GSK Retiree Health Benefits

Summary plan description

January 1, 2023

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An Overview of Your GSK Retiree Health Benefits

Total Reward at GSK LLC (the "**Company**" or "**GSK**") includes benefits ("**Retiree Health Benefits**") for eligible retirees ("**Eligible Retirees**").

This Summary Plan Description ("SPD") provides a summary of GSK's Retiree Health Benefits as of January 1, 2023. As such, this SPD focuses on the current eligibility and coverage provisions under the GSK Pre-Medicare Retiree Benefit **("Pre-Medicare Retiree Benefit")** and the GSK Retiree Medicare HRA Plan **("HRA Plan")**.

Eligible Retirees who were both terminated from their employment with GSK prior to January 1, 2014 AND eligible for Medicare prior to January 1, 2014 may be covered under the GSK Retiree Medicare benefit plan. The plan was closed to new participants as of January 1, 2014. This plan is discussed in Appendix I.

Eligible Retirees who terminated from their employment with GSK prior to January 1, 2014 may be covered under a retiree dental plan that is closed to new participants. This plan is discussed in Appendix II.

Important information that is applicable to current as well as closed plans, such as Survivor Coverage, Filing a Claim for Benefits, COBRA, and your rights under ERISA, is contained in Appendices III through VII.

If you are eligible for, or are currently enrolled in, Retiree Health Benefits, 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).

If your coverage under any GSK retiree benefit plan ends because you are rehired by GSK, eligibility for Retiree Health Benefits upon your subsequent termination will depend on the eligibility requirements and the Retiree Health Benefits then in effect.

This SPD is intended to provide accurate, understandable explanations of the main provisions relating to Retiree Health Benefits, avoiding insurance and legal terms where possible. There are plan documents that provide additional details of the Pre-Medicare Retiree Benefit and HRA Plan. 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. See "Your Rights Under ERISA?" in Appendix VII.

What are the Current Eligibility Criteria for Retiree Health Benefits?

Eligibility for Retiree Health Benefits is determined by GSK, and GSK reserves the right to change the eligibility criteria at any time. Under current provisions, you are an Eligible Retiree if you were eligible to participate in the GSK Health Plan as an active Employee at the time of your termination of employment and:

- You are age 55 or older and have completed 10 or more years of Eligible Service as a regular employee at termination; or
- You are a former SmithKline Beecham employee who subsequently ends employment with Quest, and as of December 31, 2000:
    - You were age 55 or older with 10 years of Eligible Service with SmithKline Beecham; or
    - Your age plus years of Eligible Service (minimum 20 years with SmithKline Beecham) equaled 75.

How is Eligible Service Determined?

Unless otherwise expressly communicated to you in writing by GSK, Eligible Service is determined as follows:

GSK Hire Date	Age at Hire	Service Counted for Purposes of Calculating Eligible Service
Before January 1, 2008	N/A	You will earn one year of Eligible Service for each 12 months of GSK service commencing on your date of hire
On or after January 1, 2008	Under age 40	You will earn one year of Eligible Service for each 12 months of GSK service commencing on your 40th birthday
	Age 40 or older	You will earn one year of Eligible Service for each 12 months of GSK service commencing on your date of hire

Eligible Service applies only to Retiree Health Benefits; it is not used for purposes of determining your eligibility or vesting for any other benefits provided through GSK Total Reward.

Service as a temporary employee or supplemental employee does not count toward Eligible Service.

Service with a predecessor company that did not offer a retiree benefit plan may not be considered Eligible Service for GSK Retiree Health Benefit eligibility. Service with a predecessor company that was recognized for retiree benefits at the time of acquisition by GSK may be based on service as determined by the predecessor company. If you are uncertain if your time in a company acquired by GSK will count, please call the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

To view your Retiree Health Benefit eligibility date, log in to the GSK Benefits Center portal and click on the Health and Life tab at the top. On the Health and Life page, scroll down to view 'Health Retirement Date Information'.

