GSK Health Plan

Summary plan description

January 1, 2023

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An Overview of Your GSK Health Plan Benefits

Total Reward at GSK LLC (the "Company" or "GSK") includes an array of benefits to protect your health and wellbeing. As part of its comprehensive program, GSK offers benefits-eligible, US-based employees participation in the GSK Health Plan ("Plan" or "Health Plan"), an employer-sponsored health and welfare plan designed to help you stay healthy by providing coverage when you need care. GSK offers a variety of plan options and coverage levels so you can choose the coverage that's right for you among the following choices:

- Medical Coverage (includes Mental Health and Substance Abuse Benefits and Prescription Drug Coverage)
- Health Savings Account (HSA) (if enrolled in the GSK High Deductible Health Plan (HDHP) option)
- Dental Coverage
- Vision Coverage
- Employee Assistance Program (EAP)

This Summary Plan Description ("**SPD**") provides a summary of plan coverage and contains details and limitations of the Health Plan as of January 1, 2023. Reference herein to IRS limits and GSK or Employee contribution amounts are for plan year 2023 and are subject to change in the Company's discretion or pursuant to IRS Regulations.

If you are enrolled in one of GSK's Health Plan coverage options, you should take time to read this document and keep it as a reference. This SPD and the SPDs for other benefits offered under GSK's Total Reward program are available to you on the GSK Benefits Center portal (http://digital.alight.com/gsk) or by calling the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

This SPD is intended to provide accurate, understandable explanations of the main provisions of GSK's Health Plan, avoiding insurance and legal terms where possible. For each benefit option under the Plan, there is a legal document and/or contract that provides all details. In the event of any discrepancy between a summary and the formal plan document, the plan document will govern. You have a right to review the formal plan document and related materials as described in "**What Are My Rights Under ERISA?**" later in this SPD.

Who is Eligible to Participate in the Health Plan?

US-Based Regular Employees

All US-based full-time and part-time regular employees of GSK scheduled to work at least 20 hours per week are eligible to participate in health and wellbeing benefits. Employees on an approved, unpaid leave of absence may continue to participate in certain health and wellbeing benefits by contributing toward the cost of any coverage not provided automatically by GSK.

Special Note About Temporary Employees

GSK temporary employees are not eligible to participate in any Health Plan benefit. A "**temporary employee**" is a full-time or part-time employee who is paid directly by the Company and who has been offered a position that has a fixed duration. Temporary employee assignments may not exceed a continuous eighteen (18)-month period. After completion of an assignment, or expiration of the eighteen (18)-month assignment period, whichever comes first, the GSK temporary employee may not return to GSK for six (6) months.

In the event a GSK temporary employee is hired into a regular employee position, the employee's temporary or provisional service does not in any way affect or adjust the GSK service date, such as the "**hire date**" used in determining eligibility or level of benefits under any other GSK program sponsored on behalf of its regular employees, including, without limitation, vacation entitlement and eligibility for retiree health and wellbeing benefits.

Dependents

As an eligible employee, you can enroll your eligible family members in medical, dental and vision coverages under the Plan. Documentation to verify their eligibility will be required.

Your eligible dependents include the following:

- Your legal spouse (including your common-law spouse, if legally recognized in the state where you live), or your certified domestic partner.

  GSK requires that you certify the domestic partnership when enrolling. To qualify as a domestic partner for purposes of the GSK Health Plan, you and your domestic partner must:

  - Be in an exclusive and committed relationship for at least 12 months, and intend to remain in the partnership permanently,
  - Live together in the same principal residence and intend to do so indefinitely,
  - Not have been legally married to another person within the past 12 months,
  - Not have had another domestic partner within the past 12 months,
  - Be at least 18 years of age and mentally competent to consent to a contract,
  - Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside,
  - Be engaged in a committed relationship of mutual caring and support and be jointly responsible for each other's common welfare and living expenses, and
  - Not be in the relationship solely for the purpose of obtaining medical, dental and/or vision benefits coverage.
- Your unmarried, married, divorced or legally separated children; your adopted children; children placed with you for adoption; children of your legal spouse or certified domestic partner; or any children for whom you are the court-appointed legal guardian, until they reach age 26.
  - To qualify as a child of a certified domestic partner for purposes of any GSK benefit plan, you and your domestic partner must meet the certification requirements above. If your certified domestic partnership ends, your domestic partner's child(ren) will no longer qualify as an eligible dependent.
  - If you and your spouse divorce, your ex-spouse's child(ren) will no longer qualify as an eligible dependent.
- Your unmarried, married, divorced or legally separated children; your adopted children; children placed with you for adoption; children of your legal spouse or certified domestic partner; or any children for whom you are the court-appointed legal guardian and who are incapable of self-support because of mental or physical disability occurring before they reached age 26.
  - If the child was eligible for enrollment in the GSK Health Plan before age 26, the child must have been enrolled in the Plan before the date the child would otherwise lose coverage and remain continuously covered thereafter.
  - If the child was not eligible for enrollment in the GSK Health Plan before age 26 (eg the child was greater than age 26 when the employee was hired and became eligible for coverage), then the child must have been enrolled in the Plan from your date of employment and remain continuously covered thereafter.
  - To qualify as a child of a certified domestic partner for purposes of any GSK benefit plan, you and your domestic partner must meet the certification requirements above. If your certified domestic partnership ends, your domestic partner's child(ren) will no longer qualify as an eligible dependent.
  - If you and your spouse divorce, your ex-spouse's child(ren) will no longer qualify as an eligible dependent.

Medical documentation requirements, the review of documents, and determination of disability status are completed by the medical Claims Administrator following your enrollment in the Medical Plan. Contact the Claims Administrator at the number noted below for additional information on what is required to certify your dependent as disabled at least 90 days in advance of the child's 26th birthday, if possible.

- Aetna:1-800-345-5463
- UnitedHealthcare: 1-866-649-4867

If your spouse or certified domestic partner is also a benefits-eligible GSK employee or retiree, no restrictions apply. However, having coverage under more than one medical, dental, and/or vision plan does not necessarily mean you get more benefits because coordination of benefit rules will apply. See "**What if I or My Dependent Has Other Coverage?**" later in this SPD.

Social Security Numbers Required for Your Covered Dependents

As a provider of your Health Benefits, GSK is obligated to have on file and report to the IRS your covered dependent's Social Security Number (SSN). This is required by The Mandatory Insurer Reporting Law and Section 6055 of the Internal Revenue Code, which was enacted by the Patient Protection and Affordable Care Act.

Please ensure that the SSN for any dependents is noted on your benefits record on the GSK Benefits Center portal (http://digital.alight.com/gsk). If the SSN is missing for any dependent, it could result in an interruption of their health plan coverage.

If you have any questions, you should contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

Qualified Medical Child Support Orders

Certain court orders could require GSK to cover your child under the Plan. These are known as Medical Child Support Orders.

GSK determines whether the court order is a Qualified Medical Child Support Order ("**QMCSO**"). If it is, the child gains eligibility for coverage. The child also can gain eligibility if GSK receives a National Medical Support Notice and determines it to be a QMCSO. In these situations, GSK can take deductions from your paychecks for your and your child's coverage.

The Plan is required to cover the child from the date the order is approved until the date or age stated in the order, but not beyond the normal eligibility age. The child is added to whatever coverage you're enrolled in. If you're not already enrolled, you and your child will be assigned coverage or the agency submitting the order will choose from the available coverage options.

If a QMCSO requires someone other than you — for example, your ex-spouse — to provide health coverage for your child, you can drop coverage for that child if he or she actually becomes covered under the other person's health plan(s).

The Company has established a procedure to facilitate the determination and administration of QMCSOs under the Medical, Dental and Vision plans. For further information about QMCSOs, contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

Coverage for Newborn or Newly Adopted Child

Medical expenses incurred under the Plan on behalf of a newborn or newly adopted child are covered expenses for 31 days following the birth of your child or the date you assume a legal obligation for support in anticipation of adoption of a child. However, If you do not enroll the child within 30 days of birth or adoption, no payment will be made for expenses incurred after the 31st day, and you will have to wait until the next annual enrollment period or subsequent qualifying event to add the child to your coverage.

Special Grandfathering Rules for Medical and Dental Benefits

Secondary dependents who were covered under the medical and dental plans formerly sponsored by SmithKline on December 31,1987, and former spouses who were covered under the medical and dental plans sponsored by SmithKline Beecham on December 31, 1995, may continue to be eligible for medical and dental benefits, provided they continue uninterruptedly to meet the eligibility requirements in effect at that time. Eligibility ceases on the date the former spouse remarries, or the date the employee enrolls a new spouse, whichever comes first.

A Note About Medicare Eligibility

You and your eligible dependents, excluding domestic partners, are not required to enroll in Medicare Part B as long as you are an active employee and you and your dependents remain enrolled in medical coverage.*

Domestic Partners enrolled in GSK medical coverage will need to enroll in Medicare Part B as soon as they are eligible.

If you or an enrolled dependent are eligible for Medicare due to age or disability at termination of employment, regardless of your eligibility for severance pay or COBRA election, you must contact your local Social Security Office as soon as possible to enroll in Medicare Parts A and B. If you do not enroll in Medicare when you are first eligible, as determined by the Social Security Administration, there are significant financial implications.

Contact your local Social Security Administration Office or go to SSA.gov (https://www.ssa.gov/benefits/medicare/) to learn more about Medicare enrollment.

* COBRA benefits, including any subsidized COBRA benefits offered as part of a severance package, are not considered active coverage.

If you have questions about your or a dependent(s) eligibility to participate in any benefit covered in this SPD, you should contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

What is the Cost of Coverage?

You and the Company share the cost of medical, dental and vision coverage. Your cost for coverage will depend on the coverage options you elect, who is covered, and for the GSK Medical Plan, your annual base salary. Except as may be otherwise specified in the materials provided during an annual enrollment period, "**annual base salary**" for each plan year shall be your annualized base pay as of September 1 of the preceding year, or your hire date, if later. You pay your portion of the cost with before-tax contributions. If you are not currently on the payroll (such as when you are on an unpaid leave of absence), you pay for your portion of the cost with after-tax dollars.

The cost of coverage may change annually. It is explained in the communication materials available each year during the annual enrollment period.

If you enroll your domestic partner for coverage, you pay the same amount as you would for any spouse. However, because of tax law requirements, you must pay Federal income and Social Security taxes on the full value of the coverage for your domestic partner (unless you have certified him or her as a dependent under Section 152 of the Internal Revenue Code). This amount will be included in your gross income and reported on your W-2 form.

The Employee Assistance Program (EAP) is provided at no cost to you.

How do I Enroll in the Plan?

New Employees

On or soon after your first day of employment, you will receive information from the GSK Benefits Center on how to enroll in or waive coverage under GSK's medical, dental and vision coverage options under the Plan. You will have 30 days from your date of hire to enroll and if you enroll by the enrollment deadline, coverage for you and your eligible dependents will take effect retroactive to your date of hire.

You and your eligible dependents will automatically be covered by the Employee Assistance Program.

Rehired Former Employees

If you are a former benefits-eligible employee newly rehired, the same eligibility rules that apply to newly hired employees apply to you. Your coverage options depend on when you return to work:

- **Same Year** — If you return to work in the same calendar year, you will be enrolled in the same coverage options you had when your employment ended. However, if you participated in the HSA, you will be required to make a new contribution election for the remainder of the year. If you experienced a qualified change in status following your termination from GSK, you can make changes to your coverage that are consistent with your status change if requested within 30 days of your rehire.
- **Different Year** — If you return to work in a different calendar year, you will be considered to be a new employee for purposes of enrolling in coverage under this Plan. See "**New Employees**" above.
- **Rehire of Retiree** — If you are a retiree of GSK and are rehired as an employee, your GSK retiree health and wellbeing benefits coverage is automatically suspended, and you are required to enroll in GSK health benefits coverage as an active employee.

What if I Miss My Enrollment Deadline When I Am First Eligible?

If you are newly eligible for coverage but don't enroll in or waive coverage by the deadline, you will be defaulted into employee only coverage under the GSK High Deductible Health Plan. You will have no dental or vision coverage. You may not change this coverage during the year unless you have a qualified change in status and report that change to the GSK Benefits Center within 30 days. See "**Can I Change My Coverage Elections?**" below for information on making mid-year election changes.

Can I Change My Coverage Elections?

Annual Enrollment

You may change your health plan elections during the annual enrollment period held in the fall of every year. This allows you to adjust your benefits to reflect any changes in your personal situation or financial needs. The choices you make each fall will be in effect from the following January 1 through December 31 (the "**Plan Year**"). If you are on an approved leave of absence while annual enrollment is held, there may be additional restrictions on changes to certain benefits.

Mid-Year Health Plan Election Changes

You **cannot** make new health plan choices during the year unless you have a qualified change in status that is recognized by the IRS and report that change to the GSK Benefits Center within 30 days of the event. The IRS has identified four basic types of qualifying life events that may cause you or a dependent to have a qualified change in status. These are (1) loss of health coverage, (2) changes in household, (3) changes in residence, and (4) other qualifying life events. The following are examples of qualifying life events and is not meant to be an exhaustive list.

- Status Change: If any of the following events causes you or a dependent to gain or lose eligibility for health coverage, you may make an election change that is consistent with that gain or loss

  - Your loss of benefits (If you waived medical coverage because you had other medical coverage, you may enroll in the GSK Medical Plan within 30 days after you lose that other coverage),
  - Your marriage or certification of a domestic partnership,
  - Divorce, legal separation, termination of domestic partnership, or annulment,
  - Birth, adoption, placement of a child for adoption, attainment of legal guardianship of a child, or becoming an eligible dependent. See "**Coverage for Newborn or Newly Adopted Child**" section of this SPD;
  - Child's loss of dependent status by virtue of the age limit, or loss of legal guardianship;
  - Death of a spouse/certified domestic partner or eligible child;
  - Termination or commencement of a dependent's employment;
  - Dependent's loss or gain of benefits;
  - Change in your employment status or work schedule, or the employment status or work schedule of your spouse/certified domestic partner or dependent, or
  - Change in the residence or worksite of you, your spouse/certified domestic partner or a dependent.
- Court Order: If a QMCSO requires you to cover your child under this Plan, you may add the child as a dependent. If the order requires your spouse or former spouse to cover the child, you may remove the child from coverage under this Plan.
- Medicare: If you or a dependent becomes entitled to (ie 'enrolled in') Medicare, you may change your election accordingly.
- COBRA: If you or your dependent becomes entitled to COBRA, you may change your election accordingly.
- Cost of Coverage: If there is a significant change in the cost of coverage under your spouse's/certified domestic partner's plan, you may change your election accordingly.

