authorized representative to pursue a voluntary appeal on your behalf.

Once you file a voluntary appeal with the Committee, the Committee will consider your claim. You will receive a written notice regarding the Committee's decision within 90 days of the Committee's receipt of your appeal, unless special circumstances require an extension of time for reviewing, in which case written notice of such extension will be furnished to you before the expiration of the initial 90-day period. If you are not furnished a notice within the 90-day period, your claim will be considered denied.

If the Committee denies all or part of your appeal, you or your authorized representative will be notified in writing. This notice will include:

- Specific reasons why the claim was denied;
- Specific references to applicable provisions of the Plan document(s) on which denial is based;
- The identification of any internal guideline(s), protocol(s), and/or other criteria upon which the Committee's decision was based; and
- Whether the Committee obtained advice from any medical or vocational expert in connection with the voluntary review process.

Upon request, you or your representative shall be provided (free of charge) reasonable access to and copies of all Committee documents, records and other information relevant to your claim and any internal guideline(s), protocol(s) and/or other criteria upon which the Committee's decision was based.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

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

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

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

UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling the telephone number on your ID card.

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

Health Maintenance Organization (HMO) Option

The Kaiser Permanente ("Kaiser") options are available to residents of California, Oregon and Washington only whose home address is in the Kaiser HMO service area, and include two choices:

- the Kaiser HMO, and
- the Kaiser HMO Choice with a Health Savings Account (HSA)

Each HMO option provides coverage only when you use providers who contract with Kaiser HMO. HMOs provide members with diagnostic, surgical, hospital care, prescription drugs and certain preventive services from network providers only. Emergency care is covered for emergency medical conditions from non-Kaiser HMO providers anywhere in the world while out of the service area, state and /or country. Please note that you must have the facility coordinate benefits with Kaiser Member Services and/or process a claims reimbursement form should you have to pay out of pocket. Please keep all receipts and an itemized list of services rendered. Health Plan coverage for out-of-plan emergency care includes the services of a Mobile Crisis Unit and First Responders. If a member receives out-of-plan emergency care, or services of a Mo

bile Crisis Unit or First Responder services, the provider may agree to bill for the services or may require that the member pay for the services at that time. In either case, to request payment or reimbursement from Kaiser, the member must file a claim. Please note: When the member is traveling outside of the United States, the member will be required to pay for the emergency care and then file a claim with Kaiser to seek reimbursement. We will reduce any payment we make to a non-plan or reimbursement to the member by the applicable deductible, copayments, or coinsurance, which are the same ones required for services provided by a Kaiser HMO provider.

As a member, you may obtain a copy of the Evidence of Coverage ("**EOC**") at no cost to you by contacting Kaiser's Member Services at the number on your ID Card. The EOC you receive directly from Kaiser along with this SPD serve as your summary of the plan.

PROVIDER NETWORKS

Kaiser has its own Medical Groups, and the physicians in those groups are employees of the Group. Refer to Kaiser's on-line provider directory at http://www.kaiserpermanente.org/ (this can be viewed on "Choose Your Doctor") for the most current list of providers who participate in the HMO. If you do not have internet access, you may contact Member Services at the number on your ID card for a listing.

The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directory will be accepting new patients. The status of a provider's practice may change. For the most current information, please contact the selected physician or Member Services at the toll-free number on your ID card.

If covered services are not available within Kaiser's network you may have the right to a referral to a specialist or provider outside Kaiser's network of physicians or providers. Please contact Kaiser for more information about referrals.

Choosing a Provider

As a Kaiser member you must choose a PCP for yourself and each enrolled dependent and use Participating Providers and facilities for all heath care services. You and your dependents may each have a different PCP. Generally, health care received outside the network or without a referral from the PCP is not covered, except in Emergency or Urgent care situations. For further details regarding Kaiser's networks and certification requirements please refer to your Evidence of Coverage (EOC). You can choose a PCP from any Kaiser Permanente facility, however, if you do not select one, Kaiser Permanente will assign a physician based on where you live.

COVERED EXPENSES

The following charts outline the Deductible, Coinsurance, out-of-pocket maximum and other coverage provisions for Covered Expenses under the Kaiser HMO and Kaiser HMO Choice options. These summaries are meant to be a brief descriptions of covered Benefits; for a full description of covered services, exclusions, terms and conditions of coverage please refer to Kaiser's Evidence of Coverage (EOC) for each option. Copays, covered expenses, certification requirements, exclusions, and other coverage rules and plan provisions are governed by Kaiser and may not be the same as the provisions described in this SPD for other Medical and Prescription Plan options.

2023 Kaiser California[1] HMO

Medical plan

	In-network Only
Calendar year deductible	
Individual	No deductible
Family	
Calendar year out-of-pocket maximum *(includes combined medical and prescription deductibles, co-insurance, and co-pays)*	
Individual	$1,500
Family	$3,000
Preventive care	100%, no deductible
Well-baby care *(including immunizations)*	100%, no co-pay
Routine annual physical exam *(age 4 and over)*	
Annual OB/GYN exams *(including Pap smears)*	
Mammograms	
Colonoscopies	
Office or virtual visits	
PCP	100% after $20 co-pay
Specialist	100% after $35 co-pay
Urgent care	100% after $20 co-pay
Emergency Room	
Emergency	100% after $150 co-pay; waived if admitted
Ambulance	
True emergency/medically necessary	100% after $50 co-pay
Non-emergency/not medically necessary	Pre-approval required

2023 Kaiser California HMO

	In-network Only
Hospital	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	$200 per admission
Outpatient	100% after $50 co-pay
Doctor visits	$100 after $20 co-pay (PCP) or $35 co-pay (specialist)
Surgery	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	$200 per admission
Outpatient	100% after $50 co-pay
X-ray/lab	100%, no co-pay
Infertility treatments[2]	
Inpatient	$200 per admission
Outpatient	100% after $50 co-pay
Office visits	100% after $20 co-pay (PCP) or $35 co-pay (Specialist)
Lifetime maximum	2 cycles
Mental health	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	$200 per admission
Outpatient or virtual visits	100% after $20 co-pay for individual therapy; $10 co-pay for group therapy
Substance abuse	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	$200 per admission
Outpatient	100% after $20 co-pay for individual therapy; $5 co-pay for group therapy
Transitional residential recovery services	$100 per admission
Other medical care	
Physical therapy	100% after $20 co-pay[3]
Chiropractic	100% after $15 co-pay[4] (up to 30 visits per calendar year)
Acupuncture	100% after $20 co-pay[3]
Hearing aids	$1,500 allowance per device[5]

1. Only in California; available if your home ZIP code is in the service area.
2. Subject to Kaiser infertility coverage guidelines.
3. Must be medically necessary and prescribed by a Kaiser physician.
4. Must use American Specialty Health Plans of California, Inc. for services.
5. Limited to two devices every 36 months; limited to one device per ear.

Prescription drug plan[1]

	Kaiser retail pharmacy (up to a 30-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)	Kaiser mail-order pharmacy (up to a 100-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)
Generic	$10 co-pay	$20 co-pay
Brand	$20 co-pay	$40 co-pay

1. Sexual dysfunction drugs have a limit of up to 8 doses per month.

2023 Kaiser California[1] HMO Choice

Medical plan

	In-network Only
Calendar year deductible *(includes combined medical and prescription expenses)*	
Employee only	$1,500
Employee + eligible adult, employee + children, or family	$3,000
Calendar year out-of-pocket maximum *(includes combined medical and prescription deductibles, co-insurance, and co-pays)*	
Employee only	$3,000
Employee + eligible adult, employee + children, or family	$6,000
Preventive care	100%, no deductible
Well-baby care *(including immunizations)*	100%, no co-pay
Routine annual physical exam *(age 4 and over)*	
Annual OB/GYN exams *(including Pap smears)*	
Mammograms	
Colonoscopies	
Office or virtual visits	
PCP	100% after deductible
Specialist	100% after deductible
Urgent care	100% after deductible
Emergency Room	
Emergency	90% after deductible
Ambulance	
True emergency/medically necessary	90% after deductible
Non-emergency/not medically necessary	Pre-approval required

2023 Kaiser California HMO Choice

	In-network Only
Hospital	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient semi-private room	90% after deductible
Outpatient services	90% after deductible
Doctor visits	100% after deductible
Surgery	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	90% after deductible
Outpatient	90% after deductible
X-ray/lab	90% after deductible
Infertility treatments[2]	
Inpatient	90% after deductible
Outpatient	90% after deductible
Office visits	100% after deductible
Lifetime maximum	2 cycles
Mental health	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	90% after deductible
Outpatient or virtual visits	100% after deductible
Substance abuse	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	90% after deductible
Outpatient	100% after deductible
Transitional residential recovery services	90% after deductible
Other medical care	
Chiropractic	$15 co-pay[4] after deductible (up to 30 visits per calendar year)
Acupuncture	100% after deductible3
Hearing aids	Not covered
Physical therapy	100% after deductible[3]

1. Only in California; available if your home ZIP code is in the service area.
2. Subject to Kaiser infertility coverage guidelines.
3. Must be medically necessary and prescribed by a Kaiser physician.
4. Must use American Specialty Health Plans of California, Inc. for services.

Prescription drug plan[1]

	Kaiser retail pharmacy (up to a 30-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)	Kaiser mail-order pharmacy (up to a 100-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)
Generic	$10 co-pay after deductible	$20 co-pay after deductible
Brand	$20 co-pay after deductible	$40 co-pay after deductible

1. Sexual dysfunction drugs have a limit of up to 8 doses per month.

2023 Kaiser Northwest[1] HMO

Medical plan

	In-network Only
Calendar year deductible *(includes combined medical and prescription expenses)*	
Individual	No deductible
Family	
Calendar year out-of-pocket maximum *(includes combined medical and prescription deductibles, co-insurance, and co-pays)*	
Individual	$1,500
Family	$3,000
Preventive care	100%, no deductible
Well-baby care *(including immunizations)*	100%, no co-pay
Routine annual physical exam *(age 4 and over)*	
Annual OB/GYN exams *(including Pap smears)*	
Mammograms	
Colonoscopies	
Office or virtual visits	
PCP	100% after $20 co-pay
Specialist	
Urgent care	100% after $40 co-pay
Emergency Room	
Emergency	100% after $150 co-pay; waived if admitted
Ambulance	
True emergency/medically necessary	100% after $75 co-pay
Non-emergency/not medically necessary	Pre-approval required
Hospital	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient semi-private room	$200 per admission
Outpatient services	100% after $50 co-pay
Doctor visits	100% after $20 co-pay

	In-network Only
Surgery	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	$200 per admission
Outpatient	100% after $50 co-pay
X-ray/lab	100%, no co-pay
Infertility treatments[2]	
Inpatient	90%, no co-pay
Office visits and outpatient imaging/lab	100%, no co-pay
Lifetime maximum	$30,000
Prescription Drugs for infertility	10% coinsurance
Mental health	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	$200 per admission
Outpatient or virtual visits	100% after $20 co-pay for individual therapy; $10 co-pay for group therapy
Substance abuse	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	$200 per admission
Outpatient	100% after $20 co-pay for individual therapy; $10 co-pay for group therapy
Transitional residential recovery services	$200 per admission

	In-network Only
Other medical care	
Physical therapy	100% after $20 co-pay[3]
Chiropractic	100% after $20 co-pay[4] (up to 15 visits per calendar year)
Acupuncture	100% after $20 co-pay[3] (up to 12 visits per calendar year)
Hearing aids	$1,500 allowance per device[5]

1. Only in some areas of Washington and Oregon; available if your home ZIP code is in the service area.
2. Cross-accumulated across INFL, INFO, and INFT, including GIFT, ZIFT, and IVF. Coverage is subject to Kaiser infertility coverage guidelines.
3. Must be medically necessary and prescribed by a Kaiser physician.
4. Must use CHP Group (**chpgroup.com**) for services.
5. Limited to two devices every 36 months; limited to one device per ear.

Prescription drug plan[1]

	Kaiser retail pharmacy (up to a 30-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)	Kaiser mail-order pharmacy (up to a 90-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)
Generic	$10 co-pay	$20 co-pay
Brand	$20 co-pay	$40 co-pay

1. Sexual dysfunction drugs have a limit of up to 8 doses per month.

2023 Kaiser Northwest[1] HMO Choice

Medical plan

	In-network Only
Calendar year deductible *(includes combined medical and prescription expenses)*	
Employee only	$1,500
Employee + eligible adult, employee + children, or family	$3,000
Calendar year out-of-pocket maximum *(includes combined medical and prescription deductibles, co-insurance, and co-pays)*	
Employee only	$3,000
Employee + eligible adult, employee + children, or family	$6,000
Preventive care	100%, no deductible
Well-baby care *(including immunizations)*	100%, no co-pay
Routine annual physical exam *(age 4 and over)*	
Annual OB/GYN exams *(including Pap smears)*	
Mammograms	
Colonoscopies	
Office or virtual visits	
PCP	100% after deductible
Specialist	
Urgent care	90% after deductible
Emergency Room	
Emergency	90% after deductible
Ambulance	
True emergency/medically necessary	90% after deductible
Non-emergency/not medically necessary	Pre-approval required
Hospital	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient semi-private room	90% after deductible
Outpatient services	90% after deductible
Doctor visits	100% after deductible

2023 Kaiser Northwest HMO Choice

	In-network Only
Surgery	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	90% after deductible
Outpatient	90% after deductible
X-ray/lab	90% after deductible
Infertility treatments[2]	
Inpatient	90% after deductible
Outpatient	90% after deductible
Office visits	100% after deductible
Infertility Medications	10% coinsurance after deductible
Lifetime maximum	$30,000
Mental health	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	90% after deductible
Outpatient or virtual visits	100% after deductible
Substance abuse	
Inpatient precertification	Precertification coordinated by Kaiser
Inpatient	90% after deductible
Outpatient	100% after deductible
Transitional residential recovery services	90% after deductible
Other Medical Care	
Physical Therapy	100% after deductible[3]
Chiropractic	$20 co-pay[4] after deductible (up to 15 visits per calendar year)
Acupuncture	100%[3] after deductible (up to 12 visits per calendar year)
Hearing aids	$1,500 allowance per device after deductible[5]

1. Only in some areas of Washington and Oregon; available if your home ZIP code is in the service area.
2. Cross-accumulated across INFL, INFO, and INFT, including GIFT, ZIFT, and IVF. Coverage is subject to Kaiser infertility coverage guidelines.
3. Must be medically necessary and prescribed by a Kaiser physician.
4. Must use CHP Group (**chpgroup.com**) for services.
5. Limited to two devices every 36 months; limited to one device per ear.