Are My Dependents Eligible for Retiree Health Benefits?

As an Eligible Retiree, you may cover your eligible dependents in Retiree Health Benefits.

All dependents' participation in GSK Retiree Health Benefits will end if you, the GSK Retiree, are no longer an Eligible Retiree.

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 but is otherwise an eligible dependent), the child must have been enrolled from his or her earliest possible date of enrollment 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 ("UHC"): 1-866-649-4867

If your spouse or certified domestic partner is also a benefits-eligible GSK employee or an Eligible Retiree, no restrictions apply.

As a provider of your Retiree 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.**

Can I Defer My Enrollment in Retiree Health Benefits to a Later Date?

As an Eligible Retiree, you must enroll in GSK Retiree Health Benefits immediately following your termination date, even if you are going to work elsewhere. You may not defer your enrollment to a later date. **If you do not enroll at this time, you will cease to be an Eligible Retiree. All dependents' participation in GSK retiree benefits will also end if you, the GSK Retiree, are no longer an Eligible Retiree.**

See "**How do I Enroll in Pre-Medicare Coverage?**" and "**How do I enroll in the HRA Plan**" for more information and the timeframe to enroll.

Can I Defer My Dependent's Enrollment in Retiree Health Benefits to a Later Date?

If your eligible dependents are covered under the GSK Medical Plan at the time you terminate employment, you may add them to your retiree benefits at that time.

If your dependents have coverage elsewhere, such as with their own employers, you do not have to enroll them when you leave GSK. So long as you remain an Eligible Retiree, you may add eligible dependents to your Retiree Health Benefit coverage when your dependents lose their other coverage.

When their coverage elsewhere ends, this event is considered a qualified status change. You will have 30 days from the date their other coverage ends to contact the GSK Benefits Center and add them to your GSK retiree medical benefits. If you do not add them to your GSK retiree medical benefits within the 30 days, you forfeit any right to enroll them in the future.

The only way to add a dependent to your GSK Retiree Benefits is if you or your dependent experiences a qualifying life event.

What is a Qualifying Life Event?

The IRS has identified qualifying life events that may cause you or a dependent to have a qualified change in status. You cannot change your health plan choices during the Plan Year unless you or a dependent has a qualified change in status and you report that change to the GSK Benefits Center within 30 days of the event. The following are examples of qualifying life events and is not meant to be an exhaustive list.

- 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;
- 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 to comply with a court order pertaining to coverage of your dependent child;
- Change in the residence of you, your spouse/certified domestic partner or a dependent; or
- Entitlement to, or loss of entitlement of, Medicare or Medicaid (applies only to the person entitled to Medicare or Medicaid).

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, you cannot change from one option to another (eg, if you are currently covered under the Pre-Medicare Retiree PPO option, you can't change to the Pre-Medicare Retiree HDHP option).

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

What Retiree Health Benefits are Currently Available to Eligible Retirees and Dependents?

The GSK Retiree Benefit in which you and your eligible dependents may participate is determined by each individual's eligibility for Medicare.

- **GSK Pre-Medicare Retiree Benefit:** Retirees and dependents not yet eligible for Medicare due to age or disability.
  The Pre-Medicare Retiree Benefit gives you, and your eligible dependents, a choice of medical coverage under a Preferred Provider Organization ("PPO") plan or a High Deductible Health Plan ("HDHP").
- **GSK Retiree Medicare HRA Plan:** Retirees and dependents who are eligible for Medicare due to age or disability.
  The HRA Plan provides a health reimbursement account that GSK funds to reimburse you and your eligible dependents for eligible healthcare expenses and insurance premiums.
- For example, if you are not yet eligible for Medicare but your spouse is, you may enroll in the Pre-Medicare Retiree Benefit, and your spouse should promptly enroll in Medicare Parts A and B. Following your successful enrollment in the Pre-Medicare Retiree Benefit, you may confirm your spouse's eligibility to participate in the HRA Plan.