The IRS requires that any change in your elections be consistent with the event. For example, if you marry, you may add coverage for your spouse. However, please note that you cannot change from one option to another. For example, if you are currently covered under GSK PPO plan, you can't change to the GSK HDHP option. Documentation to verify any new dependent's eligibility will be required.

What if I or My Dependent Has Other Coverage?

The purpose of the GSK Health Plan is to reimburse you at specified levels for the cost of covered expenses incurred. Therefore, benefits under this Plan generally take into account benefits from other benefit plans for which you or your covered dependents may be eligible. This is called "**coordination of benefits**".

Under coordination of benefits you can receive payment from both the GSK Health Plan and another group plan for claims incurred by you or a covered dependent. The maximum reimbursement is 100% of the covered expense and GSK only pays up to the amount it would have paid if it were the only plan.

If You Have Other Coverage

When you have a claim for yourself, the GSK Health Plan pays benefits first. It is the primary plan for you because it is your employer-sponsored plan.

If you are also enrolled in your spouse/domestic partner's plan, that plan is secondary for you. After your claim has been processed by the GSK Health Plan, you may submit the claim to your secondary plan.

If Your Dependent Has Other Coverage

Your spouse/domestic partner's or other covered dependent's plan is primary for them. When your dependent has a claim, it should be submitted first to their primary plan. The GSK Health Plan is their secondary plan. After your dependent's claim has been processed by their primary plan, they may submit the claim to the GSK Health Plan. Again, the maximum reimbursement from the two plans is 100% of the covered expense and GSK only pays up to the amount it would have paid if it were the only plan.

The chart below shows an example of how coordination of benefits works for a dependent of a GSK employee who has primary coverage under another plan and secondary coverage under the GSK Medical Plan.

	Spouse's Employer's Plan	GSK Health Plan
Dependent submits a claim to both plans for:	$1,000	$1,000
If both plans have a $300 deductible which has not been met, the deductible is subtracted:	$300	$300
Leaving this amount considered for reimbursement:	$700	$700
If both plans pay 90% coinsurance, the dependent receives:	$630 (90% of $700)	$0 (Because the dependent has already been reimbursed at the maximum amount the GSK Medical Plan allows)
If the dependent's plan pays 65% coinsurance and GSK pays 90%, the dependent receives:	$455 (65% of $700)	$175 (The difference between what the dependent's plan pays and the maximum amount the GSK Medical Plan allows)

The coordination of benefits provision does not keep you from getting benefits to which you are entitled. It simply prevents the payment of benefits over and above what the GSK Health Plan would normally pay.

There is one exception to the coordination of benefits rule for prescription drug coverage; only GSK prescription drug products are eligible for coordination of benefits. There is no coordination of benefits for non-GSK products, unless you have Medicare Part B coverage.

Coverage Taken Into Account

The coordination of benefits provision will apply where you or your dependents are covered under the GSK Health Plan and any of the following types of arrangements:

- A group insurance or group subscriber contract;
- An uninsured arrangement of group or group-type coverage;
- Group or group-type coverage through a health maintenance organization or other prepayment, group practice, or individual practice plan;
- A group-type contract not available to the general public;
- Group or group-type hospital indemnity benefits;

- Medical benefits coverage in group, group-type, or individual automobile policies, whether under a traditional "**fault**" or "**no fault**" contract; or
- Medicare or coverage under government programs or programs required by law, other than a state plan under Medicaid.

The coordination of benefits provision applies to automobile coverage even if it is an individual insurance policy or contract. Apart from automobile coverage, the coordination of benefits provision does not apply to coverage that you carry under personal, private, or individual insurance policies.

Determining Which Plan Pays First

The following rules apply in determining which plan pays first:

- A plan with no rules for coordinating benefits will pay first; otherwise,
- The plan that covers the patient as an employee pays first.
- If both plans cover the patient as an eligible child, the plan of the parent whose birthday (month and day, not year) occurs earlier in the calendar year pays first, unless the parents are separated or divorced;
- If the parents of an eligible child are separated or divorced, payment is made in this order:
  - First, by the plan of the parent who is responsible for the child's medical expenses by a court decree; then
  - By the plan of the parent with custody of the child if there is no court decree; then
  - By the plan of the person married to the parent with custody; then
  - By the plan of the parent who does not have custody.
- When you have COBRA coverage, the plan covering the individual as an active employee or a dependent of an active employee will be primary over a plan that covers the individual as a COBRA-qualified beneficiary. If the individual is the dependent of an active employee under the GSK Health Plan, but was the subscriber of a COBRA coverage, then the COBRA coverage will be primary.
- If you or your dependent had Medicare coverage **prior to** your termination of employment, you are eligible for COBRA. Medicare will be primary and COBRA will be secondary. However, if you or your dependent had End Stage Renal Disease before becoming eligible for age/disability Medicare, COBRA will be primary and Medicare will be secondary for the first 30 months.
- If no payment order can be established, the plan that has covered the patient for the longest period of time pays first in most cases.

There may be coordination of benefits scenarios that are not specifically noted above. For additional information regarding coordination of benefits for your specific situation, you should contact your insurance provider.

When Does My Coverage End?

Active coverage generally ends the last day of the month in which you terminate employment, fail to make required contributions, or the Plan is terminated.

At the time active coverage ends, you and/or your dependents may be eligible for continued coverage under COBRA at your expense. See the "**Continued Coverage Under COBRA**" section of this SPD for additional information.

Coverage for Terminated Employees Eligible for Retiree Benefits

If you are eligible for retiree benefits when your employment with GSK ends, you may be eligible for continued benefits under the GSK retiree benefits program. The plan that you will be eligible for is dependent on your eligibility for Medicare. See the "**Retiree Benefits Coverage**" summary plan document (SPD) for additional information.

Coverage During a Leave of Absence

- **Paid Leave** - Your coverage under the Plan will continue during any approved paid leave of absence, and your premium deductions will continue to be taken from your payslip.
- **Unpaid Leave** - You may continue your coverage under the Plan during any approved unpaid leave of absence, provided you continue to pay your coverage premiums. While on unpaid leave, you will be given the option by the GSK Benefits Center to be direct-billed or to have your premium amount direct debited from your bank account on a monthly basis.

Coverage if you Become Disabled

While you are on an approved, paid short-term disability leave of absence, your GSK benefits remain in effect and your usual payroll deductions will continue. If you do not return to active work when your short-term disability benefits end, your employment with GSK will end. Your active employee coverage will terminate at the end of the month in which your short-term disability benefits end. At the time coverage ends, you and/or your eligible dependents may be eligible for continued coverage under COBRA for a limited time at your expense, or if you qualify for long-term disability benefits when your short-term disability ends, you and/or your dependents may be eligible for disability continuation coverage. See the "**Disability Program**" summary plan document (SPD) for additional information.

When Does Dependent Coverage End?

Dependent coverage generally ends when your coverage ends.

Dependent coverage can also end on the last day of the month in which the dependent no longer meets the eligibility requirements of the Plan. See the "**Dependents**" section of this SPD for additional information.

At the time coverage ends, your dependents may be eligible for continued coverage under COBRA at their own expense. See the "**Continued Coverage Under COBRA**" section of this SPD for additional information.

Does the Plan Provide Coverage for my Surviving Dependents if I Die?

If you die while employed by GSK, your enrolled dependent's coverage under your GSK Health Plan option continues to the end of the month of your death.

Your surviving dependents are eligible for survivor coverage under the medical and/or dental plan if they:

- Were covered under the GSK Medical Plan and/or GSK Dental Plan at the time of your death; and
- Don't enroll in continued coverage under COBRA for medical or dental.

Survivor coverage includes medical and dental coverage only. Your eligible survivors may elect to continue vision coverage by electing COBRA at their expense. See the "**Continued Coverage Under COBRA**" section of this SPD for additional information.

Survivor coverage begins the first day of the month immediately following your death. Your eligible survivors are automatically assigned coverage in the GSK Health Plan option in which they were enrolled at the time of your death. This coverage will stay in effect until the next annual enrollment period. If your survivors don't select a new coverage option during annual enrollment, their current option, if available, will be carried over for the next plan year.

New dependents cannot be added to survivor coverage. However, your surviving spouse or domestic partner can add your eligible child to survivor coverage if the child is born after your death and the request is made by contacting the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252) within 30 days of the child's birth.

If your surviving spouse remarries (or your surviving domestic partner marries or establishes a new domestic partnership), his or her new spouse/domestic partner is not eligible for coverage.

When Does Survivor Coverage End?

Survivor coverage ends on the earliest of:

- The last day of the calendar year following the year in which your death occurs. For example, if your death occurs in 2023, survivor coverage will end at midnight on December 31, 2024.
- The last day of the month in which your surviving dependent:
  - Dies;
  - No longer meets the dependent eligibility requirements; or
  - Loses eligibility for survivor coverage.

If your surviving spouse or domestic partner dies, coverage continues for your other eligible surviving dependents until they no longer meet eligibility requirements.

If you were eligible for retiree benefits at the time of your death, your survivors will be eligible for coverage as a survivor of a retiree after the date that their coverage as the survivor of an active employee ends, provided they continue to meet the eligibility requirements of the Plan.

For example, if your death occurs in 2023, coverage as the survivor of an active employee will end on December 31, 2024. Retiree survivor coverage will begin on January 1, 2025. The Retiree Benefit that your survivors will be eligible for is based upon each individual's eligibility for Medicare, as described in the "**GSK Retiree Health Benefits**" summary plan document.

If you weren't eligible for retiree medical benefits at the time of your death, your survivors may be eligible for continued coverage under COBRA after the date that their coverage as the survivor of an active employee ends as described in the "**Continued Coverage Under COBRA**" section of this SPD.

Coverage if Survivor Becomes Eligible Employee

If your survivor becomes an eligible employee of GSK, survivor coverage is suspended for the duration of his or her employment. The same eligibility rules that apply to new hires apply to your survivor. When your survivor's employment with GSK ends, the prior survivor coverage is reinstated (if still an eligible survivor and within the time period described in "**When Does Survivor Coverage End?"** above). They will be eligible to enroll in whatever coverage options are available to them at the time of their termination.

What are the Medical Coverage Options Under the Plan?

Medical Coverage[1] includes prescription drug coverage and mental health/substance abuse benefits. Eligible employees may waive coverage or select coverage under either the GSK Preferred Provider Organization option (the "**GSK PPO**") or the GSK High Deductible Health Plan option (the "**GSK HDHP**") with Health Savings Account (the "**HSA**").

[1]Employees in Hawaii will have coverage offered through UnitedHealthcare in compliance with state regulations. For employees and covered dependents enrolled in the Hawaii plan, mental health/substance abuse and prescription drug benefits are provided through that plan.

What Participation Levels are Available Under the GSK Medical Plan?

If you elect to participate in the Medical Plan, you may choose from the following participation levels:

- Employee Only
- Employee and Spouse or Certified Domestic Partner
- Employee and Eligible Child(ren)
- Employee and Family (spouse or certified domestic partner and eligible children)

The GSK PPO and the GSK HDHP Options

The GSK PPO and GSK HDHP options offer you a network of healthcare providers that you can use for your medical care. Each medical plan option is available through your choice of either the Aetna Choice POS II or UnitedHealthcare (UHC) Choice Plus network, and covered services are the same under each. These providers have agreed to provide benefits at contracted rates and are referred to as in-network providers. When you use in-network providers, you receive a higher level of benefits. You have the flexibility to receive care from any doctor or specialist, or use any hospital, whether they are in-network or out-of-network; but, you will pay more for services provided by an out-of-network provider and you may also be required to seek pre-authorization for such services. In addition, if you receive care from an out-of-network provider, you are generally responsible for any charges above the Medicare allowed amount or R&C allowance (referred to as balance billing), in addition to your deductible and coinsurance amount (if any).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or you're treated by an out-of-network provider at an in-network hospital, or ambulatory surgical center or by an air ambulance provider, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

- "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
- "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care. Examples are when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost, such as the copayments, coinsurance, and deductibles, that you would pay if the provider or facility was in-network. Your health plan will pay out-of-network providers and facilities directly.
- You're never required to give up your protections from balance billing. You also don't have to get care out-of-network. You can choose a provider or facility in your plan's network.

You are protected from balance billing for:

- **Emergency services**

  If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount. This includes copayments, deductibles and coinsurance. You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition. The exception is if you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- **Certain services performed by an out-of-network provider at an in-network hospital or ambulatory surgical center**

  When you get services from certain out-of-network providers at an in-network hospital or ambulatory surgical center, those out-of-network providers may not balance bill you or ask you to sign a written notice and consent form that allows balance billing. You pay only your plan's in-network cost sharing amount. This applies to anesthesia, assistant surgeon, emergency medicine, hospitalist, intensivist service, laboratory, neonatology, pathology, or radiology.

  If you get other services from any other out-of-network providers at in an in-network hospital or ambulatory surgical center, these out-of-network providers can't balance bill you, unless you sign a written notice and consent form that allows balance billing and are provided with a good faith estimate of your costs from the hospital or ambulatory surgical center before services are given. If you sign the notice and consent form, you can be balance billed for out-of-network services. You are not required to sign the notice and consent form. You may seek care from an available in-network provider.

- **Air Ambulance**

  When you receive medically necessary air ambulance services from an out-of-network provider, your cost share will be the same amount that you would pay if the service was provided by an in-network provider. Any coinsurance or deductible will be based on rates that would apply if the services were supplied by an in-network provider.

Does the Medical Plan Provide Prescription Drug Coverage?

Employees and their eligible dependents who are enrolled in medical coverage automatically receive prescription drug coverage, administered by CVS Caremark, Inc.

The prescription drug benefit offers two ways to receive medications - through the retail network (typically for short term or acute medications) and the mail order benefit (for long-term or maintenance medications). You have the option to use a retail pharmacy or mail order home delivery for maintenance medications, however, your cost will be less if you choose to use mail order.

You can receive up to a 90-day supply of your maintenance medications by using mail order home delivery. You can order online or by calling 1-800-875-0867. Your medications will be delivered within about 10 days from the time your order is placed.

Prescriptions written for a 90-day supply by your physician must meet maintenance guidelines for you to receive a 90-day supply.

Eligible GSK prescription drug products labeled with a GSK National Drug Code (NDC) number, or those in which there is a co-marketing agreement, are available to you and your dependents at $0 cost, through mail order or a

retail pharmacy. Employees who waive GSK medical coverage are also eligible to receive GSK prescription drug products with a zero-dollar co-pay; however, their dependents are not eligible for this benefit.

If you are enrolled in the GSK HDHP option, you will pay the full cost of the drug, including GSK prescription drugs, until you have met your calendar year deductible.