Prescription drug plan[1]

	Kaiser retail pharmacy (up to a 30-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)	Kaiser mail-order pharmacy (up to a 90-day supply obtained from a Kaiser pharmacy and subject to formulary guidelines)
Generic	$10 co-pay after deductible	$20 co-pay after deductible
Brand	$20 co-pay after deductible	$40 co-pay after deductible

1. Sexual dysfunction drugs have a limit of up to 8 doses per month.

APPLIED BEHAVIORAL ANALYSIS (ABA) THERAPY

Kaiser covers ABA services. Please call Kaiser Customer Service at (800) 464-4000 (select Option 4, Member Services) for details on coverage, benefits and providers. You must work with your Kaiser pediatrician or primary doctor to obtain diagnostic and assessment services, and to receive a referral for ABA treatment.

WHAT THE KAISER HMO OPTIONS DO NOT COVER

Items excluded from coverage under the Kaiser HMO options include, but are not limited to the items listed below. To the extent that these exclusions do not match the exclusions found in the Kaiser Evidence of Coverage (EOC), the EOC will govern. You should always check with Kaiser, the Kaiser HMO's Claims Administrator, to determine whether or not a service is covered.

- Physical examinations and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Kaiser physician determines that the services are Medically Necessary.
- Chiropractic Services and the services of a chiropractor except for manual manipulation of the spine as described under "Outpatient Care" in the "Benefits and Cost Sharing" section of the EOC.
- Cosmetic Services: services that are intended primarily to change or maintain your appearance, except for services covered under reconstructive surgery and the following prosthetic devices:
  - prostheses needed after a mastectomy, and
  - prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.
- Custodial care: the assistance with activities of daily living (e.g., walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to hospice care services or other related services.
- Dental care and dental X-rays, including:
  - services following accidental injury to teeth,
  - dental appliances,
  - dental implants,
  - orthodontia, and
  - dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment, except for services covered in accord with Medicare guidelines or that are otherwise covered by Kaiser.
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion does not apply to disposable supplies covered in accord with Medicare guidelines or that are otherwise covered by Kaiser.

- Experimental or investigational services: a service is experimental or investigational if Kaiser determines that one of the following is true:
  - generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
  - it requires government approval that has not been obtained when the Service is to be provided.
- Eye surgery: services related to eye surgery or orthokeratologic; services for the purpose of correcting refractive defects, such as myopia, hyperopia, or astigmatism.
- Fertility services: except for artificial insemination coverage and other procedures that qualify as Infertility Treatment, all other services related to conception by artificial means, including:
  - ovum transplants,
  - semen and eggs (and services related to their procurement and storage), and
  - services to reverse voluntary, surgically induced infertility
- Hair loss or growth treatment: services for the promotion, prevention, or other treatment of hair loss or hair growth.
- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid. This exclusion does not apply to cochlear implants and osseointegrated hearing devices covered by Kaiser.
- Care in a licensed intermediate care facility. This exclusion does not apply to services covered that are otherwise covered by Kaiser.
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food. This exclusion does not apply to any of the following:
  - amino acid–modified products and elemental dietary enteral formula covered that are otherwise covered by Kaiser, or
  - enteral formula covered by Kaiser.
- Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a skilled nursing facility, inpatient respite care covered for certain Members, a licensed facility providing crisis residential services covered by Kaiser, or a licensed facility providing transitional residential recovery services covered by Kaiser.
- Routine foot care, except for Medically Necessary services covered in accord with Medicare guidelines or as otherwise covered by Kaiser.
- Services not approved by the federal Food and Drug Administration, including: drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S., unless the services are covered by Kaiser.
- Services that are not reasonable and necessary, according to the standards of the Original Medicare plan, unless these services are otherwise listed.
- When a service is not covered, all services related to the non-covered service are excluded, except for services we would otherwise cover to treat complications of the non-covered service or if covered in accord with Medicare guidelines.

- Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered services provided to a Member who is a surrogate.
- Travel and lodging expenses, except in certain situations.

There may be other excluded items. Contact Kaiser to determine whether a specific service is covered under the Kaiser HMO options.

HMO CLAIMS PROCEDURES

The Kaiser HMO handles claims for Benefits directly and exclusively. Kaiser makes all claims determinations. Claims procedures can be found in the EOC and for specific questions, or to obtain a complete copy of the claims and appeal procedures for Kaiser, contact the Member Service Center at the number listed on your ID card.

How to file a Claim Appeal for medical benefits under the Kaiser HMO Options

Kaiser has specific appeal requirements and timeframes, so it is important to contact Kaiser directly. Information on the Kaiser claim appeal procedures will also be found in the Traditional Plan EOC.

The claims procedures of Kaiser will govern your claim and appeal; provided that such claim and appeal process complies with the claim procedure regulations as required by section 503 of ERISA.

How to file a Claim Appeal for medical benefits under the Kaiser HMO Options for claims incurred outside of the United States

If you or your Eligible Dependents use a hospital or provider outside of the United States due to a medical emergency while in a foreign country, Kaiser will treat the claim as in-network. However, if you or your Eligible Dependents use a hospital or provider outside of the United States for any non-emergency care while in a foreign country, the claim will be treated as out-of-network. See How to file a Claim Appeal that does not involve a request for benefits reimbursement for procedures on filing your claim.

How to file a Claim Appeal that does not involve a request for benefits reimbursement

You or your authorized representative may file any other claims under the Plan which do not involve a request for Benefits reimbursement with the Claims Administrator within six (6) months for claims incurred inside of your home state (i.e., California, Oregon or Washington, as applicable) and twelve (12) months for claims incurred outside of your home state (i.e., California, Oregon or Washington, as applicable) or the United States after the date the claim arises. The Claims Administrator will notify you of the decision not later than 30 days after receipt of the claim. This time period may be extended up to an additional 15 days due to circumstances outside the Claim Administrator's control. In that case, you will be notified of the extension before the end of the initial period. If the extension is necessary because you have not submitted sufficient information, 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.

If your claim is denied in whole or in part, you will be notified in writing. The notice of denial will include:

- specific reasons why the claim was denied;
- specific references to applicable provisions of the Medical and Prescription Plan document(s) on which denial is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the plan's review procedures and the time limits applicable, including a statement of the claimant's rights to bring a civil action; and
- the identification of any internal guideline(s), protocol(s) and/or other criteria upon which the decision was based.

How to file a Claim Appeal that does not involve a request for benefits reimbursement

If your claim is denied by the Claims Administrator, you or your authorized representative will have 180 days following receipt of the denial to appeal the decision directly to the Appeals Administrator. You may submit written comments, documents, records and other information relative to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Appeals Administrator provide you, free of charge, copies of all documents, records and other information relevant to the claim.

You will be notified of the Appeal Administrator decision not later than 60 days after the appeal is received.

HOW TO OBTAIN PRESCRIPTION BENEFITS UNDER THE KAISER HMO OPTIONS

Kaiser HMO prescription drugs must be obtained from a Kaiser pharmacy and are subject to formulary guidelines. In order to obtain more information please refer to the Evidence of Coverage (EOC) you received from Kaiser or contact Kaiser's Member Services at the number on your ID card.

PRESCRIPTION EXPENSES THAT ARE NOT COVERED UNDER THE KAISER HMO OPTIONS

Certain items will not be covered under the Kaiser HMO options if all of the following are not satisfied:

- The prescription must be prescribed by a plan physician, or by a dentist or non-plan physician under certain limited circumstances;
- The item must meet the requirements of Kaiser's drug formulary guidelines; and
- The item must be obtained from a Kaiser pharmacy or through the Kaiser mail order program.

Items excluded from coverage under the Kaiser HMO options include, but are not limited to the items listed below.

To the extent that these exclusions do not match the exclusions found in the EOC, the EOC will govern. You should always check with Kaiser, the Kaiser HMO's Claims Administrator, to determine whether or not a service is covered.

- All drugs obtained without a valid prescription.
- Drugs used to promote fertility.
- Drugs used for symptomatic relief of cough or colds.
- Drugs used for cosmetic purposes or to promote hair growth.

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs such as Viagra, Cialis, Levitra, and Caverject when used for the treatment of sexual or erectile dysfunction.
- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
- Barbiturates and Benzodiazepines

The Dental Coverage Options

Within the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, eligible Participants are given a choice of two dental coverage options, administered by Delta Dental of California ("Delta"):

- Basic Dental Option
- Premier Dental Option

USING IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS

If you enroll in a Dental coverage option, you may choose between having dental care provided by either "in-network" or "out-of-network" providers or facilities. The Dental coverage reimburses Covered Expenses for services provided by all licensed dentists. However, your cost will be lower if you use in-network providers. In-network providers are dentists who have agreed to accept a discounted fee schedule for services rendered by participating in one of the two networks available under the Dental coverage:

Delta Dental Premier network—Available in all states for both dental options; charges are based on a fee structure agreed to in advance between participating dentists and Delta Dental.

Delta Dental PPO network — Available in most states for both dental options; offer a greater discount than the Delta Dental Premier network.

ADVANTAGES OF USING IN-NETWORK PROVIDERS

Although your Deductible and Coinsurance Amount levels are the same whether you use in-network or out-of-network providers, your actual Coinsurance Amount will be lower when in-network providers are used because it is based on the discounted fee. In addition, in-network providers' fees never exceed the R&C Fee. When out-of-network providers are used, you may be responsible for the portion of the dentist's fees that exceeds R&C Fees.

If a dentist participates in more than one of the networks described above, the dentist's fee will automatically reflect the fee that provides the deepest discount of the networks in which the dentist participates.

HOW TO FIND AN IN-NETWORK PROVIDER

The Dental coverage is administered by Delta Dental of California regardless of where you live. To find out if your dentist participates in one of the Dental coverage's networks or if there is an in-network dentist in your area, call Delta Dental directly at 1-800-765-6003 or visit Delta's website at https://www1.deltadentalins.com/group-sites/roche.html.

UNDERSTANDING DENTAL COVERAGE TERMS

You will see certain terms used throughout this section. These terms are defined below. It is important that you are familiar with their meanings:

Coinsurance Amount is the percentage of Covered Expenses paid by either you or the Company. For example, if a service is covered at 80% of the negotiated rate, your Coinsurance Amount will be the other 20% of the negotiated rate not covered by the Dental coverage (assuming you have satisfied any required Deductible).

Covered Expenses or Eligible Charges are those expenses or charges which are eligible for reimbursement. Covered Expenses may be subject to applicable Deductibles, Coinsurance Amounts, and specified maximums. In order to be eligible for coverage, all eligible charges must be dentally necessary

Deductible is the amount of money you pay before the Dental coverage begins to pay Benefits for certain Covered Expenses. Once the Deductible has been paid, the Dental coverage pays its Benefit percentage and you pay the Coinsurance Amount.

Dentally Necessary means necessary treatment required as defined in the Plan.

Family Deductible is the maximum amount at least two family members pay toward the Deductible. If at least two family members' Deductibles add up to the Family Deductible in a given calendar year, then the individual Deductibles for the family will be considered satisfied for that calendar year. After any Eligible Dependent within your family satisfies their individual Deductible, the Dental coverage will begin making payments for that person's Covered Expenses. Therefore, the most any one family member can contribute toward the Family Deductible is the amount of their individual Deductible.

Member means a person who is covered by the Dental coverage.

Qualified Medical Child Support Order (QMCSO) means a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under the state law that creates or recognizes the right of a covered Employee's child to receive Benefits for which the covered Employee is entitled under the Dental coverage and which is determined by the Company to meet the requirements of a qualified medical child support order under Section 609 of ERISA and satisfies the following requirements:

1. the order specifies your name and last known address and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the time period and each applicable plan to which it applies.

The QMCSO may not require the Dental coverage to provide coverage for any type or form of Benefit or option not otherwise provided under the Dental coverage. You must provide the Company with a copy of the QMCSO.