Note About Medicare Eligibility

You and your eligible dependents, excluding certified 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 actively enrolled in the GSK Health Plan.*

Certified Domestic Partners covered by the GSK Health Plan 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/**) prior to your termination of employment 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.**

Are Dental Benefits Available to Eligible Retirees and Dependents?

GSK does not provide retiree dental benefits. However, as a GSK Retiree, you will be eligible to enroll in an individual full service dental plan through MetLife by paying the full premium cost. You will receive information about this individual dental plan directly from MetLife and may enroll directly with MetLife.

If you choose to enroll in the Full Service Dental Plan, you must do so within 30 days of your termination date. Contact MetLife at 1-866-832-5756 for more details.

The GSK Pre-Medicare Retiree Benefit

What Coverage Options Are Available Under the GSK Pre-Medicare Retiree Benefit?

If you are eligible to enroll in the Pre-Medicare Retiree Benefit, you can choose between the GSK Pre-Medicare Retiree HDHP Plan and the GSK Pre-Medicare Retiree PPO options. More information about each of these options is available in the section "**How do the Pre-Medicare Coverage Options Work?**".

Important note: The GSK Pre-Medicare Retiree PPO and GSK Pre-Medicare Retiree HDHP options are available only to participants who are not yet eligible for Medicare due to age or disability. When you become eligible for Medicare, medical and prescription drug coverage will end on the last day of the month prior to your Medicare eligibility date, and you will be eligible to participate in the GSK Retiree Medicare HRA Plan (HRA Plan). To participate in the HRA Plan, you must enroll in Medicare Parts A and B and then confirm your enrollment to GSK within a specified time frame. You will receive information about the HRA Plan shortly before you age into Medicare. If you or a dependent becomes eligible for Medicare prior to age 65, it is your responsibility to contact the GSK Benefits Center.

How do I Enroll in Pre-Medicare Coverage?

If you are not eligible for Medicare due to age or disability as of your termination date, following your termination of employment, you will receive information from the GSK Benefits Center on how to enroll in GSK Pre-Medicare Retiree Health Benefits and the associated costs.

You may also choose to cover your eligible dependents (who are also not eligible for Medicare) who were covered by the GSK Medical Plan on your termination date.

You must enroll in GSK Retiree benefits within 30 days of your termination date on the GSK Benefits Center portal at http://digital.alight.com/gsk or by calling the GSK Benefits Center at 844-358-0600 (or 312-843-5252).

You do not have the option to defer enrollment in the Pre-Medicare Retiree Benefit until a later date.

What are the Consequences if I Miss the Enrollment Deadline?

If you miss the enrollment deadline for either yourself or a dependent, you and/or your dependent will not be able to enroll in Retiree Health Benefits at a later date.

If you, the GSK Retiree, miss the enrollment deadline, you will cease to be an Eligible Retiree. All dependents' participation in GSK Retiree Benefits will also end if you, the GSK Retiree, are no longer an Eligible Retiree.

When Does Coverage Under the Pre-Medicare Retiree Benefit Begin?

If you are eligible, overage will be effective the first day of the month following your termination of employment.

You will be billed for this retiree coverage on a monthly basis.

If you do not pay your premium by the due date on the bill, your coverage will be terminated, and you will cease to be an Eligible Retiree. All dependents' participation in GSK retiree benefits will also end if you, the GSK Retiree, are no longer an Eligible Retiree.

When Does Coverage Under the Pre-Medicare Retiree Benefit End?

Coverage under the **Pre-Medicare Retiree Benefit** will end at the earliest to occur of the following:

- You or a covered dependent becomes eligible for Medicare due to age or disability,

- You fail to make required contributions,
- You are rehired by GSK,
- You die (See **"Survivor Coverage"** in Appendix III),
- You are a covered dependent and you cease to be an eligible dependent, or
- The Plan is terminated.