Does the Medical Plan Provide Behavioral Health Care Services?

Employees and their eligible dependents who are enrolled in medical coverage are also eligible to receive behavioral health care services. Participating behavioral health care providers maintain the provider-patient relationship with you or your dependents and are solely responsible to you or your dependents for all the services they provide.

Does the Medical Plan Provide Coverage for Abortions?

Medically necessary and/or elective abortions (both in- and out-of-network) are covered services under the Plan.

If the member has to travel more than 50 miles due to legal restrictions, then:

- Out-of-network abortions covered at the in-network benefit level
- Coverage will be at the in-network cost share and based on 100% of the billed charges
- Travel and Lodging (dollar amounts in line with IRS guidelines) covered if travel to qualified provider is 50 miles or more. Receipts are required for all travel and lodging reimbursement requests.
  - Travel includes plane (economy ticket); train; bus; boat, taxi, Uber/Lyft, gas, tolls/parking
  - Lodging - $50 per person / per night; maximum $100 / night
  - Travel and Lodging Lifetime Maximum $10,000 (includes Travel and Lodging related to other benefits such as transplants)
  - Per IRS guidelines, meals are not eligible for reimbursement

In addition, both over the counter and prescription abortion drugs are covered under the prescription drug benefit.

Do I Need to Pre-Authorize Any Services?

Pre-authorization (or prior authorization) ensures that you receive the most appropriate care at the maximum level of reimbursement. If pre-authorization is required, you should begin the pre-authorization process at least two weeks before a scheduled admission, test, or procedure. In the case of an emergency, you should call within two working days following admission to the hospital. Additionally, certain prescription drugs through CVS Caremark require pre-authorization.

Plan	Who Must Pre-Authorize?
GSK PPO Plan Option **Aetna**: 1-800-345-5463 **UHC**: 1-866-649-4867	In-network providers will pre-authorize on your behalf. For an out-of-network provider, you will need to handle the pre-authorization process yourself or arrange with your provider to pre-authorize on your behalf.
GSK HDHP Option **Aetna**: 1-800-345-5463 **UHC**: 1-866-649-4867	In-network providers will pre-authorize on your behalf. For an out-of-network provider, you will need to handle the pre-authorization process yourself or arrange with your provider to pre-authorize on your behalf.
Prescription Drug Coverage **CVS Caremark**: 1-888-739-7992	You and/or your pharmacist will pre-authorize.

If you do not pre-authorize when required, your benefits may be reduced.

Failure to pre-authorize out-of-network services under the GSK PPO Plan and GSK HDHP options will result in a reduced level of benefits or no benefit coverage. There is no penalty to the member if the in-network provider fails to obtain prior authorization.

Failure to pre-authorize certain drugs will result in no coverage.

Failure to pre-authorize in-patient behavioral health care services will result in a reduced level of benefits or no benefit coverage.

These penalties raise your share of the cost of your care, and they do not apply toward your deductible or your out-of-pocket maximum.

Comparison of GSK Medical Plan Options and Covered Services

Following is a summary chart of covered medical benefits. If you have any questions about whether a service is covered, contact Aetna at 1-800-345-5463 or UnitedHealthcare at 1-866-649-4867.

Medical Plan Information administered by Aetna or UHC	GSK PPO		GSK HDHP with HSA	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Annual Deductible	$300 individual $750 family	$900 individual $2,250 family	$2,000 individual $4,000 family	$6,000 individual $12,000 family
			The "Individual" deductible amount applies only if Employee Only coverage is elected. For Employee + Spouse/Domestic Partner, Employee + Children or Employee + Family coverage, the full "Family" deductible must be met before the Plan pays benefits for any covered family member.	
Annual Out-of-Pocket Maximum <u>Applied</u> to annual out-of-pocket maximum: Deductible, coinsurance, ER and hospital confinement copays After annual out-of-pocket maximum is met, eligible expenses will be covered at 100% for the remainder of the year. <u>Not applied</u> to annual out-of-pocket maximum: Pre-authorization penalties, amounts exceeding the allowable amount and non-covered expenses	$3,000 individual / $7,500 family Note: In-network out-of-pocket amounts are <u>not</u> applied to the out-of-network out-of-pocket maximum. Copayments, coinsurance and deductibles for in-network medical and prescription drug services will not exceed $4,500 per person and $10,500 per family	$5,000 individual / $12,500 family Note: Out-of-network out-of-pocket amounts are <u>not</u> applied to the in-network out-of-pocket maximum.	$6,550 individual / $13,100 family Note: In-network out-of-pocket amounts are <u>not</u> applied to the out-of-network out-of-pocket maximum. Copayments, coinsurance and deductibles for in-network medical and prescription drug services will not exceed $6,550 per person and $13,100 per family	$13,100 individual / $26,200 family Note: Out-of-network out-of-pocket amounts are <u>not</u> applied to the in-network out-of-pocket maximum.
Health Savings Account (HSA) administered by HealthEquity (available to active employees only)				
Company contribution Note: Company contributions will begin once your HSA is established, so long as you are in a paid status. You will not be eligible to receive company contributions for any missed or unpaid pay period during the year (the annual amounts shown will be prorated).	Not Applicable		$750 individual* $1,500 family*	

Medical Plan Information administered by Aetna or UHC	GSK PPO		GSK HDHP with HSA	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Maximum annual employee contribution limit Note: The 2023 HSA contribution limit for Company and employee contributions combined is $3,850 individual/$7,750 family ($4,850 individual/$8,750 family for participants age 55 and over).			$3,100 individual* / $6,200 family* The maximum annual contribution limit for participants age 55 and over is increased by $1,000. * Company and individual contributions made by payroll deduction will end on the last day of the month prior to the month in which you become enrolled in Medicare. If you become eligible for Medicare, you must confirm with the GSK Benefits Center that you have deferred your enrollment in Medicare parts A & B.	
Prescription Drug Coverage administered by CVS Caremark [c]				
Coinsurance - Acute Medications (34-day supply at retail). Acute medications are for short-term illnesses.	10% (min $5/max $75)		10% (min $5/max $75) after deductible You pay 100% of drug cost prior to deductible being met	
Contraceptives	$0		$0	
Coinsurance - Maintenance Medications (90-day supply). Maintenance medications are used to treat long-term illnesses and conditions. Prescriptions written for a 90-day supply by your physician must meet maintenance guidelines for you to receive a 90-day supply.	Retail (first two fills): 10% (min $5/max $75) Retail (after first two fills): 10%, plus $15 (min $20/max $90) Mail Order: 10% (min $5/max $75)		Retail (first two fills): 10% (min $5/max $75) after deductible Retail (after first two fills): 10%, plus $15 (min $20/max $90) after deductible Mail Order: 10% (min $5/max $75) after deductible You pay 100% of drug cost prior to deductible being met.	
Contraceptives	$0		$0	
GSK Drugs - Maintenance or Acute Medications	$0		$0 after deductible; you pay 100% of drug cost prior to deductible being met	
Annual Out-of-Pocket Maximum (Any additional amount paid for a brand drug when a generic is available does not apply to the out of pocket maximum.)	$1,500 individual / $3,000 family. Once the maximum is reached, you will not be required to pay prescription drug coinsurance for the remainder of the calendar year.		Prescription drug costs will apply to HDHP deductible and out-of-pocket maximum.	
Note: If you choose a brand name drug instead of the generic when one is available, you will pay the generic coinsurance plus the difference in cost between the brand name and the generic drug. This does not apply if your doctor prescribes a brand name drug and indicates 'Dispense as Written' on the prescription because you have a medical need for the brand. This does not apply to GSK prescription products.				

Medical Plan Information administered by Aetna or UHC	GSK PPO		GSK HDHP with HSA	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Preventive Services (Coverage based on carrier guidelines and provider coding) [a]				
Physical exam (adult and child ages 4 through 18)	100%	100%	100%	100%
Well-baby care (through age 3)	100%	100%	100%	100%
OB/GYN exam, Pap smear and HPV screening	100%	100%	100%	100%
Immunizations	100%	100%	100%	100%
Laboratory tests	100%	100%	100%	100%
Mammography screening	100%	100%	100%	100%
Prostate screening (PSA)	100%	100%	100%	100%
Colonoscopy/sigmoidoscopy (excludes virtual colonoscopies)	100%	100%	100%	100%
Hearing exam/screening	100%	100%	100%	100%
Vision exam/screening (excludes lenses, frames, contacts)	100%	100%	100%	100%
Maternity Care				
Office Visits: • Preventive pre-natal care • High risk OB specialist office visits	100% 100% after $25 copay	70% after deductible	90% after deductible	70% after deductible
Delivery	90% after deductible	70% after deductible	90% after deductible	70% after deductible
In-hospital physician and facility [b]	90% after deductible and $250 confinement copay	70% after deductible	90% after deductible and $250 confinement copay	70% after deductible
Newborn nursery service [b e]	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Inpatient/Outpatient Services				
Virtual visit (excluding behavioral health)	100% after $15 copay	N/A	90% after deductible	N/A
Office visit (PCP & Specialist) or Behavioral health virtual visit	100% after $25 copay	70% after deductible	90% after deductible	70% after deductible
Inpatient hospital [b]	90% after deductible and $250 confinement copay	70% after deductible	90% after deductible and $250 confinement copay	70% after deductible

Medical Plan Information administered by Aetna or UHC	GSK PPO		GSK HDHP with HSA	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Inpatient surgery [b]	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Outpatient hospital facility [b]	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Outpatient surgery [b]	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Emergency room facility	90% after deductible and $100 copay (copay waived if admitted)	90% after deductible and $100 copay (copay waived if admitted)	90% after deductible and $100 copay (copay waived if admitted)	90% after deductible and $100 copay (copay waived if admitted)
Non-emergency emergency room care	Not covered	Not covered	Not covered	Not covered
Urgent care facility	100% after $25 copay	70% after deductible	90% after deductible	70% after deductible
Ambulance (life-threatening situations)	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Diagnostic x-ray and laboratory [b, d] CAT, MRI, PET Scans & other nuclear imaging tests must be pre-authorized or 20% penalty will apply.	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Home healthcare/private duty nursing [b]	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Hospice care [b]	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Skilled nursing facility [b]	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Allergy serum/injections	100% after $25 copay	70% after deductible	90% after deductible	70% after deductible
Chiropractic services/acupuncture 20 visit combined limit per calendar year	100% after $25 copay at office; 90% after deductible for x-rays at outpatient facility	70% after deductible	90% after deductible	70% after deductible
Durable medical equipment [b] (approval required for equipment over $5,000)	100% after $25 copay at office; 90% after deductible for non-office	70% after deductible	90% after deductible	70% after deductible
Hearing Aids ($5,000 per year; one per ear every three calendar years)	90% after deductible	70% after deductible	90% after deductible	70% after deductible

Medical Plan Information administered by Aetna or UHC	GSK PPO		GSK HDHP with HSA	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Infertility Services [c]	90% after deductible 100% after $25 copay – office visit only	Not covered unless an in-network provider is used	90% after deductible	Not covered unless an in-network provider is used
Occupational/physical/speech therapy (up to 60 visits per calendar year per type of therapy)	100% after $25 copay at office; 90% after deductible at outpatient facility	70% after deductible	90% after deductible	70% after deductible
Radiation/chemotherapy	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Mental Health/Substance Abuse administered by Medical Carrier (Aetna or UHC)				
Inpatient mental health [b]	90% after deductible and $250 confinement copay	70% after deductible	90% after deductible and $250 confinement copay	70% after deductible
Inpatient substance abuse [b]	90% after deductible and $250 confinement copay	70% after deductible	90% after deductible and $250 confinement copay	70% after deductible
Outpatient mental health/substance abuse	100% after $25 copay 90% after deductible at outpatient facility	70% after deductible	90% after deductible	70% after deductible

Notes

a Out-of-network plan benefits are reimbursed at 110% of the Medicare allowed amount. If a Medicare allowed amount is not available, the Reasonable and Customary (R&C) allowance will apply. If you receive care from an out-of-network provider, you are responsible for any charges above the Medicare allowed amount or R&C allowance. Any amounts over the Medicare allowed amount and the R&C allowance do not apply toward the annual out-of-pocket maximum.

b Failure to pre-authorize certain services will result in penalties, including no coverage. Refer to the pre-authorization section of your Summary Plan Description.

c Infertility: Must have a diagnosis of infertility or in advance of cancer treatment that will result in infertility. No coverage for dependent children except in advance of cancer treatment that will result in infertility. No coverage unless an in-network provider is used. Combined $25,000 lifetime maximum includes prescriptions, injectables and medical services. Excludes all donor-related expenses. System audits will validate dollars paid between each medical plan carrier and prescription drug plan. All benefits paid from a prior medical plan carrier will carry-over to the current medical plan carrier.

d Professional interpretation fees are considered separately. Some radiology and pathology fees may be considered as part of the global fee and additional reimbursement may not be made.

e Additional deductible and $250 confinement copay will be applied if baby remains confined after discharge of mother.

Summary of Benefits and Coverage (SBC)

Additional information about the coverage options and the cost of benefits can be found in the applicable Summary of Benefits and Coverage (SBC) available to you through the **GSK Benefits Center portal** (**http://digital.alight.com/gsk**) under 'Plan Information'. You may also call the GSK Benefits Center at 1-844-358-0600 (or 312-843-5252) to request a printed copy of the SBC.

What is the Health Savings Account and How Does it Benefit Me?

If you enroll in the GSK HDHP option, you have the opportunity to open a tax-advantaged health savings account ("**HSA**"). An HSA is an account funded by you, or any other person on your behalf to help you cover, on a tax-free basis, current and future "**Qualified Health Expenses**" (defined below in **Using Your HSA Funds**). An HSA is not an ERISA covered plan, which means that GSK is not a fiduciary of your HSA. This generally means that GSK is not responsible for your HSA investments.

What Participation Levels are Available under the HSA?

Your HSA participation level will be Individual or Family, based on your enrollment in the GSK HDHP:

If your HDHP participation level is:	Your HSA participation level is:
Employee Only	Individual
Employee and Spouse or Certified Domestic Partner; Employee and Eligible Child(ren); or Employee and Family (spouse or domestic partner and eligible children)	Family

HSA Eligibility

To be eligible to enroll in the HSA, you must meet the following eligibility requirements, as defined by the IRS:

- You are covered under the GSK HDHP, on the first day of the month.
- You have no other health insurance coverage, such as through a spouse's plan.
- You are not enrolled in Medicare (Part A or B).
- You have not received care under Veterans Administration benefits in the last three months, unless you were treated for a service-connected disability.
- You cannot be claimed as a dependent on someone else's tax return.
- You or your spouse cannot have a regular Flexible Spending Account ("**FSA**") or a Health Reimbursement Account ("**HRA**").