Reasonable and Customary (R&C) Fee means for any single procedure the "Usual, Customary, and Reasonable Fee" that a dentist has filed with Delta and which Delta has accepted. For purposes of the definition, the following terms have the following definitions:

1. "***Usual***" means the amount which a dentist regularly charges and receives for a given service. If the dentist charges more than one fee for a given service, the "***Usual***" fee for that service is the lowest fee which the dentist regularly charges or offers to Participants.
2. "***Customary***" means the fee that is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area that Delta determines is statistically relevant.
3. "***Reasonable***" means with respect to a fee schedule, a schedule that is "Usual" and "Customary." Additionally, a specific fee to a specific Participant is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

DEDUCTIBLES

The Dental coverage requires that you and your Eligible Dependents must each satisfy a Deductible each calendar year before Benefits for Basic, and Major Care services are paid. Preventive and Orthodontic services are not subject to the Deductible. Deductibles met during the last quarter of a calendar year (October, November and December), will be credited toward the satisfaction of the next calendar year deductible. It is the member's responsibility to submit documentation to Delta Dental to substantiate that a deductible has been paid.

Annual Dental Coverage Deductibles

	Dental Basic	Dental Premier
Individual	***$100***	***$50***
Family	***$200***	***$100***

Family Deductible – If the Deductibles of at least two covered family members total the Family Deductible in a given calendar year, the Dental coverage will reimburse dental Covered Expenses incurred by any covered family member at the applicable Coinsurance for the remainder of that calendar year.

Family Deductible Example:

Let's say your family of four elects coverage under the Dental Basic network. You and your Spouse each satisfy a $100 individual Deductible. Together, you have satisfied the Family Deductible. This means that your children will not have to satisfy an individual Deductible.

DENTAL COVERAGE MAXIMUMS

The Dental coverage limits the amount that Delta Dental will pay each calendar year to you and your Eligible Dependents for Preventive (if using an in-network provider the annual plan maximum does not apply), Basic, and Major Care. Orthodontia Benefits are not covered under the Dental Basic, and are subject to a lifetime maximum under the Dental Premier.

Annual Dental Coverage Maximum

	Dental Basic	Dental Premier
Individual	***$1,000***	***$2,000***

Lifetime Dental Coverage Maximum (Orthodontia only)

	Dental Basic	*Dental Premier*
Individual	***N/A***	***$2,500 (in-network only)*** ***$2,000 (out-of-network)***

COVERED EXPENSES

The chart on the following page outlines the deductible, Plan maximums, coinsurance and other coverage provisions for Covered Expenses under the Dental Coverage.

2023 Delta Dental

Dental Plan

	Basic		Premier	
	In-network	Out-of-network	In-network	Out-of-network
Annual deductible				
Individual	$100		$50	
Family	$200		$100	
Calendar year plan maximum *(does not apply to in-network preventive care)*				
Individual	$1,000		$2,000	
Preventive care *(no deductible)*				
Routine exams *(2 times per calendar year)* **Bitewing X-rays** *(2 times per calendar year)* **Full mouth X-ray** *(once every 3 years)* **Cleaning & polishing** *(2 times per calendar year)* **Fluoride treatments** *(covers children up to age 15)*	100% of approved fee[3]	100% of Reasonable and Customary (R&C)[1]	100% of approved fee[3]	100% of Reasonable and Customary (R&C)[1]
Basic care *(after deductible)*				
Fillings **Oral surgery** **General anesthesia** **Treatment for gum disease** **Root canal therapy** **Sealants** *(once every 3 years)* **Nightguards** *(once every 2 years)*	80% of approved fee	80% of Reasonable and Customary (R&C)[1]	90% of approved fee	90% of Reasonable and Customary (R&C)[1]
Major care *(after deductible)*				
Inlays **Crowns** **Bridges** **Cast restorations** **Implants** **Removable dentures** **Repair or maintenance for any of the above**	50% of approved fee	50% of Reasonable and Customary (R&C)[1]	70% of approved fee	70% of Reasonable and Customary (R&C)[1]
Orthodontia *(adult and child; no deductible)*				
Orthodontia	Not covered		70% of approved fee	70% of Reasonable and Customary (R&C)[1]
Lifetime maximum[2]	Not covered		$2,500	$2,000

1. Benefits for out-of-network care are based on the Reasonable and Customary (R&C) charge and program allowance for non-Delta Dental dentists. You are responsible for any amount that exceeds R&C. R&C charges are not included in the deductible or calendar year out-of-pocket maximum.
2. Combined orthodontia lifetime maximum: All amounts are added together to apply to both the in-network and out-of-network maximums.
3. In-network preventive care is not subject to the calendar year plan maximum.

LIMITATIONS

Covered Expenses are expenses incurred for necessary dental services of the types specified below, performed or prescribed by a Dentist, subject to the rules in this document. The expenses provided below are covered under the Dental coverage only to the extent they do not exceed the limitations indicated.

Preventive (In-network preventive care is not subject to the calendar year plan maximum):

- Routine Exams — two times per calendar year
- Cleaning and polishing – two times per calendar year
- Exam and cleaning limitations:
  - The Plan will pay for oral examinations (except after hours exams and exams for observation) and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a calendar year.
  - A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided.
  - Note that periodontal cleanings Procedures Codes that include periodontal cleanings and full mouth debridement are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit.
  - If you are pregnant, the Plan may pay for additional services to help improve your oral health during pregnancy. The additional services each calendar year while you are eligible for coverage in this Plan include: one additional oral examination and either one additional routine cleaning or one additional periodontal scaling and root planing per quadrant. Written confirmation of pregnancy must be provided by you or your dentist when the claim is submitted.
  - Caries risk assessments are allowed once in 36 months for covered participants age three (3) to 19.
- X-ray:
  - Full mouth series – once every 36 months
  - Bitewing—two times per calendar year
- X-ray limitations:
  - The Plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  - When a panoramic film is submitted with supplemental film(s), the Plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  - If a panoramic film is taken in conjunction with an intraoral complete series, the panoramic film is considered to be included in the complete series.
  - A complete intraoral series is limited to once every 36 months.
  - Bitewing x-rays are limited to two (2) times in a calendar year. Bitewings of any type are disallowed within 12 months of vertical bitewing procedures unless warranted by special circumstances.
  - Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime only when Orthodontic Services are covered. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

- Fluoride treatment — Topical application of fluoride solutions is limited to Eligible Dependent Children to age 15 and no more than twice in a calendar year.
- Space maintainer limitations:
  - Space maintainers are limited to the initial appliance and are covered for Eligible Dependent Children to age 13.
  - Recementation of space maintainer is limited to once per lifetime.
  - The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- Specialist consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

Basic:

- Fillings:
  - The Plan will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
  - Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- Oral Surgery:
  - Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.
  - The following Oral Surgery procedure is limited to age 19: transseptal fiberotomy/supra crestal fiberotomy, by report.
  - The following Oral Surgery procedures are limited to age 19 provided Orthodontic services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- General Anesthesia
- Treatment for gum disease
- Root Canal Therapy:
  - Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Sealants -covered once every three years. Sealants are limited as follows:
  - to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
  - repair or replacement of a sealant on any tooth within 36 months of its application is included in the fee for the original placement.
- Night Guards - once every 24 months

Major Care:

- Crowns and Inlays/Onlays:
  - When an alternate Benefit of an amalgam is allowed for Inlays/Onlays, they are limited to Members age 12 and older and are covered not more than once in any 60 month period.
  - Limited to Members age 12 and older and are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
  - Core buildup, including any pins, is covered not more than once in any 60 month period.
  - Post and core services are covered not more than once in any 60 month year period.
  - Crown repairs are covered not more than once per tooth in any 6 month period.
- Bridges -- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, benefits will be provided for only the partial denture.
- Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- Cast Restoration
- Implants:
  - Prosthodontic appliances [implants and/or implant supported prosthetics] that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Members age 16 and older. Replacement of a prosthodontic appliance [and/or implant supported prosthesis] not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. [Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Member's lifetime whether provided under Delta Dental or any other dental care plan.]
- Removable Dentures -- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, benefits will be provided for only the partial denture.
- Repair or maintenance for any of the above -- Denture repairs are covered not more than once in any six (6) month period except for fixed denture repairs which are covered not more than twice in any 60 month period.

Orthodontia:

- If extractions, surgery, or other non-related orthodontic treatment is needed while receiving orthodontic treatment, those expenses may be covered under the other parts of the Dental coverage, provided those charges are separately itemized on the claim form.
- Orthodontic Benefits will be provided in two payments after the person becomes covered (the initial payment at the banding date and the second in 12 months); however, for treatment plans of less than $500.00 or when the treatment plan is 12 months or less, one payment will be made.
- Adult and child coverage is provided in the Dental Premier Option only.

HOW ALTERNATE PROCEDURES COULD AFFECT YOUR BENEFITS

Often there are several ways to treat a dental problem, and each method may cost a different amount. In such cases, your Benefit will be based on the covered treatment that costs the least. Regardless of the Dental coverage's payment, you may choose to have the more expensive treatment. However, you may have higher out-of-pocket expenses if you choose the treatment that costs more because the Dental Plan's payment will still be based on the least expensive treatment.

SMILEWAY WELLNESS

Wellness Benefits are available to help improve the oral health of Members with certain Qualifying Medical Conditions.

Qualifying Medical Conditions

Members with one or more of the following Qualifying Medical Conditions will receive Wellness Benefits: cardiovascular (heart) disease; diabetes; cerebrovascular disease (stroke); HIV/AIDS and rheumatoid arthritis.

Wellness Benefit Consists of the Following:

Service	PPO and Premier Providers' Contract Benefit Level	Non-Delta Dental Providers' Contract Benefit Level	Limitations
Routine Cleaning, scaling in presence of moderate or severe gingival inflammation, & Periodontal Maintenance[1]	100% of approved fee	100% of R&C	any combination of four (4) each Calendar Year
Periodontal Scaling & Root Planing	100% of approved fee	100% of R&C	once every Calendar Year per quadrant with no more than two (2) quadrants covered on the same date of service.

[1]If a Member is eligible for a pregnancy benefit and is also eligible for the Wellness Benefit, then Wellness Benefits replace the additional pregnancy benefits, except such Members will be entitled to one additional oral exam each Calendar Year while pregnant provided that written confirmation of the pregnancy is submitted.

All other Benefits, Limitations and Exclusions remain unchanged. Wellness Benefits are subject to applicable Deductibles and Maximums.

Signing up for Wellness Benefits

1. Go to https://www1.deltadentalins.com/group-sites/roche.html
2. Log in to your Online Services account. (If you do not have one, click Register.)
3. Click on the Optional Benefits tab in the left column.

4. Click on Opt In next to the name of the person you want to enroll. You can enroll yourself or a dependent child (adult dependents may enroll for themselves).
5. Complete and submit the form.

WHAT THE DENTAL COVERAGE DOES NOT COVER

Items excluded from coverage under the Dental coverage include but are not limited to:

- Services for injuries covered by Workers' Compensation or Employer's Liability Laws or services which are paid by any federal, state or local government agency, except Medi-Cal benefits.
- Expenses for a work-related illness or injury that entitles you to benefits from Workers' Compensation or Occupational Disease Law. These expenses, however, may be paid by the Workers' Compensation insurance carrier. The Employer's US HR Contact must be contacted in advance of your receiving treatment for work-related illnesses or injuries.
- Services covered by any federal or state or local government agency; or services provided without cost to the covered person by any municipality, county, or political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable Covered Expense.
- Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
- Treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.
- Any single procedure, bridge, denture or other prosthodontic service which was started before you were covered by this program.
- Expenses incurred before this coverage became effective or after coverage ends, even if benefits payable on account of a treatment plan submitted prior to the date coverage ends had been pre-determined.
- Prescribed drugs, premedication or analgesia.
- Experimental procedures.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- Laboratory processed crowns for Members under age 12.
- Fixed bridges and removable partials for Members under age 16.
- Anesthesia, except for general anesthesia and IV sedation given by a dentist for covered oral surgery procedures and certain endodontic and periodontal procedures.
- Grafting tissues from outside the mouth to tissue inside the mouth (extraoral grafts).
- Services for any disturbances of the jaw joints (Temporomandibulor Joints or TMJ) or associated muscles, nerves or tissues.
- Orthodontic services (Dental Basic Option only).
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
- Expenses related to any claim submitted more than one year following date of service.

- Services or supplies received while the Member is on active duty during military service or for services or supplies provided under any federal or state laws of the United States or any foreign country or of any political subdivision of any of the foregoing.
- Services or supplies to which you are legally entitled.
- Services received through a medical department, clinic, or similar facility provided or maintained by the patient's Employer.
- Expenses for which payment is not required or for which payment is unlawful where the patient resides when expenses are incurred.
- Services other than those specifically covered under the Dental coverage.
- Services covered under any other plan sponsored by the Company or any of its Affiliates.
- Charges in excess of the Dental coverage's payment amount, in excess of the R&C Fee, or above Dental coverage limits.
- Treatment by someone other than a licensed dentist or licensed physician; except that a licensed dental hygienist can clean and scale teeth and apply fluoride if a dentist supervises, guides the treatment, and bills the patient.
- Additional charges resulting from the transfer of a patient from the care of one dentist to another during a course of treatment, or if more than one dentist renders services for the same procedure.
- Expenses resulting from services not Dentally Necessary according to accepted standards of dental practice (even if recommended by a dentist).
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.
- Services with respect to congenital or developmental malformation (including Temporomandibular Joint Dysfunction (TMJ), and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching or other whitening procedures, veneers, crowns to improve appearance, or personalization or characterization of dentures).
- Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or to treat or diagnose jaw joint and muscle problems (TMJ).
- Tooth guidance appliance, minor tooth movement, prosthetic orthodontics, or other orthodontic treatment, including any procedures prerequisite or incidental to such treatments (Dental Basic Option only).
- Replacement or repair of an orthodontic appliance (Dental Basic Option only).
- Sealants (materials, other than fluorides, painted on the grooves of the teeth in an attempt to prevent further decay) for oral hygiene and dietary instruction.
- Topical fluoride treatment for any person 15 years of age or older.
- Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting.
- Maxillofacial surgery and prosthetic appliances.
- Replacement of a lost, stolen, or missing prosthetic device or duplication of prosthetic devices or appliances.