How is My Cost for Coverage Under the Pre-Medicare Retiree Benefit Determined?

Your cost for retiree coverage under the Pre-Medicare Retiree Benefit will be based on the full annual premium for the option you choose (HDHP or PPO), and the dependents you cover (ie, your coverage units). Your share of the premium depends on your years of Eligible Service.

What is a Coverage Unit?

In most cases, a coverage unit is the same as a covered person:

- You are considered one unit,
- Your spouse or certified domestic partner is considered another unit, and
- Your dependent children are considered one unit regardless of the number of children you cover.

The maximum number of coverage units is three if you cover yourself, a spouse or partner, and child(ren).

What is My Share of the Premium?

You and the Company share the cost of medical coverage. You will pay a percentage of the full annual premium for each coverage unit, based on your years of Eligible Service, as shown in the Contribution Schedule below.

Contribution Schedule

Years of Eligible Service	Your Share of the Pre-Medicare Retiree Benefit Premium per coverage unit	
	Retiree (you)	**Dependent** (your spouse/certified domestic partner or dependent child(ren)
20+	10%	30%
19	14%	34%
18	18%	38%
17	22%	42%
16	26%	46%
15	30%	50%
14	34%	54%
13	38%	58%
12	42%	62%
11	46%	66%
10	50%	70%

Note: A different contribution schedule may apply to Retirees who terminated employment prior to January 1, 2002. If you have questions, contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

Will My Share of the Cost Increase?

The annual premium for each option under the Pre-Medicare Retiree Benefit may change year to year, which means that your share of the cost may change. In addition, you will pay a higher share of the cost if the annual premium exceeds the **Pre-Medicare Retiree Medical Premium Cap**.

You will be informed of your monthly premium for the upcoming year in the fall of each year.

What is the Pre-Medicare Retiree Medical Premium Cap?

There is an annual cap (or limit) on the amount that GSK will recognize in determining its share of the contribution for the Pre-Medicare Retiree Benefit. This premium cap applies separately to each coverage unit. In 2023, the cap is $15,224. This means that GSK will pay its portion of the annual premium only up to $15,224.

Your cost equals your percentage of the premium (up to the annual premium cap) plus any amount of the total annual premium that exceeds the premium cap.

Based on the contribution schedule above, if the annual premium exceeds the cap of $15,224, the maximum amount GSK will contribute will be $13,701.60 for a retiree with 20 or more years of Eligible Service, and the Retiree will pay 10%, or $1,522.40, plus any premium amount over the cap.*

*Contribution amounts will vary for Retirees who:

- have less than 20 years of Eligible Service,
- cover dependents, or
- have a different contribution schedule.

(See "**What is My Share of the Premium?**" above).

You will be responsible for your share of the Retiree Medical Premium in addition to 100% of all increases in the cost of coverage above the annual retiree medical premium cap, regardless of your contribution schedule.

GSK reserves the right to adjust the cap each year. GSK anticipates increasing the premium cap annually based upon changes to the Consumer Price Index ("**CPI**"), but not to exceed more than 3% in any year.

Your cost of coverage will be provided in the information you receive from the GSK Benefits Center following your termination of employment. For information about the current annual premium, contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

Can I Change My Coverage Elections?

Following your initial enrollment, you may change your coverage elections between the Pre-Medicare Retiree PPO and Pre-Medicare Retiree HDHP options and between the Aetna Choice POS II or United Healthcare Choice Plus provider networks 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**").

You cannot add dependents to your coverage during the annual enrollment period. The only way to add a dependent to your GSK Retiree Benefits is if you or your dependent experiences a qualifying life event. See "What is a Qualifying Life Event?" for more details.

How do the Pre-Medicare Coverage Options Work?