You may elect to enroll or make changes to your HSA election anytime during the year. You do not need to have a Qualified Life Event, such as a marriage or divorce, to enroll or make changes.

How Much Can I Contribute to my HSA?

The HSA maximum annual contribution amount is set by the IRS. It includes both your and Company contributions. If you and your spouse both establish an HSA, the family contribution limit will apply to your combined accounts.

- **Your Contributions**
  Following your enrollment in the HDHP, you can choose to contribute pre-tax dollars to your HSA, up to the IRS limit. You can continue to contribute to your HSA as long as you maintain your account and until you reach age 65.

Contributions can also be made by your eligible family member(s) or by any other person, so long as total contributions do not exceed the maximum annual contribution amounts.

Individuals between the ages of 55 and Medicare entitlement age may contribute an additional $1,000 to their HSA each year. This amount is subject to change by the IRS. Your Annual Enrollment materials will provide this information each year.

- **GSK Contributions**
  As long as you are an active employee (that is, actively at work), each pay period for which you remain an eligible employee GSK will also automatically contribute to your HSA.

Refer to the section entitled **Comparison of GSK Medical Plan Options and Covered Services** for 2023 contribution limits.

Contributing to Your HSA

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which the contributions reach the contribution maximum; or (ii) the annual IRS tax filing deadline for the year. If coverage under the HDHP terminates, no further contributions may be made to the HSA; however, you can still invest the funds in your account and take distributions for qualified expenses.

If you enroll in your HSA during the year (ie, not on January 1), you may still contribute up to the annual maximum amount, provided you satisfy certain conditions set by the IRS. To find out more about those conditions, consult with your tax advisor or contact HealthEquity, the HSA administrator, at 1-844-729-3539.

You may also make a one-time transfer from your IRA ("**Individual Retirement Account**") to your HSA. There is no tax consequence of this one-time transfer and the amount counts toward your HSA contribution limit for the year.

Using Your HSA Funds

The funds in your HSA will be available to help you pay your or your tax dependents' "**Qualified Health Expenses**". Qualified Health Expenses are defined as expenses relating to the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, and include: annual deductibles and coinsurance, over-the-counter products, prescription and over-the-counter medications, menstrual care products, COBRA and Medicare premiums, and masks, hand sanitizer and sanitizing wipes. You may also use your HSA funds to pay for qualifying dental and vision expenses, and hearing aids. HSA funds used for such purposes are not subject to federal income or excise taxes. Refer to **HealthEquity (https://healthequity.com/)** for a list of Qualified Health Expenses. Note that Qualified Health Expenses are determined by the IRS and are subject to change.

Be sure to keep your receipts and medical records.
If you cannot demonstrate that you used your HSA to pay for Qualified Health Expenses, you may need to report the HSA distribution(s) as taxable income on your tax return. GSK and HealthEquity will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. GSK and HealthEquity are not responsible or liable for the misuse of HSA funds by Participants, or if Participants use the HSA funds for things other than Qualified Health Expenses.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (ie, your death, your disability, or your attainment of age 65).

Some states may require you to pay state income tax on the distributions from your HSA. Refer to your state's income tax information or consult your tax advisor.

HSA Account Balances

Any money that is left over in your HSA at the end of the year rolls over to the next year to help pay for any future health care needs. The HSA rollover is not limited – your entire remaining HSA account balance will roll over to the next year – even if you decide to enroll in another medical option (such as the PPO) or waive coverage in the next year. The account is yours to continue as permitted under IRS guidelines.

What Happens to my HSA if I Die?

If you have named your legal spouse as the beneficiary of your HSA and you die, your surviving spouse will be given access to the balance in your HSA but cannot make additional contributions to it. If you name anyone other than your legal spouse as the beneficiary of your HSA (including your domestic partner), he or she will receive a taxable distribution of your account balance if you die. If you have not named a beneficiary of your HSA, your account balance will go to your estate.

Important Information Relating to Medical Coverage Under the Plan

Alternative Medical Choice – State of Hawaii

As an alternative to either the GSK PPO or GSK HDHP, state mandates in Hawaii limit the offer of coverage to only the UHC Managed Indemnity plan. Refer to separate plan materials for more information. Contact UHC for coverage questions (1-866-649-4867) or the GSK Benefits Center for enrollment questions at 1-844-358-0600 (or 1-312-843-5252).

GSK PPO and GSK HDHP are Self-Insured

The GSK PPO and GSK HDHP are self-insured, which means that GSK determines the plan provisions and pays for medical expenses and claims incurred. However, GSK contracts with insurance companies ("**Claims Administrators**") to provide access to the doctors, hospitals and other providers who manage your treatment and care plans. These Claims Administrators also process claims and provide member services. Eligible charges must be considered medically necessary and appropriate as determined by the Claim Administrator's medical director's guidelines.

While the Claims Administrators are committed to providing accessible quality care, they are independent organizations and use their own protocols for operational, administrative and clinical determinations. GSK monitors the Claims Administrators' medical coverage guidelines to ensure that the GSK PPO and GSK HDHP are administered consistently. However, interpretation and claim protocols may vary between Claims Administrators. To ensure the highest level of coverage, you should contact your healthcare provider and the Claims Administrator before you receive a service to verify and/or pre-authorize coverage.

In addition, payment of claims is based on the way your provider bills. For example, the facility at which you see your primary care physician may be considered an out-patient facility, rather than an office facility, or services provided in an office setting such as lab work may be sent by your provider to another facility for processing and billed separately. You should speak with your provider to understand how claims will be processed.

Medical Expenses Not Covered

Please call Aetna, UHC or CVS Caremark if you are unsure about covered services and exclusions. See "**Whom to Call for Help**" for contact information.

Required Notices Relating to Medical Coverage Under the Plan

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("**WHCRA**"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the GSK PPO and GSK HDHP. If you would like more information on WHCRA benefits, contact the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

Pursuant to GINA, the GSK PPO and GSK HDHP protect against discrimination based on genetic information and, unless otherwise permitted, neither will request or require any genetic information from you or your family members.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, under the GSK PPO and GSK HDHP, financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance abuse disorder benefits are not more restrictive than the predominant requirements or limitations applied to substantially all medical benefits.

Medicare Part D Prescription Drug Creditable Coverage

If you or a covered dependent are enrolled in the GSK Medical Plan (which includes prescription drug coverage) and are also eligible for Medicare due to age or disability, a federal law called the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires GSK to provide you with an annual notice ("**Notice**") addressing whether your prescription drug coverage is creditable or non-creditable. You should receive the Notice each year by October 15.

Creditable means that prescription drug coverage is expected to pay out, on average, as much or more as the standard prescription drug benefit under Medicare Part D will pay. The prescription drug coverage provided under the GSK Medical Plan is creditable coverage. This means that if you are enrolled in the GSK Medical Plan as an active employee, you don't need to enroll in coverage under Medicare Part D because your coverage under the GSK PPO or GSK HDHP is creditable.

However, if you have other coverage that is non-creditable, you may pay higher Medicare Part D premiums if you have a break in creditable coverage of 63 days or more and then enroll in Medicare Part D prescription drug coverage.

Additional information about your prescription drug coverage is available in the Notice that you receive. The Notice is intended to help you decide between Medicare Part D prescription drug coverage or GSK provided coverage, if available. You can also request a copy of the Notice by contacting the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252) if you have questions.

You should keep the Notice for your records.

What are the Dental Coverage Options Under the Plan?

Eligible employees may waive dental coverage or select coverage under the GSK Preventive Dental Plan or the more comprehensive GSK Dental Plan.

What Participation Levels are Available Under the GSK Dental Plan?

If you elect to participate in the Dental Plan, you may choose from the following participation levels:

- Employee Only
- Employee and Spouse or Certified Domestic Partner
- Employee and Eligible Child(ren)
- Employee and Family (spouse or domestic partner and eligible children)

Dental Plan Options

Both the GSK Preventive Dental Plan and the GSK Dental Plan options encourage good dental care by paying 100% for preventive care services with no deductible. Only the GSK Dental Plan option covers basic and major restorative care services and orthodontic services.

Similar to the medical coverage options, there are two levels of benefits - in-network and out-of-network - that determine the total annual expense. Both dental plan options use the MetLife Dental PDP Plus network.

- **In-network Providers:** These providers accept a set fee, or "**maximum allowable charge**," as payment in full. Your share of the cost, after the deductible (if any), will be a percentage of this discounted maximum allowable charge. When you use in-network providers, you typically reduce your out-of-pocket expenses, and there are no claim forms to file.
- **Out-of-network Providers:** When you use out-of-network providers, you file claims to get reimbursed and dental benefits are based on the reasonable and customary ("**R&C**") charge, as determined by MetLife. The R&C charge means the typical amount charged by 90% of the dentists in your geographic area for the same services. If your dentist charges more than the R&C amount, you are responsible for the difference (referred to as balance billing), in addition to your deductible and coinsurance amount (if any).

The GSK Preventive Dental Plan Option

The GSK Preventive Dental Plan option provides benefits for preventive and diagnostic dental services only. This option pays 100% for preventive and diagnostic expenses, with no deductible. If you choose a MetLife in-network provider, you won't have any claims to file and you won't be balance billed. If you choose an out-of-network dentist, you must file a claim to get reimbursed, and if your dentist charges more than the R&C amount, you are responsible for the difference.

The GSK Dental Plan Option

As an alternative, the GSK Dental Plan option is a passive preferred provider organization ("**PPO**") plan, which covers a broad range of dental care and services, including preventive care, basic and major restorative care up to an annual maximum amount of $2,000 per person, and orthodontic services up to a lifetime maximum of $2,000 per person.

In addition to your premium payments, you are required to satisfy an annual deductible before any benefit for basic or major restorative services or orthodontics are paid by the GSK Dental Plan. The individual deductible is $50 and the family deductible is $150. No family member pays more than the individual deductible in any plan year. Each covered person pays toward his or her individual deductible until the maximum family deductible is met. When the combined deductibles for all individuals equal the maximum family deductible amount, no further deductible is due.

For example, assume you have five family members with an individual deductible of $50 and a family deductible of $150. If each of your five family members has paid $30 toward their individual deductibles, the family deductible has been met.

After you or your eligible dependent pays the deductible, the GSK Dental Plan option pays 90% for basic restorative services. Basic restorative services provided out-of-network are paid at 80% of the reasonable and customary allowance. Major restorative dental services are paid out at 80% for services provided by in-network providers, and 80% of the R&C allowance for services provided by out-of-network providers.

After you or your eligible dependent pays the deductible, the GSK Dental Plan option pays 80% for orthodontics up to the orthodontic lifetime maximum of $2,000. Orthodontics provided out-of-network are paid at 80% of the R&C allowance.

Comparison of GSK Dental Plan Options and Covered Services

Following is a summary chart of covered dental services. If you have any questions about whether or not a service is covered, contact MetLife Dental at 1-888-330-3444 or http://www.metlife.com/mybenefits.

Plan Information	GSK Dental Plan		GSK Preventive Dental Plan
	In-Network	Out-of-Network	
Annual Deductible • Individual • Family	$50 $150		None None
Annual Maximum Benefit	$2,000 per person (preventive care, basic restorative and major restorative services combined)		None
Preventive Care • Oral exams and cleanings • (2 per year) • Adult bitewing x-rays (1 per calendar year) • Child bitewing x-rays • (2 per calendar year) • Full mouth x-rays (1 series every 60 months) • Fluoride treatment for children under age 19 (1 per year) • Sealants for children under age 19 (1 every 3 years) • Palliative treatment (not subject to frequency limit)	100%* with no deductible		100%*
Basic Restorative Services • Fillings/amalgams (composite) • Consultations (2 per year) • Periodontal cleanings (4 per year in addition to 2 cleanings per year) • Periodontal surgical procedures (1 quadrant every 36 months) • Scaling and root planing (1 quadrant every 24 months) • Space Maintainers for children under age 19 (1 per tooth per lifetime) • Extractions • Root canals • Repairs/recements to crowns/dentures/bridges	90% after deductible	80%* after deductible	Not covered

Plan Information	GSK Dental Plan		GSK Preventive Dental Plan
	In-Network	Out-of-Network	
Major Restorative Services • Crowns and Crown Build-ups • Bridges • Inlays and Onlays • Post and Cores • Dentures • Implant Prosthetics The above services limited to 1 replacement every 7 years. • Extractions of impacted 3rd molars (wisdom teeth) • Oral Surgery • General and general anesthesia/IV sedation	80%* after deductible		Not covered
Orthodontic Services Note: The first payment is based on 25% of the total charge and is covered at 80% after deductible. The balance is paid equally over the duration of the estimated treatment plan. **Repetitive orthodontic payments will be paid during the last month of each three-month period.**	80%* after deductible (up to $2,000 lifetime maximum)		Not covered
Orthodontic Lifetime Maximum **Note: Any associated dental charges related to orthodontia will be included in the lifetime maximum.**	$2,000 per person		N/A

*Out-of-network plan benefits are based on the reasonable and customary (R&C) allowance. If you use an out-of-network provider, you are responsible for any charges in excess of the R&C allowance, if applicable.

A pre-treatment estimate should be obtained prior to receiving service to ensure coverage of specific procedures.

Important Information Relating to Dental Coverage Under the Plan

Choosing an In-Network Dentist

You may visit any participating dentist and receive the negotiated fee — you are not required to choose one dentist from the list. To locate a participating dentist, visit the MetLife website at http://www.metlife.com/mybenefits, or you can call MetLife at 1-888-330-3444. You will need to have your ID number from your MetLife ID card and the zip code of the area in which you are seeking a dentist.

When you make an appointment with your dentist, you should identify yourself as a MetLife Dental member and reconfirm that the dentist is a MetLife Dental PDP Plus participant.

GSK Dental Plan and GSK Preventive Dental Plan are Self-Insured

The GSK Dental Plan and GSK Preventive Dental Plan are self-insured, which means that GSK determines the plan provisions and pays for dental expenses and claims incurred. However, GSK contracts with MetLife to provide access to the dentists and other providers who manage your treatment and care plans. MetLife also processes claims and provides member services. Eligible charges must be considered necessary and appropriate as determined by MetLife's guidelines. To ensure the highest level of coverage, you should contact your provider for a pre-coverage estimate and contact MetLife to verify coverage.