- X-rays and extraction procedures incident to Orthodontics, except as specifically covered under the Dental coverage (Dental Basic Option only).
- Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils).
- Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease, behavior management, or oral hygiene instruction or any equipment or supplies required.
- Services or supplies for accidental injury.
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
- Temporary procedures and appliances, pulp caps, occlusal adjustments.
- Prescribed drugs, analgesics (pain relievers such as nitrous oxide), fluoride gel rinses, and preparations for home use.
- Charges for hospitalization, including hospital visits.
- Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.
- Infection control and OSHA procedures.
- Expenses incurred for your failure to keep a scheduled dentist's appointment.
- Charges for completion of claim forms, providing documentation, and requests for pre-determination.
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Plan, will be the responsibility of the Member and not a covered benefit.
- Expenses based on misrepresentation or falsification of claims. Like any other falsification or records, this is a serious disciplinary offense which could jeopardize your employment. The other penalties for providing incomplete, false, or inaccurate information may include the denial of payment of Benefits, required reimbursement of claims paid, suspension of coverage in the Dental Plan, and/or other legal action.

HOW TO OBTAIN DENTAL COVERAGE BENEFITS

PRE-DETERMINATION ESTIMATES

After an examination, your dentist will talk to you about treatment you may need. The cost of the treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, Delta Dental encourages you to ask your dentist to request a pre-determination.

If you wish to know in advance whether a specific procedure is covered or how much the Dental Plan will pay for a course of treatment, you may obtain a pre-determination estimate. In order to receive a pre-determination,

- Your dentist must send an Attending Dentist's Statement to Delta Dental listing the proposed treatment.
- Delta Dental will send your dentist a Notice of Pre-determination which estimates how much of the treatment costs they will pay and how much you will have to pay.
- After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the statement to Delta Dental for payment when treatment has been completed.

You will be responsible for the difference between the Dental Plan's actual Benefits and the dentist's actual charges.

A pre-determination does not guarantee payment. Computations are estimates only and are based on what would be payable on the date the Notice of Pre-determination is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual maximum when completed services are submitted to Delta Dental.

Pre-determining treatment helps prevent any misunderstandings about your financial responsibilities. If you have any concerns about the pre-determination, let Delta Dental know before treatment begins so your questions can be answered before you incur any charges.

CLAIMS FOR IN-NETWORK CARE

Your costs are lower when you use a dentist who is part of the Delta Dental network. To find a dentist in your area, visit https://www1.deltadentalins.com/group-sites/roche.html or call 1-800-765-6003.

If you use an in-network provider, your dentist will submit your claim directly to Delta Dental for payment, usually by fax or electronic submission. Delta Dental will send you a statement showing your exact out-of-pocket expense for the treatment. You will be billed by the dentist for any applicable Deductible and Coinsurance Amount and amounts in excess of Dental Plan maximums.

CLAIMS FOR OUT-OF-NETWORK CARE

If you use an out-of-network provider, complete your section of the claim form, have the dentist complete their section, and submit the form to Delta Dental at the address shown on the claim form. Delta Dental will pay you directly. You are responsible for paying your dentist.

You may obtain claim forms on the Delta Dental website at https://www1.deltadentalins.com/group-sites/roche.html.

CLAIMS PROCEDURES

You may file claims for Dental Plan Benefits, and appeal adverse claim decisions, either yourself or through an authorized representative by using the Claims Procedures set forth in the COBRA/ERISA/HIPAA section of this SPD.

The Vision Coverage Options

Within the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan, eligible Participants are given a choice of two vision coverage options, administered by VSP Vision ("VSP"):

- Basic Vision Option
- Premier Vision Option

USING IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS

If you enroll in a Vision coverage option, you may choose between having vision care provided by either in-network or out-of-network providers or facilities. The Vision coverage reimburses Covered Expenses for services provided by all licensed vision care providers. However, your cost will be lower if you use in-network providers. In-network providers are those who have agreed to accept a discounted fee schedule for services rendered.

HOW TO FIND AN IN-NETWORK PROVIDER

The Vision Plan is administered by VSP Vision ("VSP"). To find a provider in VSP's network, call VSP directly at 1-800-877-7195 or visit VSP's website at https://www.vsp.com.

COVERED EXPENSES

The following chart outlines the coverage provisions for Covered Expenses under the Vision coverage.

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Roche

2023 VSP Vision

Vision Plan

	Basic		Premier[1]	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Annual exams	100% after $10 co-pay	Up to $40 after $10 co-pay	100% after $20 co-pay	Up to $40 after $20 co-pay
Retinal digital screening	100% after $20 co-pay	Not covered	100% after $20 co-pay	Not covered
Frames	Every other calendar year:		Every calendar year:	
	$150 allowance[3] after $25 co-pay; 20% off the amount over your allowance	Up to $45 after $25 co-pay	$200 allowance[3] after $20 co-pay; 20% off the amount over your allowance	Up to $45 after $20 co-pay
Lenses[2]	Every other calendar year:		Every calendar year:	
Single vision	100% after $25 co-pay	Up to $40 after $25 co-pay	100% after $20 co-pay	Up to $40 after $20 co-pay
Lined bifocal	100% after $25 co-pay	Up to $60 after $25 co-pay	100% after $20 co-pay	Up to $60 after $20 co-pay
Lined trifocal	100% after $25 co-pay	Up to $80 after $25 co-pay	100% after $20 co-pay	Up to $80 after $20 co-pay
Lenticular	100% after $25 co-pay	Up to $125 after $25 co-pay	100% after $20 co-pay	Up to $125 after $20 co-pay
Standard progressive lenses enhancement	100%	Up to $80 after $25 co-pay	100%	Up to $80 after $20 co-pay
Tints	Not covered	Not covered	100%	Up to $5 after $20 co-pay
Contacts *(in lieu of frames and lenses)*	Every other calendar year:		Every calendar year:	
Elective	$200 allowance for contacts and the contact lens exam after $25 co-pay		$200 allowance for contacts and the contact lens exam after $20 co-pay	
Medically necessary	100% after $25 co-pay	Up to $250 after $25 co-pay	100% after $20 co-pay	Up to $250 after $20 co-pay
LightCare Benefit	Every other calendar year:		Every calendar year:	
Ready-made non-prescription sunglasses or blue light filtering glasses *(in lieu of prescription lens and frames or contacts)*	$150 allowance after $25 co-pay	Not covered	$200 allowance after $20 co-pay	Not covered

2023 VSP Vision

	Basic		Premier[1]	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
VSP Easy Options				
	Not applicable	Not applicable	Choose an upgrade: • Additional $50 frame allowance, or • Additional $50 contact lens allowance, or • Anti-reflective coating, or • Premium or custom progressive lenses, or • Light reactive lenses	Not covered

1. The co-pay applies to an exam and/or materials.
2. Items such as extra-thin lenses or special lens coatings are not covered and may increase your out-of-pocket costs. Polycarbonate lenses are covered for dependents up to age 26.
3. The frame allowance for purchases from Costco is $80 in Basic and $110 in Premier.

FRAME ALLOWANCE

When you purchase frames from an in-network provider, the Vision coverage will pay a $150 allowance after a $25 copay for the Vision Basic Option and a $200 allowance after a $20 copay for the Vision Premier Option towards the retail cost of the frames (for purchases from Costco, the frame allowance is $80 for Basic and $110 for Premier). Depending upon the type of frames you choose, the allowance minus applicable copays may cover most of the cost of the frames. However, if you choose a pair of frames with a retail cost of more than the applicable allowance, you will receive a 20% discount on the amount over the allowance.

IMPORTANT INFORMATION RELATIVE TO CERTAIN COVERED EXPENSES

Spectacle Lenses/Glasses

If glasses are prescribed, the coverage described in covered expenses is for standard lenses to correct vision only and does not include cosmetic options. Certain cosmetic lens enhancements and other non-covered items, including additional pairs of glasses, may be available from in-network providers at discounted member pricing. VSP in-network providers offer savings of 30% to 40% on non-covered lens enhancements. VSP providers also offer savings of 30% on additional glasses and sunglasses from the same in-network provider who provided your last covered eye exam on the same day as the exam. Contact VSP or your in-network provider for details and prices related to various options and savings programs.

Contact Lenses

Elective contact lenses are only covered if purchased instead of glasses. The Vision plan will pay a $200 allowance for contacts every other year for the Basic Plan, and a $200 allowance for contacts every calendar year for the Premier plan.

Medically Necessary Contact Lenses

Medically necessary contact lenses are only covered if required for certain medical conditions (as determined by VSP) that prevent you from wearing eyeglasses.

Your doctor must contact VSP in advance of ordering contact lenses to determine whether VSP will consider the lenses to be medically necessary. Medically necessary contact lenses must be approved in advance by VSP before any Benefits will be paid.

Contact Lens Exam And Fitting

Contact lens fitting requires a special exam for ensuring proper fit of your lenses and evaluating your vision with the contacts. This is not the same as the standard eye exam which is covered in full through an in-network provider after a $10 copay under the Basic Plan and $20 copay under the Premier Plan. VSP in-network providers offer savings of 15% on the cost of the contact lens exam.

Essential Medical Eye Care

The Essential Medical Eye Care plan provides in-network coverage for limited vision-related medical services as a supplement to the covered person's group medical plan. Benefits are available after all other benefits under their group medical plan have been exhausted, or when the covered person is not covered under a group medical plan, for treatment and diagnosis of eye conditions such as pink eye, loss of vision, and monitoring of cataracts, glaucoma and diabetic retinopathy. A $20 copay shall be payable at the time of each Essential Medical Eye Care

office visit; coverage limitations apply for use of out-of-network providers. For coverage details, call VSP at 1-800-877-7195 or visit VSP's website at https://www.vsp.com.

LightCare Benefit

The LightCare benefit allows you to use your frame allowance towards ready-made non-prescription sunglasses or blue light filtering glasses instead of prescription glasses or contacts from your VSP doctor.

EasyOptions under Premier Plan

The EasyOptions benefit is offered for Premier Plan members only. The benefit allows you and your dependents to each choose from a variety of covered upgrades during your in-network doctor's visit. The options include choosing one of the following: additional $50 frame allowance, additional $50 contact lens allowance, anti-glare coating covered in full, premium or custom progressive lenses covered in full, or light reflective lenses covered in full.

WHAT THE VISION PLAN DOES NOT COVER

Exclusions and Limitations of Benefits - The Vision coverage is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, the Vision coverage will pay the basic cost of the allowed lenses, but you are responsible to pay the additional costs for the options. Items excluded from coverage under the Vision Plan include, but are not limited to:

- Blended lenses
- Contact lenses (except as otherwise provided herein)
- Oversize lenses
- Premium and Custom Progressive multifocal lenses
- Coated or laminated lenses:
  - Color coating
  - Mirror coating
  - Scratch coating
  - Laminated lenses
- A frame that exceeds the plan allowance
- Certain limitations on low vision care
- Cosmetic lenses
- Optional Cosmetic processes
- UV protected lenses

Not Covered - There is no benefit for professional services or materials connected with:

- Expenses related to any claim submitted more than twelve months following date of service;
- Expenses incurred before this coverage became effective or after coverage ends;
- Orthoptics or vision training and any associated supplemental testing;
- Two pairs of glasses in lieu of bifocals;
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;
- Corrective vision services, treatments, and materials of an experimental nature;
- Expenses based on misrepresentation or falsification of claims. Like any other falsification of records, this is a serious disciplinary offense which could jeopardize your employment. The other penalties for providing incomplete, false, or inaccurate information may include the denial of payment of Benefits, required reimbursement of claims paid, suspension of coverage in the Vision coverage, and/or other legal action; and
- An eye examination, or any corrective eye wear, required by your Employer as a condition of your employment.

HOW TO OBTAIN VISION COVERAGE BENEFITS

IN-NETWORK

To find out if your doctor participates or to locate an in-network vision care provider, visit VSP's website at www.vsp.com or call VSP Member Services at **(800) 877-7195**.

If the provider determines that lenses or frames are necessary, they will coordinate the prescription with an in-network lab. The provider will also itemize any non-covered charges and have you sign a form to document that you received services. VSP will pay the provider directly for covered services and eyewear. You are responsible for paying any required copays for the eye exam, lenses, and/or frames. You are responsible for any additional costs resulting from cosmetic options or non-covered services and eyewear you have selected.

OUT-OF-NETWORK

You must pay the out-of-network provider the full amount of the bill and request a copy of the bill that shows the amount of the eye exam, lens type, and frame.

Send a copy of the itemized bill(s) to VSP within twelve months following date of service. The following information must also be included in your documentation:

- The name, address, and phone number of the out-of-network provider.
- Covered member's name, address, and phone number.
- Covered member's Employer's name and group number (group numbers can be obtained from by contacting VSP).
- Covered member's social security number.
- Patient's name, address, phone number, relationship to covered member, and date of birth.

Please mail the itemized bill(s) and form to the following address:

VSP VISION
P.O. Box 385018
Birmingham, AL 35238-5018

You may also submit out-of-network claims on vsp.com. Simply go to vsp.com and log in, click Claim & Reimbursement, complete the form, attach your receipts and click Submit.