- **GSK Pre-Medicare Retiree HDHP Option**. Coverage under the GSK Pre-Medicare Retiree HDHP ("**Retiree HDHP**") option is the same as coverage under the GSK Retiree HDHP option for active employees, except that you will not be eligible for any GSK contributions to your Health Savings Account ("**HSA**"). However, you can continue to contribute your own funds to an existing HSA as long as you are enrolled in the GSK Retiree HDHP option. The funds in your existing HSA may be used at any time to pay for eligible expenses. You may continue to pay for HSA eligible expenses from your existing HSA at any time.
- **GSK Pre-Medicare Retiree PPO Option**. Coverage under the GSK Pre-Medicare Retiree PPO option ("**Retiree PPO**") is the same as coverage under the GSK PPO option for active employees, except that coinsurance for services provided by an in-network provider will be 80%, not 90%.

Covered services are the same under each option, and both options offer you a network of healthcare providers that you can use for your medical care, available through your choice of either the Aetna Choice POS II or UnitedHealthcare (UHC) Choice Plus network. 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-network and out-of-network expenses do not cross-accumulate.

The eligible expenses used to meet the in-network out-of-pocket maximum are not applied toward your out-of-network limit and vice versa.

Is Prescription Drug Coverage Provided Under the Pre-Medicare Retiree Benefit?

You and your eligible dependents who are enrolled in the Pre-Medicare Retiree Benefit 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 phone at 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 eligible dependents enrolled in the Pre-Medicare Retiree Benefit at $0 cost, through mail order or a retail pharmacy.

If you are enrolled in the Pre-Medicare Retiree 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 Pre-Medicare Retiree Benefit Provide Behavioral Health Care Services?

Retirees and their eligible dependents who are enrolled in the Pre-Medicare Retiree Benefit 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.

Is Pre-authorization Required for Medical Services or Prescription Drug Coverage?

In certain situations, pre-authorization is required. When 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 Calls?
GSK Pre-Medicare Retiree PPO 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 Pre-Medicare Retiree 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 Retiree PPO and Retiree HDHP options may result in a reduction or no coverage for benefits. 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. There is no penalty to the member if the in-network provider fails to obtain prior authorization.

Comparison of GSK Pre-Medicare Retiree Medical Plan Options and Covered Services

Following is a summary of covered medical benefits. If you have any questions about whether or not a service is covered, contact Aetna at 1-800-345-5463 or United Healthcare at 1-866-649-4867.

Plan Information	GSK Pre-Medicare Retiree PPO		GSK Pre-Medicare High Deductible Health Plan (HDHP)	
	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 Retiree Only coverage is elected. For Retiree + Dependent(s) coverage, the full “Family” deductible must be met before the Plan pays benefits for any covered family member.	
Annual Out-of-Pocket Maximum [a] Applied 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. Not applied 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 not 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 not applied to the **in-network** out-of-pocket maximum.	$6,550 individual $13,100 family Note: **In-network** out-of-pocket amounts are not 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 not applied to the **in-network** out-of-pocket maximum.

Plan Information	GSK Pre-Medicare Retiree PPO		GSK Pre-Medicare High Deductible Health Plan (HDHP)	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Prescription Drug Coverage administered by CVS Caremark				
Coinsurance - Acute Medications (34-day supply at retail) Note: Acute medications are for short-term illnesses. Contraceptives	10% (min $5/max $75) $0		10% (min $5/max $75) after deductible You pay 100% of drug cost prior to deductible being met $0	
Coinsurance - Maintenance Medications (90-day supply) Note: 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. Contraceptives	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) $0		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. $0	
GSK Drugs - Maintenance or Acute Medications	$0		$0 after deductible You pay 100% of drug cost prior to deductible being met	
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.				
Preventive Services (Coverage based carrier guidelines and provider coding) [a]				
Physical exam (adult and well-child)	100%	100%	100%	100%
OB/GYN exam, Pap smear and HPV screening	100%	100%	100%	100%
Mammography screening	100%	100%	100%	100%
Immunizations	100%	100%	100%	100%
Laboratory tests	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%