Pre-Treatment Estimate

The purpose of a "**pre-treatment estimate**" is to verify eligibility and to determine if the services are covered and to provide an estimate of the dental charges. MetLife will determine the estimated benefits and advise you and the dentist before treatment begins. Following the review by MetLife, you and your dentist will receive a "**predetermination of benefits payable**" statement. If a treatment plan is not submitted in advance, MetLife reserves the right to determine the benefits payable, taking into account alternative procedures, services, or courses of treatment based on accepted standards of dental practice. A "**course of treatment**" is a planned program of one or more services or supplies, whether rendered by one or more dentists, to treat a dental condition diagnosed by the attending dentist based on an oral exam. Emergency treatments and oral exams, including prophylaxis and dental X-rays, are considered part of a course of treatment, but may be completed before the pre-treatment estimate.

Services for the treatment of TMJ (temporomandibular joint disorder) should be submitted for a pre-treatment estimate and medical necessity review to determine if the services will be covered as a dental benefit.

To request a pre-treatment estimate, use the standard claim form. Indicate clearly on the top margin of the form that it is being filed for the purpose of predetermining benefits. Your provider may submit the pre-treatment estimate on your behalf.

As part of the pre-treatment estimate - or any claim - MetLife has the right to require an oral examination of the patient. In addition, you are responsible for providing MetLife with all required diagnostic and evaluative material MetLife may request, such as x-rays, models, and charts.

What Vision Benefits are Available Under the Plan?

Eligible employees may waive vision coverage or select coverage under the GSK Vision Plan.

What Participation Levels are Available Under the GSK Vision Plan?

If you elect to participate in the Vision Plan, you may choose from the following participation levels:

- Employee Only
- Employee and Spouse or Certified Domestic Partner
- Employee and Eligible Child(ren)
- Employee and Family (spouse or domestic partner and eligible children)

The GSK Vision Plan

The GSK Vision Plan is administered by EyeMed Vision Care. All claims are processed through First American Administrators ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care, LLC. There are two levels of benefits - in-network and out-of-network - that determine the total annual expense.

Benefits available under the GSK Vision Plan include: (i) a contact lens benefit, (ii) a frame benefit, and (iii) a lens benefit. The contact lens benefit provides for coverage of materials only.

Eye exams are covered under the GSK Medical Plan, not the GSK Vision Plan.*

The EyeMed network of providers includes private practitioners, as well as many of the nation's premier retailers. Providers are subject to change. Call the EyeMed Member Services Department at 1-866-488-1517 or use the EyeMed provider locator service at www.eyemed.com to locate an in network provider.

Online options: You can also use your in-network benefits to purchase glasses, contacts and prescription sunglasses online. Simply visit contactsdirect.com, glasses.com, lenscrafters.com, ray-ban.com or targetoptical.com to instantly apply your eyewear benefits at checkout.

When you receive services at a participating EyeMed Provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any plan allowances. You also will owe state tax, if applicable, and the cost of any non-covered expenses (for example, vision perception training).

If you use an out-of-network provider, you will have to pay the entire cost at the time of service and will be responsible for submitting the claim to EyeMed.

Generally, you are entitled to benefits once every calendar year. However, you are not able to use both the contact lens benefit and the lens benefit in the same calendar year. In addition, you are entitled to discounts on Laser Vision treatments and additional purchases of contact lenses and eyewear.

*For participants residing in New Mexico, eye exams will also be covered under the GSK Vision Plan.

Medically Necessary Contact Lenses

In-Network: You are entitled to a paid-in-full benefit applied toward medically necessary contact lenses when one the following conditions exist:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers

- **Keratoconus** mild/moderate - when keratoconus is present and the member's vision is not correctable to 20/ 25 in either or both eyes using standard spectacle lenses
- **Keratoconus** advanced/ectasia – when keratoconus is present and one or more specified conditions are met
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Out-of-Network: Member is entitled to be reimbursed up to $200.00 for material when one of the above noted medical conditions exist. The Member must pay the out-of-network provider at the point of service and file a complete claim to receive the reimbursement.

Additional Purchases and Out-of-Pocket Discount

Members are also eligible for additional discounts on eyewear purchases after the full Lens (or Contact Lens) and Frame benefit has been used for the year. Once these benefits have been used, members are eligible for 40% off the retail price of a complete pair of eyeglasses and 15% off conventional (non-disposable) contact lenses.

Laser Vision Benefit

EyeMed Vision Care, in connection with the US Laser Network, owned and operated by LCA Vision, offers savings to you for LASIK and PRK. You are entitled to the following discounts: $800 off LASIK at Featured Provider Lasik***Plus*** - or - at any other in-network provider you can receive 15% off standard price or 5% off any promotional price.

For additional information or to locate a network provider, visit **www.eyemedlasik.com** or call **1-877-5LASER6**. Once you choose your provider, make sure to identify yourself as an EyeMed member to receive your discount and get further member instructions.

GSK Discount Vision Program

Employees who choose to waive coverage under the GSK Vision Plan will automatically be eligible for the GSK Discount Vision Program. There is no cost to participate in the Discount Program and no enrollment is required. However, there is no out-of-network coverage in the Discount Program.

Important Information About Vision Benefits Under the Plan

Fully Insured Plan

The GSK Vision Plan is a fully insured plan. This means that the insurer, not GSK, is responsible for making benefit determinations and paying benefit claims.

Comparison of GSK Vision Plan, GSK Discount Vision Program and Covered Services

Following is a summary chart of covered vision benefits. If you have any questions about whether a service is covered, contact EyeMed at 1-866-488-1517.

Plan Information	GSK Vision Plan		GSK Discount Vision Program (active employees only)
Enrollment	Required		Automatic
Eligibility	Employees and Eligible Dependents		Employees and Eligible Dependents
Premium	Yes		No
Benefit Frequency	Once every calendar year*		Once every calendar year
	In-Network Benefit	**Out-of-Network Reimbursement**	
Vision Exam	Not Covered Vision exam covered by GSK Medical Plan, if enrolled		
Frames	$165 allowance You pay 80% of balance over $165	Reimbursement: Up to $55	Discount of 35% off retail
Standard Plastic Lenses*	$15 copay for each of the following: • Single Vision • Bifocal • Trifocal • Standard Progressive	Reimbursement: • Single Vision: Up to $25 • Bifocal: Up to $40 • Trifocal: Up to $55 • Standard Progressive: Up to $55	Copay for each of the following: • Single Vision: $50 • Bifocal: $70 • Trifocal: $105 • Standard Progressive: $135
Lens Options	$0 copay for each of the following: • UV Coating • Tint • Standard Scratch Resistance • Standard Polycarbonate • Standard Anti-Reflective Coating Premium Progressive: $15 copay; $120 allowance You pay 80% of balance over $120 Other add-ons and services: 20% off retail	Reimbursement: • UV Coating: Up to $5 • Tint: Up to $5 • Standard Scratch Resistance: Up to $5 • Standard Polycarbonate: Up to $10 • Standard Anti-Reflective Coating: Up to $10 Other add-ons and services: No benefit	Copay for each of the following: • UV Coating: $15 • Tint: $15 • Standard Scratch Resistance: $15 • Standard Polycarbonate: $40 • Standard Anti-Reflective Coating: $45 Other add-ons and services: 20% off retail
Contacts*	**Non-Disposable:** $165 allowance You pay 85% of balance over $165 **Disposable**: $165 allowance You pay 100% of balance over $165	**Non-Disposable**: Reimbursement up to $135 **Disposable**: Reimbursement up to $135	**Non-Disposable**: 15% off retail **Disposable**: No benefit
Lasik	15% off retail price, or 5% off promotional price	No benefit	15% off retail price, or 5% off promotional price

*Benefit limited to either lenses or contacts once every calendar year.

What Services are Available Under the GSK Employee Assistance Program?

The Employee Assistance Program ("**EAP**"), provided by Optum, is a counseling and consultation service to help you address short-term personal issues and problems on a confidential basis. Coverage is automatic – there is no requirement to enroll. You and your benefits-eligible dependents, as well as any individual residing in your home, may each receive up to eight short-term counseling sessions (pre-authorized by Optum) with a health practitioner per issue per calendar year.

The EAP's role is to provide initial assessment, referrals, and short-term counseling. For longer-term needs, if you are enrolled in the GSK PPO or GSK HDHP, you and your covered dependents should use the benefit provided by your medical plan. You will be referred to the medical plan if your issue requires longer-term counseling and/or inpatient services. This means that you may immediately be directed to the medical plan by Optum for appropriate care.

Obtaining EAP Services

The EAP providers are separate from the other providers in the GSK Health Plan. Optum's nationwide network of licensed counselors can provide support by helping you identify and resolve issues involving:

- Relationships/marital issues;
- Family conflicts;
- Child and elder care issues;
- Stress, anxiety, and emotional distress; and
- Life changes.

To receive coverage for EAP services, you must contact Optum to pre-authorize the services. If you fail to do so, EAP services will not be covered and no reimbursement will be made. You must use an Optum participating provider for your EAP sessions to be covered by the program.

There is no cost to you for EAP services that have been pre-authorized. You do not need to submit claim forms, and you will not be liable for any fees for the authorized EAP sessions.

Call the EAP 24 hours a day, 365 days a year: 1-866-248-4096. Translation into 140 languages is available.

For the hearing impaired, TDD is available: Dial 700 and enter 1-866-248-4096

Go to https://liveandworkwell.com (Access code: GSKLAWW) to locate a provider or access resources on a variety of topics.

What Happens When You Call the EAP?

When you call to seek professional help, a clinical assessment model is followed to review your needs and recommend an appropriate treatment plan. The EAP specialist will assess your situation and suggest any one of a number of the following steps, depending on your needs:

- EAP follow-up visits and short-term counseling;
- Referral to the GSK Medical Plan (if enrolled) for longer-term outpatient counseling and/or in-patient services;
- Referral to a hospital for emergencies or severe conditions; or

- Consultation with an Optum Legal or financial consultant.

Optum will count one of your EAP counseling sessions toward the eight-visit maximum if you fail to cancel at least 24 hours in advance, unless the appointment is missed because of an emergency or circumstances beyond your control and you are unable to give 24 hours advance notice of cancellation.

If you have a condition that will require treatment beyond your EAP session limit or meets the criteria of a formal diagnosis serious enough to warrant Behavioral Healthcare treatment, you may be eligible for Behavioral Healthcare Services. Coverage is provided through the GSK PPO or GSK HDHP. You and/or your covered dependent must be enrolled in medical coverage under the GSK Health Plan to be eligible to receive the Behavioral Healthcare benefit.

Choosing an EAP Provider

Optum maintains a database of information on each EAP participating provider. If you have any questions regarding any of the providers, you can call Optum 24 hours a day, 365 days a year, or directly contact the provider. Optum's roster of providers is subject to change as new providers join Optum and some leave the network. Therefore, GSK cannot guarantee the initial or continued availability of any particular provider.

Remember that all EAP services must be provided by a participating provider. For pre-authorization and a referral to an Optum participating provider, call Optum at 1-866-248-4096. Exceptions to this rule are made only in cases of emergency, if authorization is provided in writing by Optum's Director of Provider Network Services.

Can I Change My EAP Provider?

When you call Optum, an intake specialist will make every attempt to select a provider who will best meet your needs. If you are dissatisfied with the provider you've seen, call Optum at 1-866-248-4096. After discussing your needs and preferences, an intake specialist will provide you with another referral. There may also be times when you require care that your initial provider is unable to administer. In this case, just call Optum or have your provider call Optum. Optum will promptly make a referral to another provider.

EAP Counselors and Confidentiality

Optum counselors include licensed psychologists, licensed clinical social workers, and licensed marriage and family counselors. All counselors are trained specialists who are located close to where you live or work.

Your call to Optum is confidential, and no one at GSK will have access to information about your personal circumstances. However, there are exceptions to confidentiality that include reporting of child abuse, elder abuse, persons dangerous to themselves or others, and litigation involving mental health.

Emergency Assistance

If you are experiencing severe symptoms and are impaired in your functioning to the extent that you present an immediate danger to yourself or others, it is considered to be an emergency. If you are in a crisis and need immediate assistance, you may call Optum's licensed counselors at 1-866-248-4096, 24 hours a day, 365 days a year, for an immediate telephone intervention and consultation, or you can call the 911 emergency response system.

EAP Limitations and Exclusions

We recommend that you carefully read the following limitations and exclusions before seeking any counseling or treatment through Optum. The EAP benefit does **not** provide coverage for:

- Inpatient treatment of any kind, or outpatient treatment for any medically treated illness;
- Prescription drugs;
- Treatment or services for mental retardation or autism;
- Counseling services beyond the number of sessions covered;
- Multiple services or procedures incurred in excess of the allowable amount during any one given EAP session;
- Services for diagnostic conditions that Optum determines should be evaluated under the Behavioral Healthcare benefit;
- Services rendered by a resident, intern, or any other provider not fully credentialed and licensed;
- Services by counselors who are not part of the EAP network;
- Counseling required by law or a court, or paid for by Workers' Compensation;
- Formal psychological evaluations and fitness-for-duty opinions;
- Investment advice (nor does Optum loan money or pay bills);
- Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents, or immigration; and
- Tax representation or preparation services.

EAP Information for California Employees Only

CA Timely Access to Care

Beginning July 1, 2017, Senate Bill (SB) 1135 requires information regarding the standards for timely access to care; including information about appointment wait times for urgent care, non-urgent primary care, non-urgent specialty care; wait times for telephone screening; and information related to availability of interpreter services at the time of the appointment. OptumHealth Behavioral Solutions of California ("**OHBS-CA**") has established the following standards to ensure you are able to obtain treatment in a timely manner in accordance with California Health & Safety Code § 1367.03.

Standard	Criteria	Time Frame
Non-Life-Threatening Emergency	A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others	You must be offered an appointment within 6 hours of the request for the appointment
Urgent	A situation in which immediate care is not needed for stabilization but, if not addressed in a timely way, could escalate to an emergency situation	You must be offered an appointment within 48 hours of the request for the appointment
Routine (non-urgent)	A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others	You must be offered an appointment within 10 business days of the request for the appointment
Telephone Access to OHBS-CA Representatives	Triage or screening waiting time: the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care	Not to exceed 10 minutes during normal business hours Not to exceed 30 minutes after normal business hours

Please note: The time for a particular, non-emergency appointment may be extended if it is determined* and documented that a longer waiting time will not have a detrimental impact on your health. Rescheduling of appointments, when necessary, must be consistent with good professional care and ensure there is no detriment to you.

*An extension to the time for a non-emergency appointment may be determined by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and is consistent with professionally recognized standards of practice.

Additional Information

- OHBS-CA expects all network providers to return calls to members within 24 hours.
- Interpreter services are available to you at the time of the appointment as requested by you or the provider. To request interpreter services, contact us at the phone number on your EAP benefits card. Language interpretation services are available at no cost to you.