CLAIMS PROCEDURES

You may file claims for Vision Plan Benefits, and appeal adverse claim decisions, either yourself or through an authorized representative by using the Claims Procedures set forth in the COBRA/ERISA/HIPAA section of this SPD.

Additional Information Applicable to All Plan Members

POWERS OF ATTORNEY AND GUARDIANSHIP AND CONSERVATORSHIP ORDERS

Unless otherwise stated in the Plan, the Plan will only accept Powers of Attorney in the following situations:

1. To change coverage option election or terminate coverage on behalf of a Participant. The Plan will accept a Power of Attorney provided it is accompanied by a letter on the letterhead of the Participant's attending Physician verifying the Participant is incapacitated and is incapable of making this kind a change; or
2. To sign a HIPAA authorization form on behalf of a Participant.

The Plan Administrator (or their designee) may review certified court orders, guardianship agreements, or conservatorship agreements, and powers of attorney and shall determine whether either of the above actions requested by third parties will be permitted. Certified court orders, guardianship agreements, conservatorship agreements, and powers of attorney will be reviewed only at the time they are invoked and must be accompanied by a written request from the agent under the POA stating the transaction the agent wishes to perform.

In the absence of a valid court order, guardianship agreement, conservatorship agreement, or power of attorney, the Plan will allow a family member acting on behalf of a Plan Participant to change that Participant's residential address provided the family member submits satisfactory documentation demonstrating that:

- the Participant is incapacitated and unable to make such change; and
- the Participant lives at the new address.

COORDINATION OF PLAN BENEFITS WITH MEDICARE AND OTHER HEALTH PLANS

If you have a Healthcare Account (under this Plan) or have Healthcare Credits (under the Roche Post-Employment Healthcare Plan), since these programs only reimburse Eligible Healthcare Expenses that have not been covered by another healthcare plan, these programs will always reimburse after all other benefits have been paid by all other healthcare plans.

If you are participating in Coverage under this Plan, the following Coordination of Benefits rules apply for Participants under age 65 or not otherwise eligible for Medicare:

COORDINATION OF BENEFITS WITH OTHER PLANS

The Coordination of Benefits (COB) provisions determine which plan pays first and which one pays second, or possibly third, when you or your Eligible Dependents are covered by more than one group health plan. The COB provisions described below apply to all Coverages in the Plan except for the Kaiser HMO options. For COB provisions applicable to the Kaiser HMO options, you must refer to the Evidence of Coverage provided by Kaiser.

When more than one group plan covers an individual, the order in which benefits will be determined is as follows:

1. **Absence of COB Rules:** The benefits of any plan which does not contain provisions governing coordination of benefits with other plans will be determined before the benefits of this Plan.
2. **Active Employee/Retiree vs. Dependents:** Generally, plans pay benefits based on the following hierarchy:
   - The plan that covers a person as an active employee or retiree pays before the plan that covers the person as a dependent.

- The plan that covers a person as an active employee pays before the plan that covers the person as a retiree (or otherwise inactive employee)
- The plan that covers a person as the dependent of an active employee pays before the plan that covers the person as a dependent of a retiree (or otherwise inactive employee)
  - If the person is also Medicare eligible, benefits are determined in this order:
    - First, the plan covering the person as an active employee or an active employee's dependent pays
    - Then, Medicare pays, and
    - Finally, the plan covering the person as a retiree or a retiree's dependent pays

3. **COB Rules for Hawaii:** If you live in Hawaii, the plans pay benefits based on the following hierarchy:
   - First, the UHC Hawaii PPO Plan, which has been filed with the state of Hawaii, pays, and
   - Then, the ASO Managed Indemnity Plan (the Out of Area Plan), which has benefits identical to the in-network benefits under the UHC PPO Plan, pays

4. **Dependent Child/Parents Not Separated or Divorced:** When children are covered by two group plans, the plan of the parent with the earliest birthday (month and day) in the year pays first (this is known as the "Birthday Rule"). If both parents have the same birthday, the plan which covered the parent longer pays before the plan which covered the other parent for a shorter period of time.

5. **Dependent Child/Separated, Divorced or Unmarried Parents:** If two or more plans cover a person who is a dependent child of **divorced**, separated or unmarried parents, benefits for the child are determined in this order when one parent has custody of the child:
   - First, the plan of the parent with custody of the child;
   - Then, the plan of the Spouse of the parent with custody of the child;
   - Then, the plan of the parent not having custody of the child; and
   - Finally, the plan of the Spouse of the parent not having custody of the child, if applicable.
     - However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the plan obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply when any benefits are actually paid or provided before the plan has that actual knowledge.
     - Additionally, if the parents share joint custody without stating that one of the parents is responsible for health care expenses of the child, the plans covering the child shall follow the Birthday Rule (see rule 3). If the Birthday Rule is followed, the dates of birth of the natural parents are considered before the dates of birth of a stepparent.

6. **COBRA Continuation Coverage:** If a person has coverage provided by COBRA and is covered under another group plan, the plan that covers the person as an active or retired employee, or as that employee's dependent, pays first and the plan that covers the person as a COBRA participant pays second.

7. **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of benefits, the benefits of the plan that covered a person longer are determined before those of the plan that covered that person for the shorter time.

8. **Other Group Plan Exclusions or Limitations:** If another group plan:

- contains a provision coordinating its benefits with this Plan that would, according to its rules, determine its benefits after the benefits of this Plan have been determined, or
- contains a provision or design which limits the amount paid due to the existence of other coverage, and the rules described above would require this Plan to determine benefits after such other group plan,
- then the rules of such other group plan would be ignored for the purposes of determining the benefits under this Plan and this Plan will reduce benefits to reflect whatever the other group plan would have paid in the absence of those other group plan provisions.

NON-DUPLICATION OF BENEFITS

A PPO Plan, like many other plans, contains a procedure to make sure that it does not duplicate any benefits you or an Eligible Dependent might be eligible for under another group plan. Under this "non-duplication" procedure, when a PPO Plan pays second, it will pay up to the same amount it would have paid if it had paid first less the amount the other group plan actually paid. The box below contains two examples of how this works.

COB Examples

Example 1

- Your Spouse incurs $1,000 in Covered Expenses that are reimbursable at 80% under the PPO Plan (assumes Deductible has been satisfied).
- Your Spouse is covered under both the PPO Plan and their own employer's medical plan.
- This means your Spouse's employer's plan pays first and the PPO Plan pays second for your Spouse's Covered Expenses.
- Your Spouse's plan paid $500 of the expense.

The PPO Plan will first determine how much it would have paid if there was no other coverage. Since this is an expense reimbursable at 80%, the PPO Plan would have paid $800 of the expense ($1,000 x 80%) if there were no other coverage.

The PPO Plan will then pay the claim as follows:

Amount PPO Plan would pay if no other coverage:	$800
Less amount paid by Spouse's plan:	-500
Amount PPO Plan will pay as secondary payer:	$300

Example 2

If, in Example 1, your Spouse's plan had paid $800 instead of $500, the PPO Plan would pay as follows:

Amount PPO Plan would pay if no other coverage:	$800
Less amount paid by Spouse's plan:	-$800
Amount PPO Plan will pay as secondary payer:	$0

COORDINATION with MEDICARE

Please be aware that once you and/or your Eligible Dependents become Medicare-eligible, you must sign up for both Medicare Part A and Part B as soon as they become available in order to avoid any lapse of medical coverage. Coverage under this Plan will terminate when you become Medicare eligible.

If you delay enrolling in Medicare Part A and Part B, there may be consequences, including lack of medical coverage, financial penalties under Medicare, and/or a delay in Medicare enrollment. Please check with a Medicare counselor to determine the best course of action. Example of when you and/or your Eligible Dependents may become eligible for Medicare include:

- Attaining age 65;
- After receiving Social Security Disability benefits for 24 months;
- If diagnosed with end stage renal disease.

PAYMENT OF BENEFITS

You may not assign your Benefits under the Medical and Prescription Plan or any cause of action related to your Benefits under the Medical and Prescription Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in the section below.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that **UnitedHealthcare** in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which **UnitedHealthcare** makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Overpayment and Underpayment of Benefits

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

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of benefits payable under any Company-sponsored benefit plans, including the Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

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

Refund of Overpayments

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

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, your Spouse or your Eligible Dependents, but all or some of the expenses were not paid by you or did not legally have to be paid by you, your Spouse or your Eligible Dependents ;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

If the refund is due from you, your Spouse or your Eligible Dependents and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you, your Spouse or your Eligible Dependents that are payable under the Plan. If the refund is due from a person or organization other than the you, your Spouse or your Eligible Dependents , the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, from future Benefits that are payable in connection with services provided to you, your Spouse or your Eligible Dependents under the Plan. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

WHEN YOUR ELIGIBLE DEPENDENTS' COVERAGE ENDS

Your Eligible Dependent(s)' coverage ends when yours does, with the exception of your death if the Eligible Dependent(s) meet the definition of Eligible Survivor. In addition to the reason stated above, coverage for your Eligible Dependent(s) will also end at 11:59 p.m. on the day before they no longer meet the definition of Eligible Dependent. However, in the case of a Dependent Child attaining age 26, coverage will end at 11:59 p.m. on the last day of the month in which your child's 26th birthday occurs.

Spouses/Eligible Domestic Partners and step-children/children of Eligible Domestic Partners cease to be Eligible Dependents upon the date of your **legal separation, divorce, or termination of Domestic Partnership.** In addition, coverage of an Eligible Domestic Partner ceases on the day they no longer meet the definition of Eligible Domestic Partner.

If you or an Eligible Dependent ceases to be eligible for coverage under the terms of the Plan, you may be able to continue coverage temporarily under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA continuation of group coverage is described in the COBRA/ERISA/HIPAA section of this document.

HOW YOU COULD LOSE BENEFITS UNDER THE U.S. ROCHE HEALTH AND WELFARE BENEFITS RETIREE HEALTHCARE PLAN

This Plan is designed and maintained by the Plan Sponsor to give you a coordinated program of healthcare protection. Yet, you should be aware that there are certain circumstances that could result in a loss of benefits, including, but not limited to, the following:

- If the Company no longer provides group health coverage to any of its Employees, Plan membership will end.
- If you do not make required contributions, Plan membership will end.
- If you or an Eligible Dependent does not elect coverage, if available, within the required time period, the opportunity to do so will be lost.If you or an Eligible Dependent whose coverage terminates do not elect COBRA continuation coverage, if available, within the required time period, the opportunity to do so will be lost.
- If you do not apply for benefits or submit the claim and appropriate documentation within 12 months of the date of service or, in the case of reimbursement of premiums under a health plan, within 12 months of the date the premiums are due, no benefits can be paid.
- If you return to employment with an Employer. Note: If you return to employment for an Employer that does not participate in this Plan, that Employer may have different benefits. In addition, if you transfer to and retire from that or another Employer that does not participate in this Plan, your coverage upon termination will be determined by the plan, if any, offered by the Employer from which you terminate. However, if no medical plan coverage is available when your employment with the last Employer terminates, and you are otherwise eligible to elect coverage under this Plan as a Retiree Participant or Eligible Survivor, then you will be eligible to enroll under this Plan. If eligible, you must elect coverage under this Plan within **31** calendar days of the later of: (1) your termination date from the Employer; or (2) your loss of other employer group coverage (including COBRA coverage).
- Misrepresentation or falsification of claims, like any other falsification of records, is a serious disciplinary offense which could jeopardize your Coverage and subsidy under the Plan. The other penalties for providing incomplete, false, or inaccurate information may include the denial of payment of benefits, required reimbursement of claims paid, suspension of coverage in the Plan, and/or other legal action.

PLAN'S RIGHT OF REIMBURSEMENT AND SUBROGATION

Reimbursement and Subrogation: If you or an Eligible Dependent is injured as a result of action or inaction of a third party, the Plan will pay health care Benefits for injuries according to the relevant provisions described in the Plan. If any resulting recovery (e.g., insurance settlement, damage award) is obtained for health care expenses resulting from the third party's action or inaction, you will be required to reimburse the Plan for the health care Benefits paid, whether or not the recovery identifies the Benefits the Plan provided, and even if the recovery does not make you whole, is designated for attorney fees, or is designated for pain and suffering or non-economic damages only. In addition, the Plan retains the right to sue the party responsible for the injury for repayment of

expenses paid by the Plan. You and/or your Eligible Dependent must do whatever is required to secure these rights and may not do anything to prejudice the Plan's right of reimbursement. You must notify United Healthcare, OptumRx or Kaiser within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries. Under such circumstances, you may be asked to agree in writing to immediately reimburse United Healthcare, OptumRx, Kaiser and/or the Company for Benefits paid to you, whether by legal action, settlement or otherwise. In addition, you may be asked to provide the Company with a completed and signed Lien and Order Directing Reimbursement of Medical Benefit Payments, up to the amount of healthcare treatment Benefits the Company paid to you. Contact The People Support Team at 800-816-8221 for additional information and forms.

Right of Recovery

Whenever payments for a claim have been made in excess of the maximum limit for that claim under this Plan, the Plan shall have the right to recover such amounts to the extent of the excess from whomever received the excess payment and/or the Participant.

The Company and/or the claims administrators can exchange benefit information with other Employers, administrators, and insurers to determine responsibility for Benefits between the PPO option and other coverage. The Company also has the right to recover any over-payment or make adjustments to the payment of future claims to meet the coordination of Benefits provisions.