Plan Information	GSK Pre-Medicare Retiree PPO		GSK Pre-Medicare High Deductible Health Plan (HDHP)	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Vision exam/screening - excludes lenses, frames, contacts	100%	100%	100%	100%
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]	80% after deductible and $250 confinement copay	70% after deductible	90% after deductible and $250 confinement copay	70% after deductible
Inpatient surgery [b]	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Outpatient hospital facility [b, c]	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Outpatient surgery	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Emergency room facility	80% after deductible and $100 copay (copay waived if admitted)	80% 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)	80% after deductible	80% after deductible	90% after deductible	90% after deductible
Diagnostic x-ray and laboratory [b, c] CAT, MRI, PET Scans & other nuclear imaging tests must be pre-authorized or 20% penalty will apply.	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Home healthcare/private duty nursing [b]	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Hospice care [b]	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Skilled nursing facility [b]	80% after deductible	70% after deductible	90% after deductible	70% after deductible

Plan Information	GSK Pre-Medicare Retiree PPO		GSK Pre-Medicare High Deductible Health Plan (HDHP)	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]
Other Services				
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; 80% 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; 80% after deductible non-office	70% after deductible	90% after deductible	70% after deductible
Hearing Aids $5,000 per year; one per ear every three calendar years	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Occupational/physical/speech therapy up to 60 visits per calendar year per type of therapy	100% after $25 copay at office; 80% after deductible at outpatient facility	70% after deductible	90% after deductible	70% after deductible
Radiation/chemotherapy	80% 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]	80% after deductible and $250 confinement copay	70% after deductible	90% after deductible and $250 confinement copay	70% after deductible
Inpatient substance abuse [b]	80% 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 80% after deductible at outpatient facility	70% after deductible	90% after deductible	70% after deductible

Plan Information	GSK Pre-Medicare Retiree PPO		GSK Pre-Medicare High Deductible Health Plan (HDHP)	
	In-Network	Out-of-Network[a]	In-Network	Out-of-Network[a]

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 deductible or 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 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.

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). If you are unable to access the GSK Benefits Center portal, you may call the GSK Benefits Center at 1-844-358-0600 (or 312-843-5252) to request a printed copy of the SBC.

What if I or My Dependent(s) Has Other Coverage?

The purpose of the Pre-Medicare Retiree Benefit 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 Pre-Medicare Retiree Benefit 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 Pre-Medicare Retiree Benefit pays benefits first. It is the primary plan for you unless you are covered by another group health plan as an active employee. In this case, your coverage as an active employee will pay first and your coverage as a GSK retiree will be secondary.

If you are also enrolled in your spouse/certified domestic partner's plan, that plan is secondary for you. After your claim has been processed by the Pre-Medicare Retiree Benefit, you may submit the claim to your secondary plan.

If Your Dependent Has Other Coverage

Your spouse/certified 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 Pre-Medicare Retiree Benefit is their secondary plan. After your dependent's claim has been processed by their primary plan, they may submit the claim to the Pre-Medicare Retiree Benefit. 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 coverage.

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 Pre-Medicare Retiree Benefit 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 Pre-Medicare Retiree Benefit 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; otherwise
- The plan that covers the patient as a retiree 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 the following 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.

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.

Required Notices Relating to Medical Coverages

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 your Retiree Health Benefit Plan. If you would like more information on WHCRA benefits, contact the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

Pursuant to GINA, Retiree Health Benefits protect against discrimination based on genetic information and, unless otherwise permitted, your Retiree Health Benefit Plan will not 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 your Retiree Health Benefit Plan, 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.

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
Coverage, 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 • **United Healthcare:** 1-866-649-4867 www.myuhc.com/groups/gsk or www.myuhc.com
Prescription drug benefits	**CVS Caremark, Inc.:** 1-888-739-7992 www.caremark.com

See Appendices III through VII for Important Information Relating to Medical Coverage Under the Plan.