OHBS-CA is committed to offering clinically appropriate and timely access to care pursuant to Section 1367.03 of the California Health and Safety Code. If you are unable to obtain a timely referral to an appropriate provider, you may contact OHBS-CA for assistance by calling us at the phone number on your EAP benefits card. Additionally, the Department of Mental Health Care (DMHC) Help Center may be contacted at 1-888-466-2219 to file a complaint if you are unable to obtain a timely referral to an appropriate provider.

CA Language Assistance Program

Senate Bill (SB) 853 requires essential elements of the Language Assistance Program ("**LAP**") to include: (i) standards for enrollee assessment, (ii) standards for provision of language assistance services, (iii) standards for training USBHPC personnel, and (iv) standards for monitoring compliance. The LAP provides for meeting enrollees' needs for written and spoken language assistance in seeking health care services at all administrative and clinical points of contact.

OptumHealth Behavioral Solutions of California and Optum serve members from many cultures. Our members may speak a language other than English. We want to be sure that language is not a reason to not get care. OHBS-CA and Optum offer free language assistance for members who speak or read a language other than English. Interpreter services are available to members at the time of an appointment as requested by the member or provider. OHBS-CA and Optum have interpreters for members. We can also translate certain documents in writing.

Call us at 1-844-701-5148 or email us at clinical_ops_lap@uhc.com to tell us your preferred language. If you have already given us this information, you don't need to contact us again. Also, you don't need to call us if your preferred language is English. For help with language at any time, you may use the phone number on your EAP benefits card.

Filing Claims

Claims for covered health care expenses, including hospitalization, are processed and paid by the Claims Administrators. The Claims Administrators have the right to withhold or recover payment whenever claims or bills are incomplete, inaccurate, or fraudulent. If you submit a fraudulent claim, your employment with the Company may be terminated.

If you need help completing a claim form, contact the Claims Administrator at the number noted below.

Any checks not cashed within one (1) year of the date of issue will be considered void and will not be reissued.

Filing a Claim for Medical and Behavioral Health Care Benefits

For in-network care you are not required to submit a claim form because your participating provider will file for you. For out-of-network services, including behavioral health care services (mental health/substance abuse benefits), you or your provider must submit a completed claim form for reimbursement.

Filing a Claim for Prescription Drug Benefits

If you use a participating pharmacy, show your CVS Caremark ID card to the pharmacist, who will fill your prescription. You will pay the applicable coinsurance and there are no claims to file.

If you use a non-participating pharmacy or you do not have your CVS Caremark ID card, you must submit a completed claim form for reimbursement, together with a receipt that includes the National Drug Code ("**NDC**") for each prescription, along with the seven-digit NCPDP number of the pharmacy. Ask the pharmacist to give you the NDC for your medication if you do not get it with your receipt.

Claim forms are available from the Claims Administrators' websites

- UnitedHealthcare: Members can access a claim form by logging into their myuhc.com account or calling the toll-free number on the back of their ID card. A generic medical claim form can be accessed at https://www.uhc.com/individual-and-family/member-resources/forms.
- Aetna: https://www.aetna.com/dsepublic/#/contentPage?page=providerResults&site_id=gsk
- CVS Caremark: www.caremark.com

Submit claims to the appropriate Claims Administrator

Aetna	**UnitedHealthcare**	**CVS Caremark**
P.O. Box 981106 El Paso, TX 79998-1106 Attention: Member Services	P.O. Box 740800 Atlanta, GA 30374-0800 Attn: Claims Department	P.O. Box 52136 Phoenix, AZ 85072-2136 Attention: Claims Department
Telephone: 1-800-345-5463	Telephone: 1-866-649-4867	Telephone: 1-888-739-7992

Claims must be received no later than one (1) year from the date of service or prescription fill. Any claim received after this date will not be considered eligible for reimbursement.

Filing a Claim for Dental Benefits

If you use an in-network provider, you do not need to submit a claim form. The dentist will submit the claim for you. If you use an out-of-network provider, you are responsible for submitting the claim to MetLife. Reimbursement will be sent to you or to your dentist, as indicated on the claim form.

Claim forms are available on-line at http://www.metlife.com/mybenefits or by calling MetLife Dental at 1-888-330-3444. Dental providers may call 1-877-638-3379.

Submit claims to the Dental Benefits Claims Administrator

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Claims must be received by MetLife no later than one (1) year from the date of service.

Accident Claims

Accident claims are generally considered medical rather than dental expenses. Therefore, if the patient is covered under the GSK PPO or GSK HDHP Plan, these claims should be submitted to the patient's medical plan as a medical claim.

If you are a participant in another medical plan, check with your particular provider to ensure that you have coverage for this type of treatment.

Filing an Out-of-Network Claim for Vision Benefits

Claim forms are available by calling EyeMed Vision Care at 1-866-488-1517. EyeMed Vision Care Customer Service can be reached 7 days a week Monday through Friday 7:30 am to 11:00 pm, Saturday 8:00 am to 11:00 pm and Sunday 11:00 am to 8:00 pm Eastern Time.

Submit claims to the Vision Care Claims Administrator

EyeMed Vision Care
Attn: Out-of-Network Claims
P.O. Box 8504
Mason, OH 45040-7111

Or you can file online: To access the out-of-network form or to check the status of a claim, log in to Member Web and navigate to the Claims tab. Remember to upload an itemized paid receipt with your name included.

Claims must be received by EyeMed Vision Care within 15 months from the date of service.

Filing a Claim for EAP Benefits

You do not need to submit claim forms for EAP services.

Foreign Claims

A foreign claim is a medical, pharmacy or dental expense that is incurred outside the United States. The GSK medical and dental plan options each provide coverage for eligible emergency and non-emergency care received outside the US Claims are processed using the in-network benefit level, and eligible charges are based on the billed amount.

Types of Claims

Group health benefits can be classified as either urgent, pre-service or post-service.

Urgent care claims require a quick decision because your health would be threatened if the Plan took the normal time permitted to decide a pre-service claim. If a physician with knowledge of your medical condition tells the Plan that a pre-service claim is urgent, the Plan must treat it as an urgent care claim and a decision must be decided as soon as possible, taking into account your medical needs, and no more than 72 hours after the Plan receives the claim. The Plan must tell you within 24 hours if more information is needed and give you at least 48 hours to respond. Then the Plan must decide the claim within 48 hours after receiving the missing information or within 48 hours of the deadline to supply the missing information, whichever comes first. The Plan cannot extend the deadline to make the initial decision without your consent. The Plan must notify you that your claim has been granted or denied before the end of the allotted time. The Plan may notify you orally as long as it furnishes a written notification within three days after the oral notification.

Pre-service claims are requests for approval required before medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary. Pre-service claims must be decided within a reasonable time period appropriate to the medical circumstances, and no later than 15 days after the Plan receives the claim. The Plan may extend the time period up to 15 days if, for reasons beyond its control, the Plan cannot make the decision within the first 15 days. However, the Plan must notify you before the first 15-day period ends:

- Explaining the reason for the delay,
- Requesting any additional information, and
- Advising you when it expects to make the decision.

If the Plan requests more information, you have at least 45 days to supply it. The Plan must then decide the claim within 15 days after receiving the additional information or within 15 days after the deadline to supply the additional information, whichever comes first. The Plan cannot extend the deadline without your consent. The Plan must notify you in writing that your claim has been granted or denied before the deadline for the decision

Post-service claims are all other claims for benefits under your group health plan, including claims after medical services have been provided, such as requests for reimbursement or payment for the provided services. Most claims for group health benefits are post-service claims. Post-service health claims must be decided within a reasonable time period, and no later than 30 days after the Plan receives the claim.

The Plan may extend the time period up to 15 days if, for reasons beyond its control, the Plan cannot make the decision within the first 30 days. However, the Plan must notify you before the first 30-day period ends:

- Explaining the reason for the delay,
- Requesting any additional information needed, and
- Advising you when it expects to make the decision. If the plan requests more information, you have at least 45 days to supply it.

The Plan must then decide the claim within 15 days after receiving the additional information or within 15 days after the deadline to supply the additional information, whichever comes first. The Plan cannot extend the deadline without your consent. The Plan must notify you that your claim has been denied in whole or in part (paying anything less than 100 percent of a claim is a denial in part) before the deadline for the decision.

How Can I get Help with Filing a Claim?

GSK knows that navigating the healthcare system can be confusing and this is why GSK has partnered with Advocacy Services. You should contact Advocacy Services to speak with a Health Pro when you need help to:

- Understand your benefits

- Verify care coverage
- Resolve billing errors
- Understand claims denials

To contact Advocacy Services, call 1-888-286-8014 x0378, 8:00 a.m. to 7:00 p.m. Eastern time, Monday through Friday. You may also call the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252) and follow the prompt to Advocacy Services.

How Do I Know if My Claim is Denied?

If your claim is denied, the Claims Administrator must send you a notice, either in writing or electronically. The notice must include:

- Specific reasons for denial (for example, not medically necessary, not covered by the Plan, or reached maximum amount of treatment permitted under the Plan);
- A reference to any specific Plan provision relied upon for the denial;
- If denied for a lack of information, a description of any additional material needed and an explanation of why it's necessary;
- A description of the Plan's review procedures (for example, how appeals work and/or how to initiate an appeal);
- If denied based on rules, guidelines, or protocols, either a description of the rules, guidelines, or protocols relied upon in denying the claim, or a statement that a free copy of such items will be provided upon request;
- If denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that an explanation will be provided for free upon request; and
- A description of your right to go to court to recover benefits due under the Plan.

You must file a request for review of your denied claim with the appropriate Claims Administrator.

What Can I Do if My Claim is Denied?

If your initial claim for benefits is denied in whole or in part, you (or your beneficiary or authorized representative) may file an appeal (ie submit a Level 1 appeal) as follows:

- The request must be made in writing and submitted to the applicable Claims Administrator by the deadline shown on the "**Claims Review Time Limits**" chart.
- State the reason(s) for the appeal, including the issues involved.
- Include any evidence or documentation to support your (or your beneficiary's or authorized representative's) position.
- You may request any relevant documents you may wish to review.

After the appeal of a denied benefit claim has been received by the Claims Administrator, a decision will normally be made within the number of days specified on the "**Claims Review Time Limits**" chart following this section. Contact information for each Claims Administrator is shown in the "**Administrative and Funding Information**" chart at the end of this SPD. You (or your beneficiary or authorized representative) will receive a written copy of the decision, including the rationale and reference to the Plan provisions on which it is based.

For vision appeals, the decision on appeal will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

If your appeal for medical or dental benefits is denied, you must seek a second level appeal before you are entitled to seek review by an External Review Organization. Medical benefits include prescription drug and behavioral health.

If your Level 1 appeal is denied, you must contact Advocacy Services for assistance, if you have not already done so. This is a required step before any Level 2 appeal can be considered. To contact Advocacy Services, call 1-888-286-8014 x0378, 8:00 a.m. to 7:00 p.m. Eastern time, Monday through Friday. You may also call the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252) and follow the prompt to Advocacy Services.

How do I Submit a Second Level Appeal for a Denied Medical or Dental Claim?

Second level appeals are available for denied medical and dental claims. Second Level appeals are reviewed by the Plan Administrator. Like first level appeals, the review of a second level appeal will afford no deference to prior determinations and will be conducted by someone other than the individuals or subordinates of such individuals who made the prior determinations. Also, if the first level appeal was denied based on a medical necessity, the Plan Administrator may consult with a health professional with appropriate training and experience in the pertinent field of medicine, and who is not a professional consulted during the prior determinations, or a subordinate of such professional.

You (or your beneficiary or authorized representative) may request a second level review as described below.

- The request must be made in writing by the deadline shown on the "**Claims Review Time Limits**" chart.
- State the reason(s) for the appeal, including the issues involved.
- Include any evidence or documentation to support your (or your beneficiary's or authorized representative's) position.
- You may request any relevant documents you may wish to review.

After the request for review of a denied medical or dental claim has been received by the Plan Administrator, a decision will normally be made within the number of days specified on the "**Claims Review Time Limits**" chart following this section.

You (or your beneficiary or authorized representative) will receive a written copy of the decision, including the rationale and reference to the Plan provisions on which it is based.

For second level dental appeals, the decision on appeal will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

How do I Request Review by an External Review Organization (ERO)?

If you have exhausted the levels of appeals for medical benefits, you have the right to request a review by an independent, external review organization ("**ERO**"). All correspondence related to a request for review through the Plan's external appeals process should be sent to the applicable Claims Administrator identified in the "**Administrative and Funding Information**" chart at the end of this SPD. The request should include any relevant or previously mentioned information contained in prior appeals. The ERO will send you and the Plan written notice of its decision within the time period specified in the Claims Review Time Limits chart). The decision by the ERO will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

You may not bring legal action to recover benefits under any plan unless you have pursued and exercised all administrative benefit claim and appeal rights within the time limits stated in the relevant plan document and this summary plan description, and the requested plan benefits have been denied in whole or in part (or there is any other adverse benefit determination). Any civil action for the recovery of a benefit must be commenced within one year after the Plan's claims review and appeal procedures have been exhausted.

Claims Review Time Limits

Deadline	Health Claims Medical (including prescription drug and behavioral health), Dental, Vision and EAP		
	Urgent Health Claim	**Health Claims for Pre-certified Services**	**All Other Health Claims**
For Claimant to File Initial Claim	**12 months** from date of service.	**12 months** from date of service.	**12 months** from date of service.
For Claims Administrator to Notify Claimant of Initial Claim Determination	48 hours[1,2] after receiving completed initial claim or after the 48-hour claimant deadline, whichever is earlier. 72 hours[1] after receiving the initial claim, if it was proper and complete.	**15 days[2]** after receiving the initial claim. **30 days[2]** after receiving the initial claim if plan requires more claimant information and if plan provides an extension notice during initial 15-day period.* *Claimant has **45 days** to complete the initial claim after receiving the extension notice.	**30 days** after receiving the initial claim. **45 days** after receiving the initial claim if plan requires more claimant information and if plan provides an extension notice during initial 30-day period.* *Claimant has **45 days** to complete the initial claim after receiving the extension notice.
For Claimant to submit a Level 1 Appeal of an Initial Claim Denial	**180 days[2]** after receiving initial claim denial.	**180 days** after receiving initial claim denial.	**180 days** after receiving initial claim denial.
For Claims Administrator to Notify Claimant of Level 1 Appeal Decision	**72 hours** after receiving Level 1 appeal.	**30 days** after receiving Level 1 appeal. **15 days** after receiving a Level 1 appeal if plan allows two levels of appeal.	**60 days** after receiving Level 1 appeal. **30 days** after receiving a Level 1 appeal if plan allows two levels of appeal.
For Claimant to submit a Level 2 Appeal to Plan Administrator of a Level 1 Denial*[4] *Prior to filing a Level 2 appeal, claimant must contact Advocacy Services as noted in **What Can I Do if My Claim is Denied** above.	**180 days** after receiving Level 1 denial.	**180 days** after receiving Level 1 denial.	**180 days** after receiving Level 1 denial.