Other Information You Should Know

No Guarantee of Employment

The descriptions of the Plan in this SPD do not constitute a contract. This means that no promise of any kind is intended by the benefits described herein. Nothing in the SPD or the Plans described in it gives, or is intended to give any person the right to be retained in the employment of the Employer, or to interfere with the right of the Employer to terminate the employment of any person.

QMCSOs

A Qualified Medical Child Support Order or "**QMCSO**" against the Retiree Participant, LTD Participant, or Severance Participant must be sent to the Plan Sponsor to implement. A QMCSO will not be implemented before being issued by a court or through a state administrative process; however, submitting a draft for review in advance may prevent amendments which may be difficult and time-consuming. For more information about QMCSOs, including sample language, please contact the Plan Administrator listed in the Important Notice and Contact Information section of this SPD.

Future Of The Plan

U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan

The U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan described in this SPD is offered by the Plan Sponsor voluntarily and may be amended or terminated at any time by action of the Board of Directors of Genentech, Inc. or its designee. The Plan Sponsor's Head of Human Resources, who is also a standing member of the NAM Governance Committee, may make amendments to this plan in writing provided that such amendments

do not materially add to the Plan Sponsor's or Employer's cost under this plan and do not result in the termination of this plan, and prior to approval of any such amendments the Plan Sponsor's Head of Human Resources consults with the NAM Governance Committee and the Plan Sponsor's Executive Committee, and Plan Sponsor's Head of Human Resources is acting in his or her capacity as an officer of the Plan Sponsor rather than as a fiduciary. The Director, Employee Benefits & Services of the Plan Sponsor may sign insurance contracts for this Plan on behalf of the Plan Sponsor, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that they consider to be administrative in nature or advisable in order to comply with applicable law. Amendments may, among other things, affect contribution rates, benefit coverage, reimbursement rates, procedures, participation, etc., with respect to current or future Employees, retirees or other terminated Employees or their dependents or survivors, regardless of whether they are participating in the Plan at the time of amendment.

Roche Diagnostics Retiree Healthcare Plan

The Roche Diagnostics Retiree Healthcare Plan described in this SPD is offered by the Plan Sponsor voluntarily and may be amended or terminated at any time by action of the Board of Directors of Roche Diagnostics Corporation or its designee. The Director, Employee Benefits & Services of the Plan Sponsor may sign insurance contracts for this Plan on behalf of the Plan Sponsor, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable in order to comply with applicable law. Amendments may, among other things, affect contribution rates, benefit coverage, reimbursement rates, procedures, participation, etc., with respect to current or future Employees, retirees or other terminated Employees or their dependents or survivors, regardless of whether they are participating in the Plan at the time of amendment.

The Employee Retirement Income Security Act Of 1974, As Amended (ERISA)

The Plan is subject to ERISA. For information relative to your rights under ERISA, the Plan's number, the name, EIN and address of the plan sponsor and Plan Administrator, the plan year, the agent for service of legal process, COBRA information, information about hospital stays after childbirth, information about breast reconstruction following mastectomy, and Participating Companies please refer to the ERISA section of this document.

COBRA/ERISA/HIPAA

COBRA

Continuing Health Care Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

Participants covered under the Plan Sponsor health care plans shown above are eligible for a temporary extension of coverage (called "continuation coverage"), if that coverage would otherwise end due to certain events (called "**Qualifying Events**"). Participants who are eligible for continuation coverage are known as "**Qualified Beneficiaries**."

Please Note: The COBRA law does not apply to Domestic Partners, however, the Plan Sponsor has elected to extend continuation coverage similar to that required by COBRA to Eligible Domestic Partners and their covered children if coverage is lost due to what otherwise would be considered a COBRA Qualifying Event. For purposes of this COBRA section the them "Spouse" includes Domestic Partner.

This section is intended to inform you, in a summary fashion, of your rights and obligations under COBRA.

COBRA provides Qualified Beneficiaries who experience a Qualifying Event which results in loss of health coverage the opportunity to continue coverage at 102% of the Plan Sponsor's group rate for a specified amount of time. The chart below in this section lists the COBRA Qualifying Events that trigger COBRA eligibility, the duration of coverage available, extensions that may apply, and time limits for electing coverage. Qualified Beneficiaries are only eligible to continue health coverage in which they are enrolled on the day before the Qualifying Event. If a Qualified Beneficiary elects continuation coverage, the coverage provided will be identical to the coverage provided under the applicable Plan Sponsor health Plan(s) to similarly situated employees or dependents. If this coverage changes for similarly situated employees or dependents, the coverage available to Qualified Beneficiaries will change accordingly.

Disability Extension

If the Social Security Administration determines that a Qualified Beneficiary is totally disabled at the time of the Qualifying Event or within the first 60 days of a continuation coverage period, health coverage for all Qualified Beneficiaries may be continued for up to 29 months instead of 18 months (regardless of whether the disabled family member elects COBRA).

To get this additional 11 months of coverage you must notify the COBRA Administrator in writing within 60 days of the date that Social Security made the determination and before the end of the initial 18-month period. You also must notify the COBRA Administrator in writing within 30 days of the day the Social Security Administration makes a final determination that the applicable person is no longer disabled. Coverage can only be extended to the earlier of (1) 29 months from the Employee's initial Qualifying Event date, or (2) the month that begins more than 30 days after Social Security makes a final determination that the applicable person is no longer disabled.

The monthly cost for continuation coverage for all covered Participants during months 19-29 will be increased from 102% of Plan Sponsor cost to 150% of Plan Sponsor cost if the person who has been declared disabled by the Social Security Administration has elected continuation coverage. Please contact the COBRA Administrator for the current 150% costs if you are in this category.

Special Rules Applicable to Spouses and Children

If you are the covered Spouse or child of an Employee, your coverage under the Plan ceases when the Employee's coverage ceases. Spouses and/or children may make separate elections to continue coverage under COBRA even if the Employee declines continuation coverage.

Second Qualifying Event

If your Spouse and/or dependent children experience another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is given to the COBRA Administrator. This extension may be available to your Spouse and any dependent children receiving continuation coverage if you die, you become entitled to Medicare benefits (under Part A, Part B, or both), or you get divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your Spouse and/or dependent child(ren) to lose coverage under the Plan had the first qualifying event not occurred. Qualified Beneficiaries must inform the COBRA Administrator in writing that a second Qualifying Event has occurred within 60 days of the second event to be eligible for this extension of COBRA coverage.

How to Obtain COBRA Continuation Coverage

In the Event of Divorce, Legal Separation, or the End of Domestic Partnership

Husbands/wives, stepchildren, Domestic Partners and qualified children of a Domestic Partner cease to be Eligible Dependents upon the date of your legal separation, divorce or the day your Domestic Partner no longer meets the definition of Eligible Domestic Partner as defined in the Plan.

You must notify the Plan Administrator listed in the Other Important Information section of this SPD as soon as practicable once your Spouse/Domestic Partner or any dependent child(ren) ceases to meet the Plans' definition of Eligible Dependent. If you contact your Plan Administrator listed in the Other Important Information section of this SPD within 60 days of the Qualifying Event date, full details of the COBRA continuation option will be furnished to all Qualified Beneficiaries. If notice is not provided to your Plan Administrator listed in the Other Important Information section of this SPD within 60 days of the date of the Qualifying Event, Qualified Beneficiaries will lose the right to continue health coverage under COBRA.

In the Event of a Child Turning Age 26 or Older and not a Qualified Disabled Dependent

The child's coverage will end on the date he or she ceases to be an Eligible Dependent. If a child is a qualified Disabled Dependent as defined in the Eligibility Requirements of the applicable section of this SPD, the child's coverage will end 6 months after the date he or she ceases to be a qualified Disabled Dependent.

You must notify your Plan Administrator listed in the Other Important Information section of this as soon as practicable once your dependent child(ren) ceases to meet the Plans' definition of Eligible Dependent. If you contact your Plan Administrator listed in the Other Important Information section of this SPD within 60 days of the Qualifying Event date, full details of the COBRA continuation option will be furnished to all Qualified Beneficiaries. If notice is not provided to your Plan Administrator listed in Other Important Information section of this SPD within 60 days of the date of the Qualifying Event, Qualified Beneficiaries will lose the right to continue health coverage under COBRA.

Once You Receive Your COBRA Notification Package

- Complete the Request for Continuation Coverage form. You must return the form to the address on the instruction sheet within 60 days of the later of its receipt or the date coverage ceases. Your COBRA package will include premium payment instructions. You will be notified within 14 days if COBRA is unavailable.
- You have 45 days from the date you elect continuation coverage to pay your first month's premium. If your initial payment is not received within 45 days of the date your Request form is submitted, you will lose your right to continue coverage. All subsequent monthly payments are due the first of the month and must be received within 30 days of the first day of the month due or coverage will be lost.
- If you elect continuation coverage under the medical plan, prescription coverage will also continue. You cannot elect prescription, coverage without electing medical coverage.
- If you are enrolled in an HMO and you relocate to an area outside of the HMO's service area, you may elect continuation coverage under any other medical option available to other similarly situated active employees who reside in that area.

When COBRA Coverage Ends

Continuation coverage under COBRA may be terminated for any of the following reasons:

- The Plan Sponsor and any Affiliate no longer provides group health plan coverage to any of its employees;
- The premium for continuation coverage is not paid on a timely basis;
- After electing COBRA coverage, the covered person becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition that applies to the covered person;
- After electing COBRA coverage, the covered person becomes entitled to Medicare;
- There is a Social Security Administration (SSA) determination that a covered person, previously determined by the SSA to be disabled, is no longer disabled (applies to 11-month disability extension only); or
- The covered person requests cancellation of COBRA coverage in writing.
- Misrepresentation or falsification of claims, like any other falsification of records, is a serious offense which could jeopardize your COBRA continuation coverage.

If your COBRA coverage ends prior to the maximum period of coverage allowed, you will be notified.

For Retiree Participants, LTD Participants, and Severance Participants: If you participate in an insured California HMO, you may be eligible for an Extension of Benefits as provided for by California State law. If you lose eligibility for COBRA coverage because you exhaust the length of time allowed for COBRA coverage, you may be eligible to continue your Group coverage. For additional information on who may qualify and how to apply for the extension please contact the HMO's Member Service Center.

Qualified Beneficiary	Qualifying Event	Maximum Continuation Period — From Qualifying Event Date	Possible Extension To:	Period During Which You Must Apply For Continuation
Divorced or legally separated Spouse and stepchildren, or Eligible Domestic Partner and their child(ren)	• Divorce or legal separation date or • Date no longer meets the definition of Domestic Partner.	36 months	Not available	Within 60 days of the later of: • date COBRA Enrollment packet is received by Beneficiary or • divorce or • legal separation or • ceased to meet Domestic Partner definition

Qualified Beneficiary	Qualifying Event	Maximum Continuation Period — From Qualifying Event Date	Possible Extension To:	Period During Which You Must Apply For Continuation
Eligible Dependents of deceased employee/retiree	Death of employee/retiree	36 months	Not available	Within 60 days of death
Child that ceases to be an Eligible Dependent	The date on which the child ceases to be eligible to be covered as your Eligible Dependent.	36 months	Not available	Within 60 days after Qualifying Event date

Please note that if you are an Employee's Spouse or dependent child, you may also elect up to 36 months of continued health care coverage for yourself under certain circumstances if you lose coverage due to the Employee's entitlement to Medicare. If you are an Employee and initially eligible for 18 months of continuation coverage and you become entitled to Medicare, your dependents may be entitled to continue coverage for up to 36 months total, from the date of the initial Qualifying Event. Also, if you are an Employee and become entitled to Medicare and, within 18 months, experience a termination of employment or reduction in hours resulting in a loss of coverage, your covered dependents may elect to continue coverage for the period ending 36 months after the date you became entitled to Medicare. If, after electing COBRA continuation coverage, you first become entitled to Medicare, your COBRA coverage will end,

In some situations, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to an Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and dependent children will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

COBRA is a temporary extension of coverage made available if your coverage ends due to certain "Qualifying Events." Eligible Dependents may make separate elections to continue coverage, even if the Employee declines coverage.

ERISA

Claims Procedures for Fully Insured or HMO Benefits

For purposes of determining the amount of, and entitlement to, Benefits of the Plan provided under insurance or contracts, the respective insurer or HMO is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the Benefits provided under the applicable insurance or HMO contract.

To obtain Benefits from the insurer or HMO of the Plan, you must follow the claims procedures under the applicable insurance contract or HMO, which may require you to complete, sign, and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company or HMO will decide your claim in accordance with its reasonable claims procedures, as required by Section 503 of ERISA. The insurance company or HMO has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company or HMO denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or HMO for a review of the denied claim. The insurance company or HMO will decide your appeal in accordance with its reasonable claims procedures, as required by Section 503 of ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

Notwithstanding the above, the Plan may provide for an independent outside appeal right after the Appeals Administrator makes its final determination. Such independent external appeal will comply with applicable claim procedure regulations as required by Section 503 of ERISA.

In no event will these claims procedures be administered in a way that requires a Participant to file more than two (2) appeals of an Adverse Benefit Determination, prior to bringing a civil action under ERISA Section 502(a).

See the Coverage section of this SPD for more information about how to file a claim and for details regarding the insurance company's or HMO's claims procedures.

Claims procedures for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, Benefits under the Plan provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the Benefits provided through a self-funded arrangement.