The GSK Retiree Medicare HRA Plan

The GSK Retiree Medicare HRA Plan (the "**HRA Plan**") is an arrangement, funded solely by GSK, that reimburses the cost of qualified medical expenses.

Who is Eligible to Participate in the HRA Plan?

You are eligible to participate in the HRA Plan if you are an Eligible Retiree or dependent, you are eligible for Medicare due to age or disability and you are enrolled in Medicare Parts A and B.

How do I Enroll in the HRA Plan?

If you are eligible for Medicare due to age or disability as of your termination date, following your termination of employment you will receive information from the GSK Benefits Center on how to enroll in the HRA Plan. If your dependent is eligible for Medicare due to age or disability but you are not, you may enroll your dependent in the HRA Plan following your successful enrollment in the Pre-Medicare Retiree benefit. If you need assistance, you should contact the GSK Benefits Center.

If you or a dependent are enrolled in the GSK Pre-Medicare Retiree benefit following your termination of employment because you are not yet eligible for Medicare due to age or disability, you will receive information from the GSK Benefits Center prior to your 65th birthday on how to enroll in the HRA Plan. If you or a dependent becomes eligible for Medicare prior to age 65 (due to a disability) you should promptly notify the GSK Benefits Center.

You do not have the option to defer enrollment in the HRA Plan until a later date.

Medicare enrollment is required to participate in the HRA Plan. If you or your Medicare-eligible dependent do not enroll in Medicare when you are first eligible, you will not be eligible to participate in the GSK Retiree Medicare HRA Plan.

To participate in the HRA Plan, you and your eligible dependent must:

- Enroll in both Medicare Parts A and Part B during your Medicare Initial Enrollment Period or Special Enrollment Period, and
- Certify your enrollment in Medicare Parts A and B, as soon as possible, but within eight months of your Medicare eligibility date by contacting the GSK Benefits Center at 1-844-358-0600 or online at http://digital.alight.com/gsk and documenting your Medicare Effective Date.

A Note About Medicare:

Your 'Medicare Eligibility Date' is the first date you may be able to enroll in Medicare.

Your 'Medicare Effective Date' (or Entitlement Date) is the date you become entitled to Medicare (that is, you have successfully enrolled in Medicare).

GSK will make an annual contribution to your HRA Plan account. This amount will be prorated in the first year, retroactive to your Medicare Effective Date (or Entitlement Date).

Do I Need to Enroll in Supplemental Health Insurance to Participate in the HRA Plan?

Participation in supplemental health insurance coverage is not required. If you choose to participate in a Medicare Supplement or Medicare Advantage Plan, the amount of such premiums may be reimbursed to you through your HRA up to the unused amount in your HRA.

What if I do not Timely Certify My or My Dependent's Enrollment in Medicare?

If you do not timely certify your or your eligible dependent's enrollment in Medicare within eight months of your Medicare Eligibility Date, you or your dependent will not be eligible to participate in the HRA Plan.

If you, the GSK Retiree, miss the enrollment deadline, you will cease to be an Eligible Retiree. All dependents' participation in GSK retiree benefits will also end if you, the GSK Retiree, are no longer an Eligible Retiree.

When Does Coverage Under the HRA Plan Begin?

After you have timely certified your or your eligible dependent's enrollment in the HRA Plan, coverage will begin retroactive to your or your dependent's Medicare Effective Date.

When Does Coverage Under the HRA Plan End?

Coverage under the HRA Plan will end at the earliest to occur of the following:

- You are rehired by GSK;
- You die (See **"Survivor Coverage"** in Appendix III);
- You are a covered dependent and you cease to be an eligible dependent;
- The Plan is terminated.

Do I Need to Recertify Eligibility for the HRA Plan each Year?