Deadline	Health Claims Medical (including prescription drug and behavioral health), Dental, Vision and EAP		
	Urgent Health Claim	**Health Claims for Pre-certified Services**	**All Other Health Claims**
For Plan Administrator to Notify Claimant of Level 2 Appeal Decision	As soon as possible, taking into account your medical needs, and no more than 72 hours after receiving the Level 2 appeal.	Within a reasonable time period appropriate to the medical circumstances, and no more than 30 days after receiving the Level 2 appeal.	Within a reasonable time period, and no more than 60 days after receiving the Level 2 appeal.
For Claimant to Request External Review Organization ("ERO") Medical Review[5]	**120 days** after receipt of a notice or second-level internal adverse benefit determination.	**120 days** after receipt of a notice or second-level internal adverse benefit determination.	**120 days** after receipt of a notice or second-level internal adverse benefit determination.
Medical Carrier and ERO Requirements	Carrier must perform preliminary review **immediately** upon receipt. Carrier must **immediately** assign ERO. Carrier must **immediately** send to ERO via e-mail, fax, or phone. ERO has **72 hours** to render a decision and notify member.		Carrier has **5 business days** following the date of receipt of request to complete preliminary review to determine eligibility and/or completeness of request. Carrier has **1 business day** after completion of preliminary review to respond to member to advise if request was complete/incomplete, eligible/ineligible. Carrier has **24 hours** to assign ERO if request is complete. Carrier has **5 business days** after date of assignment of ERO to provide file to ERO. ERO has **45 days** after receipt of the request to respond to member (and the carrier) with the final determination.

[1]Plan may provide notice orally if written or electronic notice is provided within three days after oral notification.

[2]Plan notice requirement applies to claim approvals as well as claim denials.

[3]For claims under the GSK Vision Plan, claimants have 180 days after receiving initial claim denial to appeal.

[4]The GSK Vision Plan and the EAP do not allow two levels of appeal.

[5]Not applicable to Dental, Vision or EAP claims.

What Rights Do I Have Under COBRA?

Continued Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**") is a federal law that includes provisions designed to protect you and your family against the loss of health care coverage provided through the Company. Under COBRA, if you and/or your covered family members lose coverage because of a "**qualifying event**," as explained later in this section, continued health care coverage may be available at your expense. This summary is intended to inform you of your rights and obligations under COBRA.

Specifically, COBRA applies to the Company's medical coverage, dental coverage, and vision coverage. COBRA does not apply to coverages under the EAP or the Health Savings Account (HSA).

Eligibility and Duration of Coverage

COBRA Qualifying Event	Who May Continue	How Long
Your work hours are reduced or you leave the Company (unless you are dismissed for gross misconduct)[1]	• You • Your legal spouse/certified domestic partner • Your children and/or children of your legal spouse/certified domestic partner	18 months (Up to 29 months if you or a qualified beneficiary is disabled within 60 days of beginning COBRA coverage)[2] If you are on duty in the uniformed services for more than 31 days, your dependents may continue coverage for up to 24 months
You enroll in Medicare and drop your GSK medical plan[3]	• Your legal spouse/certified domestic partner • Your children or children of your legal spouse/certified domestic partner	36 months
Divorce/legal separation (ex-spouse is no longer an eligible dependent)[4]	• Your ex-spouse/ex-certified domestic partner or your legally separated spouse • Your children and/or children of your ex-spouse/ex-certified domestic partner/legally separated spouse	36 months[5]
Child is no longer an eligible dependent	• Your children and/or children of your legal spouse/certified domestic partner	36 months
You die	• Your legal spouse/certified domestic partner • Your children or children of your legal spouse/certified domestic partner	36 months

[1] If you leave GSK as a result of international trade changes, you may be eligible for a tax credit toward the purchase of COBRA coverage and a second COBRA election period.

[2] If the disabled individual (under the Social Security definition) entitled to the extension has nondisabled family members who are entitled to COBRA coverage, the nondisabled family members may continue coverage for up to 29 months as well.

[3] If you enroll in Medicare before you terminate employment or before you lose eligibility for benefits, your dependents may continue coverage up to the later of 36 months from the date you enroll for Medicare, or 18 months from the date of your termination or reduction in hours. For example, if you enroll for Medicare on January 1 and terminate employment a month later on February 1, your spouse and children may continue coverage for up to 36 months, counting from January 1. If your spouse is enrolled in Medicare prior to your termination of employment, they may continue coverage for up to 36 months.

[4] The end of a domestic partnership is not a COBRA qualifying event. However, GSK allows ex-domestic partners and their children to individually elect COBRA coverage.

[5]If your divorce or legal separation occurs while COBRA coverage is in effect, only your covered spouse and any dependent children can elect to extend coverage from 18 to 36 months (see "**Second Qualifying Events**" below).

Qualified Beneficiaries

If you and/or your spouse/certified domestic partner or covered children have a "**qualifying event**" while you are covered by the GSK Health Plan, you will be considered "**qualified beneficiaries**" and eligible for continued coverage. In addition, a newborn or newly adopted child or a child placed for adoption during the COBRA continuation period may be added to the covered employee's COBRA coverage as qualified beneficiaries within 30 days of birth, adoption, or placement for adoption. Qualified beneficiaries are eligible to purchase continued coverage for 18, 24, 29, or 36 months from the date of the "**qualifying event**," as outlined above. Each qualified beneficiary has the right to make an individual election.

Nonqualified Beneficiaries

A qualified beneficiary can also add certain nonqualified beneficiaries to his or her COBRA coverage. Nonqualified beneficiaries are family members who were eligible for coverage under the GSK Health Plan but were not covered on the day before the qualifying event.

Nonqualified beneficiaries receive the same coverage that the qualified beneficiary elects. They do not have independent coverage election rights under COBRA.

Second Qualifying Events

If your spouse/certified domestic partner and/or children (who are also COBRA-qualified beneficiaries) have another qualifying event while already on COBRA coverage because of your employment termination or reduction in hours, they can elect to extend their COBRA coverage for up to 36 months from the date of the employment termination or reduction in hours. For example, assume that your child has COBRA coverage because of your employment termination. If that child then turns age 26, he or she could elect to continue COBRA coverage for up to 36 months from the date your employment terminated.

Notification Procedures

In the event of a divorce, legal separation, or loss of dependent status, you, your spouse, or child has the responsibility of notifying the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252) as soon as possible, but not more than 60 days after the event, so that continued coverage can be arranged. The GSK Benefits Center will notify you, your spouse, and children (individually or jointly) of your right to elect COBRA coverage. The notification will be sent to your (the employee's) home address on record, and it is your responsibility to forward the notification to any dependent who is losing coverage if they do not reside at your address.

If you, or your spouse or child, fail to provide the GSK Benefits Center with timely notice when one of the above qualifying events occurs, the right to COBRA coverage will be waived.

GSK will notify you, your spouse/certified domestic partner, and/or your covered children of the right to continue coverage in the event of your death, termination of employment (including retirement), reduction in working hours, or election to discontinue GSK Plan coverage when you become entitled to Medicare.

After receiving notification, you must decide whether to continue your coverage within 60 days of the later of the following two dates: (1) the date the COBRA enrollment notice and election form is sent or (2) the date your active coverage with the company ends. COBRA coverage is retroactive to the date your active coverage ends.

If you do not choose continued coverage or if you fail to reply within 60 days, your coverage will end on the date specified in the notification.

If you have requested COBRA coverage but the COBRA continuation coverage was denied, the GSK Benefits Center will send you a denial notice explaining the reason for the denial.

Disability Extension

If you or a qualified beneficiary is determined to be totally disabled by the Social Security Administration at the time of a reduction in hours or termination of employment, and within 60 days of beginning COBRA coverage, the disabled person and family members who are also eligible for COBRA coverage may extend the continuation coverage period an additional 11 months for a total of up to 29 months.

To extend coverage beyond the 18-month period, you must provide a Letter of Determination to the GSK Benefits Center within 60 days of its receipt and before the end of the 18-month period.

If the Social Security Administration determines that you are no longer disabled, you must notify the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252) within 30 days of the final determination by the Social Security Administration. COBRA coverage will stop on the first of the month following 30 days after the determination that you or a qualified beneficiary is no longer disabled.

Cost of Continued Coverage

If you elect to continue medical, dental and/or vision coverage, you must pay a premium equal to the group rate plus a 2% administration charge monthly, for a total premium of 102% of the group rate. The total premium includes the Company’s contribution and any contribution a participant is required to make under the Plan.

If your employment is terminated and you receive benefits under the Severance Pay Plan (and you have signed and not revoked the General Release), and if you elect COBRA continuation of your medical and/or dental coverage, GSK may subsidize the COBRA premium for your medical and/or dental coverage as outlined in the summary plan description for the Severance Pay Plan. GSK will not subsidize any premiums for GSK Vision Plan coverage in this instance.

- This subsidized COBRA coverage is applicable to you and your eligible dependents who were covered under the GSK medical and dental plans prior to your termination date. Medical and dental benefits continued during the Severance Period will count against the period of continued coverage under COBRA to which the participant is entitled.
- When your period of subsidized COBRA coverage ends, participants may elect to continue COBRA medical (if they are not enrolled in Medicare) and/or dental coverage that may be available at full cost, as described in this summary document.

Participants who enroll in Medicare following their COBRA election may elect to continue COBRA dental and/or vision coverage only. COBRA medical coverage for any participant will end at the time a participant enrolls in Medicare, or eight months following their Medicare eligibility date, whichever comes first. A specific timeframe exists for enrollment in Medicare. Participants are strongly urged to contact their local Social Security office as soon as possible for information about enrolling in Medicare.

If you or your qualified beneficiaries are eligible for the additional 11 months of coverage because of a disability, the premium for the additional 11 months increases to 150% of the group rate.

The first payment must be made within 45 days following the date of your election and must cover the number of full months from the coverage termination date to the time of your election. Premium payment for the months after your election will regularly be due on the first day of the month and must be paid within 30 days of the date due.

Premium rates will change periodically for continued coverage as costs to the Company change.

If you incur any claims and you have not paid the COBRA premium for that period, the relevant plan will not consider those claims for payment until you pay the premium. If you have not paid the premium within 30 days of your premium due date, COBRA coverage will terminate and any claims incurred after the termination date will be ineligible.

Coverage Available

Under continued coverage, you will have the same health care benefits available to you as active employees and their qualified beneficiaries. Should benefit levels or costs change, both active and COBRA participants will experience the same change.

You and each of your qualified beneficiaries may elect to continue:

- Medical coverage only;
- Dental coverage only;
- Vision coverage only;
- Medical and dental coverage;
- Medical and vision coverage;
- Dental and vision coverage; or
- Medical, dental, and vision coverage.

When COBRA coverage is first elected, you and/or your qualified beneficiaries may continue only the same medical, dental, and/or vision option that you had as an active employee.

Each qualified beneficiary may make an independent benefit selection of the types of coverage to be continued, unless you or your spouse/certified domestic partner makes an election to provide any other qualified beneficiary with coverage. Then, that election will be binding on all your qualified beneficiaries.

Changes to Continued Coverage

During annual enrollment, each qualified beneficiary may elect different coverage in the same manner as an active employee. During annual enrollment, you may also add or delete coverage for your spouse or certified domestic partner, and covered children in the same manner as an active employee. If you experience a qualified change in status between enrollment periods, you may change your continued coverage election (eg, add or delete dependents) as long as you contact the GSK Benefits Center within 30 days of your status change. You may also add your spouse or eligible child who involuntarily loses health coverage under another employer's group health plan within 30 days after the loss of other coverage, provided you pay the required premium. Otherwise, you must wait until the next annual enrollment period to make changes.

Spouses or certified domestic partners, and children added at annual enrollment are not qualified beneficiaries and do not have independent COBRA election rights. They receive the same coverage as the qualified beneficiary.

When COBRA Continuation Coverage Ends

COBRA continuation coverage will automatically cease at the end of the applicable 18-, 24-, 29-, or 36-month period. There is no conversion option for medical, dental, or vision insurance at the end of the applicable 18-, 24-, 29-, or 36-month period.

Coverage will end immediately if you, your spouse or certified domestic partner, or your covered children:

- Fail to pay the premium on time (ie, within 30 days of the due date, or 45 days of the due date for the initial payment);
- Enroll in Medicare (applies to medical coverage only). A specific timeframe exists for enrollment in Medicare. All participants are strongly urged to contact their local Social Security office as soon as possible for information about enrolling in Medicare as soon as they are eligible to avoid a gap in coverage;
- Fail to apply for, or return to, active employment with GSK following active duty in the uniformed services;
- Are determined to no longer be disabled under the Social Security laws (if eligibility is due to the special extended coverage period for disabled individuals);
- Have obtained benefits fraudulently; or
- Become covered under another group health care plan.

Also, coverage may end if GSK ends the medical, dental or vision plans for all employees.

Certification of Coverage Under HIPAA

The GSK Health Plan does not limit benefits based on pre-existing conditions. You and your covered dependents are entitled to a certificate from your prior health plan to show evidence of prior health coverage. You will be automatically provided a Certification of your creditable coverage free of charge from GSK if you request it before losing coverage, or if you request it up to 24 months after losing coverage when:

- You or a dependent loses coverage under the GSK Health Plan;
- You or a dependent becomes entitled to elect COBRA continuation coverage; or
- You or your dependent's COBRA continuation coverage ceases.

GSK will issue the Certification to the employee and/or the employee's spouse/certified domestic partner and/or eligible children at the same time as when a notice is required under COBRA. If the loss of coverage is not due to a COBRA-qualifying event, the Certification will be issued within a reasonable time after coverage ends.

The COBRA administrator will issue a separate Certification within a reasonable time after COBRA coverage ends.

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the GSK Benefits Center informed of any changes in the addresses of family members, as well as an ex-spouse who is enrolled for coverage.

If you have questions about your COBRA continuation coverage, or to report an address change, contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

Important Information About Benefits Under the GSK Health Plan

Independent Contractors

Aetna, UHC, CVS Caremark and GSK are independent contractors in relation to one another and no joint venture, partnership, employment, agency, or other relationship is created. Neither Aetna, UHC, CVS Caremark, nor GSK is liable for any act, negligence, or omission of the other, nor are they each other's agents or employees. Neither Aetna, UHC, CVS Caremark, nor GSK is authorized to represent the other for any purpose.