To obtain Benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by Section 503 of ERISA. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by Section 503 of ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

Notwithstanding the above, the Plan may provide for an independent outside appeal right after the Appeals Administrator makes its final determination. Such independent outside appeal will comply with applicable claim procedure regulations as required by Section 503 of ERISA.

In addition, a Participant may submit a voluntary level of appeal to the Plan Sponsor, as Plan Administrator, for Benefits for final determination, pursuant to specific rules.

In no event will these claims procedures be administered in a way that requires a Participant to file more than two (2) appeals of an Adverse Benefit Determination, prior to bringing a civil action under ERISA Section 502(a).

See the Coverage section of this SPD for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

HIPAA

Privacy Notice of the U.S Roche Health and Welfare Benefits Retiree Healthcare Plan and the Roche Diagnostics Retiree Healthcare Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice provides information required by the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**") and the Health Information Technology for Economic and Clinical Health Act ("**HITECH**") and sets forth the duties and privacy practices of the U.S. Roche Health and Welfare Benefits Non-VEBA Plan (the "**Plan**") to protect the privacy of your medical information. The Plan provides health, dental and/or vision benefits to you as described in your SPD and the applicable Component Documents. The Plan receives and maintains your medical information in the course of providing these health benefits to you. The Plan hires business associates, such as United Healthcare, Delta Dental, Vision Service Plan, OptumHealth, and Alight, to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. The Plan is sponsored by Genentech, Inc. (the "**Plan Sponsor**").

The Plan is required to provide this Privacy Notice (the "**Notice**") to you pursuant to HIPAA.

HIPAA protects only certain medical information known as "protected health information" which generally is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

- your past, present or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present or future payment for the provision of health care to you.

If you have any questions concerning this Notice or about the privacy practices, please contact Plan Sponsor listed in the Other Important Information section of this SPD.

THE EFFECTIVE DATE OF THIS NOTICE IS SEPTEMBER 23, 2013.

Our Responsibilities:

The Plan is required by HIPAA to protect the privacy of your protected health information and provide you with certain rights with respect to your protected health information. The Plan will provide you with a copy of this Notice, explaining the legal duties and privacy practices with respect to your protected health information. The Plan is required to follow the terms of this Notice until it is replaced. The Plan reserves the right to change the terms of this Notice at any time. If the Plan makes changes to this Notice, the Plan will revise it and send a new

Notice by electronic mail to all subscribers covered by the Plan at that time. The Plan reserves the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new Notice.

Use or Disclosure of Protected Health Information:

Under HIPAA, the Plan may use or disclose your protected health information under certain circumstances, without your permission. The following categories describe the different ways the Plan may use and disclose your protected health information:

- *Health Care Providers' Treatment Purposes*. The Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. For example, the Plan may disclose your protected health information to your doctor, at the doctor's request, for your treatment by him/her.
- *Payment*. The Plan may use or disclose your protected health information to determine your eligibility for Plan benefits, facilitate payment for treatment, to determine benefit responsibility or to coordinate Plan coverage. For example, the Plan may use or disclose your information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.
- *Health Care Operations*. The Plan may use or disclose your protected health information for other necessary Plan operations. For example, the Plan may use or disclose your information (i) to conduct quality assessment and improvement activities, for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (ii) to authorize business associates to perform data aggregation services, (iii) to engage in care coordination or case management, and (iv) to manage, plan or develop the Plan's business. The Plan will not use your genetic information for underwriting purposes.
- *Health Services*. The Plan may use your protected health information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its business associates to assist the Plan in these activities.
- *As required by law*. The Plan will disclose your protected health information when required to do so by federal, state or local law. For example, the Plan may disclose your information when required by public health disclosure laws.
- *To Business Associates*. The Plan may disclose your medical information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your protected health information. For example, the Plan may disclose protected health information to a business associate to administer claims or to provide support services.
- *To Plan Sponsor*. The Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information to assist in administering the Plan. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor that fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your protected health information to the Plan Sponsor for Plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your information. The Plan Sponsor must also agree not to use or disclose your information for employment-related activities or for any other benefit of benefit plans of the Plan Sponsor.

- *To Avert a Serious Threat to Health and Safety*. The Plan may use or disclose your protected health information when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure would be to someone able to prevent the threat.

Special Situations:

In addition to the above, the following special categories describe other possible reasons that the Plan may use and disclose your protected health information:

- *Family Member, Friend or Other Person*. The Plan may disclose your protected health information to a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and cannot give your agreement to the Plan.
- *Workers' Compensation*. The Plan may release your protected health information for workers' compensation or other similar programs that provide benefits for work-related injuries or illnesses.
- *Lawsuits and Disputes*. If you are involved in a lawsuit or dispute, the Plan will disclose your information to comply with legal proceedings, such as a court or administrative order or subpoena.
- *Law Enforcement*. The Plan may disclose your protected health information to law enforcement officials for limited law enforcement purposes.
- *Research*. The Plan may disclose your protected health information to researchers when individual identifiers have been removed or in other limited circumstances.
- *Coroners, Medical Examiners and Funeral Directors*. The Plan may disclose protected health information to a coroner, medical examiner, or funeral director about a deceased person.
- *Organ or Tissue Donation*. If you are an organ donor, the Plan may release your protected health information to an organ procurement organization in limited circumstances.
- *Health Oversight Activities*. The Plan may disclose your protected health information to a governmental agency authorized to oversee the health care system, government programs and compliance with civil rights laws.
- *National Security*. The Plan may disclose your protected health information to federal officials for lawful intelligence, counterintelligence and other national security purposes.
- *Public Health Risks*. The Plan may disclose your protected health information for public health purposes, like to prevent or control disease, injury or disability, or to report child abuse or neglect or reactions to medications.
- *Military and Veterans*. If you are a member of the armed forces, the Plan may release your information to appropriate military authorities.

Mandatory Disclosures:

The Plan is required to disclose your protected health information under the following circumstances:

- *Governmental Audits*. The Plan must disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

- *Disclosure to You*. When you request, the Plan is required to disclose to you the portion of your protected health information that contains medical records, billing records or any other records used to make decisions regarding your health care benefits. In addition, the Plan is required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures:

The Plan may disclose your protected health information but only as directed by you, under the following circumstances:

- *Spouses and other Family Members*. With only limited exceptions, the Plan will send all mail to the employee, including mail relating to Plan benefits for the employee's Spouse or other family members who are covered under the Plan. If a person covered by the Plan has requested Restrictions or Confidential Communications (for more information, see below under "Your Rights"), and if the Plan has agreed to such request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.
- *Personal Representatives*. The Plan will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney in fact, etc., so long as you provide the Plan with a written authorization and any required supporting documentation (i.e., power of attorney).
- *Other Authorizations*. Other uses or disclosures of your protected health information not listed above will only be made with your written authorization. The Plan will not use or disclose your medical information for any other purposes unless you give the Plan your written authorization to do so (e.g., among other usage or disclosure, without your written authorization to do so, the Plan will not (i) use or disclose your psychiatric notes, (ii) use or disclose your protected health information for marketing, or (iii) sell your protected health information). If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this Notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization.

Your Rights:

You may make a written request to the Plan to obtain one or more of the following rights concerning your protected health information that the Plan maintains:

- *Right to Request Restrictions*. You have a right to put additional restrictions on the Plan's use and disclosure of your protected health information that the Plan uses or discloses for treatment, payment or health care operations. In addition, you can restrict or limit he protected health information that the Plan discloses to someone who is involved in your care or payment for your care, such as a family member or friend. In your written request, you must tell the Plan, what information is restricted, whether you want to limit the Plan's use, disclosure, or both and to whom you want the restriction to apply. The Plan does not have to agree to your request. If the Plan does agree to your request, the restriction will remain in place until you revoke it or the Plan notifies you otherwise.
- *Right to Request Confidential Communications*. You have a right to communicate with the Plan in confidence about your medical information by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence.

- *Right to Inspect and Copy*. You have a right to see and get copies of your protected health information that may be used to make decisions about your health care benefits. If you request a copy of the information, the Plan may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. In very limited circumstances, the Plan does not have to agree to your request.
- *Right to Amend*. You have the right to correct your medical information if you feel that the protected health information that the Plan has about you is incorrect or incomplete by providing a written request to amend and reasons that support your request. In some cases, the Plan does not have to agree to your request. If the Plan denies your request, you have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include your statement.
- *Right to an Accounting of Disclosures*. You have a right to receive a list of disclosures of your protected health information that the Plan and its business associates made for certain purposes for the last 6 years. Your request should indicate in what form you would like the disclosure list (e.g. paper or electronic). The first list you request during a 12-month period will be provided free of charge. For additional disclosure lists, the Plan may charge you the cost of providing the list after notifying you of the cost involved and allow you to choose to withdraw or modify your request at that time before any costs are incurred.
- *Right to a Paper Copy of this Notice*. You have a right to request that the Plan send you a paper copy of this Notice if you received this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this Notice, please contact the Plan Sponsor listed in the Other Important Information section of this SPD. The Plan will give you the necessary information and forms for you to complete and return to Plan Sponsor listed in the Other Important Information section of this SPD. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

In addition, the applicable insurance company should have given you a privacy notice that explains these rights with respect to any fully-insured health care benefits under the Plan. To exercise these rights with respect to either fully-insured or self-insured health care benefits under the Plan, you should contact the applicable insurer or contractor at the address and/or telephone number listed in Appendix A-1 and Appendix A-2 of the Plan.

Notification upon Breach:

The Plan restricts access to your protected health information to those who need the information in order to provide products or services to you. The Plan also maintains physical, administrative and technical security measures to comply with HIPAA's privacy and security rules to safeguard your protected health information.

- *Notification*: Following its discovery of any breach of any unsecured protected health information, the Plan is required by HIPAA to notify each individual whose unsecured protected health information has been, or is reasonably believed to have been, inappropriately accessed, acquired, used or disclosed as a result of the breach, as set forth below. The Plan also is required to notify the Secretary of the Health and Human Services and, in certain cases, the media, of any breach of unsecured protected health information.

A "breach" is defined for this purpose as the acquisition, access, use or disclosure of protected health information in a manner that is not permitted by HIPAA's privacy rule and which poses a significant risk of financial, reputational or other harm to the individual, as determined by the Plan. However, a "breach" does not mean (a) any unintentional acquisition, access or use of protected health information by a member of the workforce of the Plan Sponsor or any Affiliate, or any person acting under the authority of the Plan or its business associate, if the acquisition, access or use was made in good faith and within the scope of authority and does not result in a

further use or disclosure in a manner that is not permitted under the HIPAA privacy rules; (b) any inadvertent disclosure by a person who is authorized to access the protected health information at the Plan or its business associate to another person authorized to access the protected health information at the Plan or same business associate, and the information received as a result of such disclosure is not further used or disclosed in a manner that is not permitted under the HIPAA privacy rules; or (c) a disclosure of protected health information where the Plan or its business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Any business associate of the Plan is also required to notify the Plan of any breach of unsecured protected health information and provide the Plan with information concerning the breach. In turn, the Plan would notify the individual whose unsecured protected health information was breached.

- *Timing and Notice Requirements*: Any breach notification required to be made by the Plan will be made in writing to the affected individual (or next of kin or personal representative of the individual if the individual is known by the Plan to be deceased) at the last known address of the individual (or next of kin or personal representative) by first class mail (or by electronic mail to the individual if previously agreed to by the individual and such agreement has not been withdrawn). This notification will be made without unreasonable delay, but in no event later than sixty (60) calendar days after the discovery of the breach by the Plan. However, such notification may be delayed if a law enforcement official determines that the notification would impede a criminal investigation or cause damage to national security. If there is insufficient or out-of-date contact information that does not allow written notification to the individual as set forth above, a substitute form of notice reasonably calculated to reach the individual will be provided by the Plan. In any case deemed by the Plan to require urgency because of a possible imminent misuse of unsecured protected health information, the Plan may provide information to individuals by telephone or other means, as appropriate, in addition to the written notice specified above. Notification of a breach of unsecured protected health information may be provided in one or more mailings as information is available, and will, to the extent possible, include: (a) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; (b) a description of the types of unsecured protected health information that were involved in the breach (such as whether full name, Social Security Number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved); (c) any steps the individuals should take to protect themselves from potential harm resulting from the breach; (d) a brief description of what the Plan is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and (e) contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, an e-mail address, web site, or postal address.

Complaints:

If you believe that your privacy rights under HIPAA have been violated or the Plan has not complied with this notice, including the breach notification requirements set forth above, you may file a written complaint with the Plan's Privacy Officer at the address listed on the first page of this notice and/or with the Office for Civil Rights of the Health and Human Services Department (the "**OCR**"). All complaints must be submitted in writing. You can request a copy of the Plan's complaint procedure, including a sample complaint form, free of charge, by contacting the Plan's Privacy Officer at Genentech, Inc., at 1-650-225-1000, or toll-free at 1-800-626-3553 (for the Roche Health and Welfare Benefits Retiree Healthcare Plan) or The People Support Team at 1-800-816-8221 (for

the Roche Diagnostics Retiree Healthcare Plan). To file a complaint with the OCR, please contact the OCR using the toll-free number: 1-800-368-1019.

No Retaliation or Waiver:

The Plan supports your right to protect the privacy of your protected health information and will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you (or any other individual) for the exercise of any right established under HIPAA's privacy rule, including filing a complaint with the Plan or the OCR; testifying, assisting or participating in an investigation, compliance review, proceeding or hearing under HIPAA's privacy rule; or opposing any act or practice made unlawful by HIPAA's privacy rule, provided that you have a good faith belief that the practice opposed is unlawful and the manner of the opposition is reasonable and does not involve a disclosure of protected health information in violation of HIPAA's privacy rule.