Non-Assignability of Benefits

You may not transfer the coverage and benefits of this Plan to another person without the prior written consent of the Plan Administrator (except as delegated to UHC or Aetna). Such a request may be denied for any reason. The Plan Administrator reserves the right to make payment of benefits, at its sole discretion, directly to the in-network provider or to you.

Right to Receive and Release Information

As a condition of enrollment and as a condition to receive benefits under this Plan, Aetna, UHC or CVS Caremark, its agents, independent contractors, and in-network providers are entitled to release to, or obtain from, any person, organization, or government agency, any information and records, including patient records, that Aetna or UHC requires or is obligated to provide pursuant to legal process, or federal, state, or local law. You or your dependents expressly consent to authorize and direct in-network providers, or others who are giving treatment or advice, to furnish and make available to Aetna, UHC or CVS Caremark such medical and mental health reports, records, and other information, or copies thereof, as the Plan Administrator may request for the purposes of administering the Plan.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave employment to serve in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") may provide you with certain rights under the Plan. If you have any questions, please contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 ("**FMLA**") applies to the Plan during any calendar year when GSK employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (ie, participating employees who have been employed by the Company for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

If you go on an FMLA leave, you may continue health coverage during the leave on the same basis and at the same participant contribution rate as if you had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by the Company). However, if you take a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA is 26 weeks per 12-month period. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is available.

HIPAA and the HITECH Act

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") imposes numerous requirements on employer health plans concerning the use and disclosure of certain individual health information. This information, known as "**Protected Health Information**", includes virtually all individually identifiable health information held by the GSK Health Plan ("**Covered Plan**") — whether received in writing, in an electronic medium, or as an oral communication. The Health Information Technology for Economic and Clinical Health ("**HITECH**") Act is a related federal law that expanded the HIPAA privacy, security, and enforcement requirements.

The Covered Plan is required by law to maintain the privacy of your protected health information and to provide you with this notice of their legal duties and privacy practices with respect to that health information. It's important to note that these rules apply only to the Covered Plan, not GSK as an employer. Different policies may apply to other GSK programs or to data unrelated to the Covered Plan listed above.

The Covered Plan, or their health insurers, may disclose your health information without your written authorization to GSK for plan administration purposes. GSK may need your health information to administer benefits under the Covered Plan. GSK agrees not to use or disclose your health information other than as permitted or required by the Covered Plan documents and by law. Designated GSK staff are the only GSK employees who will have access to your health information for plan administration functions.

The Plan also will comply with applicable requirements under the HITECH Act, which include providing notice to affected individuals if the Plan or its business associates discover a breach involving unsecured protected health information.

Right to Recover or Withhold Benefits

The Plan has the right to recover or withhold payments whenever claims or bills are incomplete, inaccurate, or fraudulent. Submitting a fraudulent claim is grounds for termination of coverage or termination of employment with GSK.

The Plan may recover any payments made in error or overpayments from one or more of the following:

- Any persons to whom, or for whom, or with respect to whom, such payments were made;
- Any other insurance companies; or
- Any other organization.

Third-Party Liability (Subrogation)

If you receive medical or dental benefits under the GSK Health Plan as a result of an injury, illness or condition caused by another party, the Plan has the right to seek repayment of those benefits from the party that caused the injury, illness or condition. In other words, the Plan subrogates or substitutes for you, and assumes your right to seek recovery from the responsible party that caused your injury.

The Plan's right to subrogation applies to you, and to the extent they are covered, your spouse, domestic partner, and dependents. By enrolling for benefits under the Plan, you, your covered spouse, domestic partner, and dependents affirm and agree to the Plan's right of subrogation.

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of compensation you recover. You also agree to disavow reliance on the "make whole" doctrine. This doctrine typically arises under insurance law and requires an insurer who pays less than an insured's total loss to refrain from exercising the right of subrogation until the insured is "made whole" for his or her total loss.

If you bring a liability claim against the responsible party, benefits payable under the GSK Health Plan must be included in the claim. When the claim is settled, you must reimburse the Plan for the benefits that were provided up to the full amount of the compensation received from the other party. This applies regardless of how that compensation may be characterized, including as legal fees payable to your attorney, and the Plan's right to subrogation extends to all amounts paid to you, not just those that may be set aside for the payment of benefits to you. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your liability claim.

The Plan has the right to recover such compensation from you via equitable restitution. You agree to be designated a constructive trustee of the Plan with respect to such compensation and you agree to hold any such compensation paid to you in constructive trust for the Plan's benefit.

You are obligated to avoid doing anything that would prejudice the Plan's rights of subrogation and recovery. You agree to cooperate fully with the Plan's efforts to recover benefits paid by the Plan. You are to notify the Plan or its Claims Administrator of any recovery compensation agreed with the other party prior to receipt of such funds, or within 5 days of receipt if no advance notice is given. Further, you shall provide all information related to your liability claim and any recovery compensation received upon request by the Plan or the Claims Administrator.

Interpretation of Plans

GSK reserves the absolute right to interpret the Plan provisions, to determine fact and eligibility for benefits, and to decide any dispute that may arise regarding the rights of employees, and their dependents or beneficiaries, under the Plan. Any such determinations shall apply uniformly to all persons similarly situated and shall be binding and conclusive upon all interested persons.

Company's Right to Change Benefits

There may be business, legal, or other reasons for an employer to modify or discontinue an employee benefit plan. Therefore, GSK reserves the absolute right to revise or discontinue at any time the Plan in its entirety or any coverage option under the Plan.

Each participating US affiliate may also change specific provisions subject to corporate approval. Corporate approval is obtained from the GSK LLC Board of Managers or the Benefits Committee, as described below.

The Board of Managers, or its delegate, may amend or terminate any GSK employee benefit plan at any time. In its deliberation on any proposed amendment to an employee benefit plan, the Board may consider any recommendations of the Benefits Committee. Board actions are approved according to the Limited Liability Company Agreement of GSK LLC.

Effect on Employment

This SPD in no way guarantees your continued employment with the Company. If you terminate your employment or if you are discharged, neither the Plan nor individual coverage options give you any right to any benefit or interest in the funds in any coverage option, except as specifically provided in each coverage option.

See the "**Continued Coverage Under COBRA**" section of this SPD for further information on what happens when your employment ends.

No rights to employment accrue to any employee, dependent, or beneficiary by any statement in or omission from this SPD, or by the operation of the Plan or coverage option thereunder.

What Are My Rights Under ERISA?

As a participant in the benefit plan options listed in this SPD, your rights are protected under the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"). ERISA provides that all Plan participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

- Review without charge all Plan documents, including insurance contracts and administrative services agreements and copies of the latest annual reports (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the operation of the Plan, including insurance contracts and administrative services agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. You may have to pay a reasonable charge for photocopying. To request this information, contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

Right to Prudent Management

You also have the right to expect the people who are responsible for the management of the Plan ("**fiduciaries**") to act prudently and in the sole interest of the Plan participants. Under ERISA, fiduciaries may be removed for imprudence, and they have a legal obligation to make good any losses they have caused the plan.

Right to Claim Benefits

You are encouraged to bring to the attention of the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252) any problems you may encounter with regard to your benefits. You may not be terminated or discriminated against in any way due to any attempt to obtain your benefits or exercise your rights under ERISA.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days (barring circumstances beyond GSK's control), you have the right to file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have been improperly denied a benefit, you have the right to file suit in a state or federal court. In addition, if you disagree with the Plan's decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If you believe a fiduciary has misused Plan funds, or if you are discriminated against for asserting your rights, you may request assistance from the US Department of Labor, or you may file suit in federal court. If you should win such a case, the court may require that your legal costs, including attorney fees, be paid by the other party. If you lose the suit, the court may order you to pay these costs and fees, if it, for example, finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, call the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252). If you have any questions about this summary or about your rights under ERISA, or if you need assistance in

obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration of the US Department of Labor, listed in your telephone directory, or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US 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.

Administrative and Funding Information

Official Plan Name and Type of Program	Plan Number	Name of Insurer, Trustee, or Administrator of Services	Source of Contributions	Source of Benefits
GSK Health & Welfare Benefits Plan for US Employees	900			
Medical including Mental Health and Substance Abuse Benefits • GSK PPO • GSK HDHP	900	Plan administration services, including network establishment, maintenance and management, pre-certification review determinations, claims processing and Level 1 and Level 2 appeal determinations, ongoing case management, and other administrative services are provided by the following: UnitedHealthcare Administrative Services: UnitedHealthcare Services, Inc. 9900 Bren Road East Minnetonka, MN 55343 Level 1 Appeals (Medical only): UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 Level 1 Appeals (Behavioral Health only): United Behavioral Health Appeals P.O. Box 30512 Salt Lake City, UT 84130	Company and/or employee contributions	Medical, mental health and substance abuse, and pharmacy benefits are provided through a self-funded program that is financed with Company and employee contributions

Official Plan Name and Type of Program	Plan Number	Name of Insurer, Trustee, or Administrator of Services	Source of Contributions	Source of Benefits
		Level 2 Appeals (Medical and Behavioral Health) Claims and Appeals Management/GSK P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1832 External Review Requests (Medical): UnitedHealthcare Central Escalation Unit Attn: External Review Request 4316 Rice Lake Road Duluth, MN 55811 External Review Requests (Behavioral Health): United Behavioral Health Appeals P.O. Box 30512 Salt Lake City, UT 84130		
		Aetna Administrative Services: Aetna 151 Farmington Avenue Hartford, CT 06156 Level 1 Appeals: Aetna P.O. Box 14463 Lexington, KY 40512 Level 2 Appeals Claims and Appeals Management/GSK P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1832 External Review Requests: Aetna and/or Aetna Life Insurance Company National External Review Unit 1100 Abernathy Road, Suite 375 Atlanta, GA 30328		

Official Plan Name and Type of Program	Plan Number	Name of Insurer, Trustee, or Administrator of Services	Source of Contributions	Source of Benefits
Prescription Drug Coverage	900	CVS Caremark **Administrative Services:** CVS Caremark, Inc. 1 CVS Drive Woonsocket, RI 02895 **Level 1 Appeals:** CVS Caremark Appeals Department – MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Level 2 Appeals: Claims and Appeals Management/GSK P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1832 External Review Requests: CVS Caremark Appeals Department – MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172		

Official Plan Name and Type of Program	Plan Number	Name of Insurer, Trustee, or Administrator of Services	Source of Contributions	Source of Benefits
Dental • GSK Dental • GSK Preventive Dental	900	Plan services, including network establishment, maintenance, management, pre-treatment reviews, claims processing and first-level appeal determinations and ongoing case management are provided by: MetLife Dental **Administrative Services:** MetLife Dental 501 Route 22 West Bridgewater, NJ 08807 Level 1 Appeals: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 Level 2 Appeals: Claims and Appeals Management/GSK P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1832 External reviews are not applicable for Dental	Company and/or employee contributions	Dental benefits are provided through a self-funded program that is financed with Company and employee contributions.
Vision	900	Plan administration services, including network establishment, maintenance and management, claims processing and determinations, and other administrative services. This plan is financed through a group insurance contract with: EyeMed Vision Care, L.L.C. Administrative Services: EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 Level 1 Appeals: EyeMed Vision Care, L.L.C. Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Level 2 appeals and External reviews are not applicable for Vision	Employee contributions	Insurance contract

Official Plan Name and Type of Program	Plan Number	Name of Insurer, Trustee, or Administrator of Services	Source of Contributions	Source of Benefits
Employee Assistance Plan	900	Optum Health **Administrative Services:** Optum EAP/Legal 7632 SW Durham Road # 300 Tigard, OR 97224 **Level 1 Appeals:** Optum Appeals and Grievances P.O. Box 30512 Salt Lake City, UT 84130-0512 Level 2 appeals and External reviews are not applicable for the EAP	Company contributions	Insurance contract

Plan Information

Plan Administrator

GSK LLC
410 Blackwell Street
Durham, NC 27701
ATTN: Plan Administrator (US Benefits 17.1E)

GSK LLC ("**GSK**") sponsors and administers these plans for its eligible employees. When the terms "**Company**" and "**GSK**" are used in the plan descriptions, they refer to GSK LLC and its US affiliates.

Individuals within each business sector have been appointed to be responsible for the day-to-day operation of the plans.

Employer Identification Number

If you write to any federal agency about a plan, you must use the plan reference number listed in the above chart and the following "**Employer Identification Number**" (EIN): 23-1099050.

Plan Year

The plan year is January 1 through December 31 for all benefit plans described here. The plan year is the period used to maintain a plan's fiscal records.

Agent for the Service of Legal Process

Legal process may be served upon the Plan Administrator. Legal process may also be served on the applicable insurer listed in the above chart.

Insured Plans

The following programs are insured through insurance contracts.

- Vision Coverage
- Employee Assistance Program

The insurers are responsible for investing the premiums and paying benefit claims. The insurers guarantee the payment of claims incurred before the group insurance contracts terminate.

Self-Insured Plans

The following programs are self-insured and unfunded. In other words, current employee contributions and GSK's contributions will pay only current benefit claims and do not fund future benefit claims.

- Medical (including behavioral health and prescription drug coverage)
- Dental

Whom to Call for Help

Provider directories, claim forms, or information about a claim, along with detailed information about each coverage option are available from your health plan provider.

Questions about:	Contact:
Eligibility, enrollment, and billing	**GSK Benefits Center:** 1-844-358-0600 (or 1-312-843-5252) http://digital.alight.com/gsk
Medical coverage (including behavioral health), pre-authorization, coordination of benefits	Your Claims Administrator **Aetna:** 1-800-345-5463 https://www.aetna.com/dsepublic/#/contentPage?page=providerResults&site_id=gsk or www.aetna.com **UnitedHealthcare:** 1-866-649-4867 https://www.whyuhc.com/gsk or www.myuhc.com
Prescription drug benefits, pre-authorization*	Claims Administrator **CVS Caremark, Inc.*:** 1-888-739-7992 www.caremark.com
Dental coverage, pre-treatment estimates, coordination of benefits	Claims Administrator **MetLife Dental:** 1-888-330-3444 http://www.metlife.com/mybenefits
Vision benefits	Claims Administrator EyeMed Vision Care: 1-866-488-1517 www.eyemed.com
Employee Assistance Program (EAP) and Life/Work services	**Optum:** 1-866-248-4096 https://liveandworkwell.com/public (Register or browse as a guest using Access Code: GSKLAWW)

* Does not apply to the UHC Hawaii Plan. Contact the UHC Plan directly for prescription drug benefit information.