The Plan will not require you to waive your privacy rights under HIPAA's privacy rule as a condition of treatment, payment, enrollment in the Plan, or eligibility for benefits.

Contact Office:

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact the Plan Sponsor listed in the Other Important Information section of this SPD.

Statement of ERISA Rights

Your Rights	As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan Participants shall be entitled to:
Receive Information About Your Plan and Benefits	Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.
COBRA and HIPAA Rights	Continue health care coverage for yourself, your Spouse, Domestic Partner, or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
Prudent Actions by Plan Fiduciaries	In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

Enforce Your Rights	If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan 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 per 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, which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
Assistance with Your Questions	If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information		
Plan Name	U.S Roche Health and Welfare Benefits Retiree Healthcare Plan.	The Roche Diagnostics Retiree Healthcare Plan
Type of Plan	The Plan is a welfare benefit plan and includes the following programs, each of which contains one or more Component Plans: • Medical, including Prescription Drug Benefits; • Dental Benefits; • Vision Benefits; • Healthcare Account Benefits	The Plan is a welfare benefit plan and includes the following programs: • Premium Contribution Percentage Program
Plan Year	The plan year is January 1–December 31.	
Funding Medium and Type of Plan Administration	Some Benefits under the Plans are self-funded, and some are fully insured. The Plans are funded through the Employers' general assets. The medical and prescription (with the exception of the Kaiser HMO component and the state-filed Hawaii plan which are fully insured), dental, and vision coverage and the healthcare subsidy programs are self-funded by the Company (i.e., not insured through a contract with an insurance company). The insurance companies, HMOs and service providers, not the Employer, are responsible for paying claims with respect to these programs. The Employer shares responsibility with the insurance companies, HMOs and service providers for administering these program benefits. Insurance premiums for Participants are paid in part by the Employer out of its general assets and in part by Participants. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent enrollment periods and upon request.	
Plan Sponsor	Genentech, Inc. 1 DNA Way, Mail Stop 8014 South San Francisco, CA 94080	Roche Diagnostics Corporation 9115 Hague Road Indianapolis, IN 46250
Plan Sponsor's Employer Identification Number	94-2347624	13-2511923
Insurance Companies/HMO	See Appendix A	

Other Important Information		
Plan Administrator	Genentech, Inc. c/o Director, Employee Benefits & Services 1 DNA Way, Mail Stop 8014 South San Francisco, CA 94080 The Plan Sponsor has full discretionary authority to administer, interpret, and determine eligibility for the Plan. Certain administrative duties are performed by Plan Administrator.	Roche Diagnostics Operations, Inc. c/o Director, NAM HR Shared Services Center 9115 Hague Road, Bldg. G, 1st Floor Indianapolis, IN The Plan Sponsor has full discretionary authority to administer, interpret, and determine eligibility for the Plan. Certain administrative duties are performed by Plan Administrator.
Named Fiduciary	Genentech, Inc. 1 DNA Way, Mail Stop 8014 South San Francisco, CA 94080	Roche Diagnostics Corporation 9115 Hague Road Indianapolis, IN 46250
Agent for Service of Legal Process	Genentech, Inc. c/o General Counsel 1 DNA Way South San Francisco, CA 94080 Service for legal process may also be made on the Plan Administrator.	Roche Diagnostics Corporation c/o General Counsel 9115 Hague Road Indianapolis, IN 46250 Service for legal process may also be made on the Plan Administrator.

Important Notice and Contact Information

NEITHER THIS SPD NOR THE POLICIES AND PROCEDURES CONTAINED HEREIN CONSTITUTE A CONTRACT. THIS MEANS THAT NO PROMISE OF ANY KIND IS INTENDED BY THE BENEFITS DESCRIBED IN THIS SPD. NOTHING IN THE SPD OR THE PLANS DESCRIBED IN IT GIVES, OR IS INTENDED TO GIVE ANY PERSON THE RIGHT TO BE RETAINED IN THE EMPLOYMENT OF THE EMPLOYER, OR TO INTERFERE WITH THE RIGHT OF THE EMPLOYER TO TERMINATE THE EMPLOYMENT OF ANY PERSON.

The benefit plans described in this SPD are offered by the Plan Sponsor voluntarily and may be amended or terminated at any time by action of the Board of Directors of the Plan Sponsor or its delegate. Amendments may, among other things, affect contribution rates, benefit coverage, reimbursement rates, procedures, participation, etc., with respect to current or future employees, retirees or other terminated employees or their dependents or survivors, regardless of whether they are participating in the Plan(s) at the time of amendment.

This SPD is a general summary of various benefit plans applicable to employees of the Employers listed at the end of each section. This SPD is not meant to interpret, extend, or change the benefit plans in any way. Every attempt has been made to ensure the accuracy of the information in this SPD. However, if there is any discrepancy between the contents of this SPD and the official Plan documents and contracts, the official Plan documents and contracts will always govern.

Contact Information

FOR ADDITIONAL INFORMATION AND ASSISTANCE, CONTACT:	
For Participants in the Healthcare Account or Premium Contribution Percentage Program:	**Alight Service Center** **US: 1-833-882-3585 or** **International: 669-210-8658**
For Participants in the Percentage Program or Healthcare Credits Program of the Roche Post-Employment Healthcare Plan:	**Alight Service Center** **US: 1-833-882-3585 or** **International: 669-210-8658**
Participating Employers	
Hoffmann-La Roche Inc. Roche Laboratories, Inc. HLR Service Corporation Roche Molecular Systems, Inc. Roche Holdings, Inc. Roche Madison Inc. Ventana Medical Systems, Inc. Spring Bioscience Corporation Roche Health Solutions, Inc. Roche Operations Ltd Roche NimbleGen, Inc.	Roche Sequencing Solutions 454 Life Sciences Corporation Roche Palo Alto LLC Roche Insulin Delivery Systsems Inc. Roche Diagnostics Corporation Roche Diagnostics Operations, Inc. Genentech, Inc. Genentech USA, Inc. Roche TCRC, Inc. Roche Diabetes Care, Inc. GenMark Diagnostics Inc

Claims Administrators				
	Medical and Prescription Coverage		Dental Coverage	Vision Coverage
	PPO Options	HMO Option		
Type of Service	Administrative services only	Covered benefits as outlined in the Evidence of Coverage are insured by the following HMO.	Administrative services only	Administrative services only
Service Provided by	Claims Address: United Healthcare P.O. Box 30555 Salt Lake City, UT 84130-0555 1-888-264-0749 National Appeals: United Healthcare Appeals National Appeals Center ASO P.O. Box 30432 Salt Lake City, UT 84130-0432 1-888-264-0749 www.myuhc.com/	Northern CA: Kaiser Permanente Attn: California Claims P.O. Box 12923 Oakland, CA 94604-2923 Southern CA: Kaiser Permanente Claims Administration Dept. P.O. Box 7004 Downey, CA 90242-7004 (800) 464-4000 Northwest: Kaiser Permanente Claims Administration P.O. Box 370050 Denver, CO 80237-9998 1-800-813-2000 www.kaiserpermanente.org	Delta Dental P.O. Box 997330 Sacramento, CA 95899-7330 (800) 765-6003 www.deltadentalins.com	VSP P. O. Box 997100 Sacramento, CA 95899-7100 (800) 877-7195 www.vsp.com
	Addresses shown above may not be the same as the address for general claims submission. Contact the applicable claims administrator to obtain claim forms with correct addresses.			

Claims Administrators				
	Medical and Prescription Coverage		Dental Coverage	Vision Coverage
	PPO Options	HMO Option		
Healthcare Account Program Premium Percentage Contribution Program				
Type of Service	Administrative services only			
Service Provided by	Roche Claims and Appeals Management (CAM) Dept 03406 P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 224.333.2333 Phone: US: 1-833-882-3585 or International: 669-210-8658 https://digital.alight.com/roche			
	Addresses shown above may not be the same as the address for general claims submission. Contact the Plan Administrator or the applicable claims administrator to obtain claim forms with correct addresses.			

Addendum A - Hawaii

The following terms and conditions apply to employees (and their eligible dependents) who are residents of the state of Hawaii:

1. Participants who are Hawaii residents and their eligible dependents may only participate in the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and prescription plans and cannot elect to participate in the Select PPO or Health Choice PPO medical and prescription option;
2. Participants who are residents of the state of Hawaii, whether full-time, part-time, on-call, or temporary, will be eligible for coverage under the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and the PPO prescription plan if they work at least 20 hours each week (an "*Eligible Hawaii Employee*"). Notwithstanding anything to the contrary, the eligibility requirements in the preceding sentence will be construed in a manner that is in compliance with the State of Hawaii Prepaid Health Care Act of 1974, as amended, and any regulations of official guidance issues by the State of Hawaii Department of Labor & Industrial Relations, Disability Compensation Division (the "*PHC Law*");
3. Default coverage for Eligible Hawaii Participant who has not made an affirmative election to participate shall be in the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and the PPO prescription plan;
4. Penalty for noncompliance with the preadmission certification program is at least a 70% benefit with a maximum penalty of $400/admission and in the aggregate $1,000/year;
5. The UnitedHealthcare state-filed insured plan wrapped around the managed indemnity plan and PPO prescription plans' exclusion of benefits for injuries resulting from the commission of or attempt to commit a felony by the insured does not apply;
6. The UnitedHealthcare state-filed insurance plan wrapped around the managed indemnity medical plan and PPO prescription plans' exclusion of benefits for any care in a hospital or other facility owned or operated by any state entity does not apply;
7. The UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and PPO prescription plans' exclusion of benefits for any illness or injury related to employment, whether or not a claim is filed, is hereby replaced with a subrogation right entitling the Medical and Prescription Plan to a right to recovery. Generally, a work-related disability is covered under the workers' compensation law, while a nonwork-related disability should be filed as a medical plan claim. In Hawaii, if you file a workers' compensation claim and it is being denied, you may still file a claim for benefits under the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and PPO prescription plans and the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and PPO prescription plans may provide, to the extent required by the PHC Law, medical and/or prescription benefits if you are an Eligible Hawaii Employee and your injury is covered under the terms of the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and PPO prescription plans. However, if you are subsequently awarded workers' compensation benefits for the same disability or injury, **the U.S. Roche Health and Welfare Benefits Retiree Healthcare Plan has the right to subrogate your workers' compensation benefits to the extent the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and PPO prescription plans provided benefits to you earlier**.

Subrogation may also extend to benefits resulting from a legal action on liability if such benefits are awarded subsequently for the same disability covering the same disability period;

8. The UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and PPO prescription plans' exclusion of benefits for services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member is modified to only exclude services provided by a parent, child, or spouse; and
9. To the extent not already provided, medical coverage under the UnitedHealthcare state-filed insured plan wrapped around the managed indemnity medical plan and PPO prescription plans shall be continued for a disabled employee for at least 3 months following the month of disability.

Appendix A

Benefit Plan Contracts/Policies for U.S. Roche Health and Welfare Benefits Retiree Healthcare Plans and Roche Diagnostics Retiree Healthcare Plan

PLANS	INSURER/CONTRACTOR	ADDRESS	TYPE OF FUNDING
MEDICAL			
Medical HMO (including prescription drugs)	Kaiser Permanente (HMO) Northern CA Group #: 35200 Southern CA Group #: 228503 Northwest Group#: 20512	Northern CA: Kaiser Permanente Attn: California Claims P.O. Box 12923 Oakland, CA 94604-2923 1-800-464-4000 Fax: 1-866-889-6021 Southern CA: Kaiser Permanente Claims Administration Dept. P.O. Box 7004 Downey, CA 90242-7004 1-800-464-4000 Fax: Must be mailed, no fax available Northwest: Kaiser Permanente Claims Administration P.O. Box 370050 Denver, CO 80237-9998 1-800-813-2000 www.kaiserpermenente.org	Fully-Insured

PLANS	INSURER/CONTRACTOR	ADDRESS	TYPE OF FUNDING
Medical and Prescription PPO (Select and Health Choice)	United Healthcare Group #: 751992	Claims Address: United Healthcare P.O. Box 30555 Salt Lake City, UT 84130-0555 1-888-264-0749 National Appeals: United Healthcare Appeals National Appeals Center ASO P.O. Box 30432 Salt Lake City, UT 84130-0432 1-888-264-0749 www.welcometouhc.com	Self-Insured
DENTAL			
Dental	Delta Dental Premier Delta Dental Basic Group #: 376	Delta Dental of California P.O. Box 997330 Sacramento, CA. 95899-7330 1-800-765-6003 https://www1.deltadentalins.com/group-sites/roche.html	Self-Insured
VISION			
Vision	VSP Premier VSP Basic Group #: 00812101	Vision Service Plan P. O. Box 997105 Sacramento, CA. 95899-7105 1-800-877-7195 www.vsp.com/	Self-Insured

PLANS	INSURER/CONTRACTOR	ADDRESS	TYPE OF FUNDING
SUBSIDY PROGRAMS			
Healthcare Account Program (including the Genentech Legacy Bridge to Medical Program) **Roche Diagnostics Premium Contribution Percentage Program**	Alight Service Center	Alight Service Center PO Box 661096 Dallas, TX 75266-1096 Fax: 224-404-3014 Phone: US: 1-833-882-3585 or International: 669-210-8658 https://digital.alight.com/roche	Self-Insured