Annual HRA Contributions for GSK Retirees — No action is required

Following your initial enrollment in the HRA Plan, no further action is required for your own continued participation in the HRA Plan. GSK will automatically fund your HRA Plan account with your annual contribution amount the first week of January of each following year.

Annual HRA Contributions for Dependents — Action is required

Following your dependent's initial enrollment in the HRA Plan, you will be required annually to contact the GSK Benefits Center to verify their continued eligibility to participate in the HRA Plan. Annual dependent verification must be completed by February 28 (February 29 in a leap year) of each year in order for your dependent to participate in that year. When your dependent verification is complete, GSK will fund your HRA Plan account with your dependent's annual contribution. Information about the dependent verification process for the upcoming year will be mailed to your home address at the end of each preceding year.

If your dependent participates in the HRA Plan and you do not contact the GSK Benefits Center to verify their eligibility for the upcoming year, your dependent will not be eligible for the HRA Plan for that year and you will forfeit your dependent's HRA account funding for that year.

What Amount Will GSK Contribute to My HRA Plan?

GSK will make an annual contribution to your HRA Plan account, as shown below (this amount will be prorated in the first year, based on your Medicare Effective Date).

GSK annual contributions for 2023 are:

- **Retiree**: $87.69 per year of Eligible Service*.
  This rate may be adjusted each year at the rate of inflation up to 3%, to a maximum of $150 per year. However, the amount GSK will contribute to your account in any year will not exceed $3,000.
- **Spouse or other dependent**: $67.80 per year of Eligible Service*.
  This rate may be adjusted each year at the rate of inflation up to 3%, to a maximum of $116 per

year. However, the amount GSK will contribute on behalf of your dependents in any year will not exceed $2,320.

*Contributions will be based on the GSK Retiree's completed years of Eligible Service at termination of employment, up to a maximum of 20 years' service.

The amount of your annual funding will be communicated to you at the start of each year. The amount of your dependent's annual funding will be communicated to you following your successful completion of the annual dependent verification.

All HRA contributions provided by GSK for you and your eligible dependents will be deposited into a single HRA account. Eligible healthcare premiums and expenses for you and your eligible dependent(s) will be reimbursed from that one account. However, if you and your spouse are both retirees of GSK and have made separate elections for retiree benefits, you will have separate HRA accounts.

Note: The amount contributed to your HRA is determined by GSK, and GSK reserves the right to change the GSK HRA Plan at any time.

How Much Can I Contribute to My HRA Plan?

You are not permitted to contribute to the HRA Plan.

Can I Continue to Use Amounts in My Health Savings Account (HSA) to Pay Claims or Get Reimbursed?

If you have established a Health Savings Account (HSA), you can continue to use your HSA to pay qualified medical expenses that are not able to be reimbursed under your HRA Plan. However, you may not be reimbursed for the same medical expense by both your HRA and HSA.

What Expenses are Eligible for Reimbursement Under the HRA Plan?

You can use the funds in your HRA Plan to reimburse the following expenses incurred by you or your dependent(s):

- Any qualifying health-related expense (as described below);
- Premium amounts for coverage under any voluntary supplemental health insurance coverage; and
- Medicare premiums and voluntary supplemental insurance premiums.

Reimbursable Health Related Expenses

Generally, you can be reimbursed through your HRA Plan for any qualifying health-related expense that:

- The Internal Revenue Service would allow you to deduct for tax purposes;
- You do not claim on your tax return; and
- Is not reimbursed by health insurance, an HSA or by Medicare.

IRS Publication 502 details eligible health-related expenses that qualify for reimbursement.

For a complete list, call 1-800-TAX-FORM and ask for IRS Publication 502, or you can download a copy of the publication from the IRS web site at **www.irs.gov**.

Here is an overview of some reimbursable expenses. Keep in mind that eligible expenses may change if the tax laws are revised.

- Medical and dental charges above the reasonable and customary (R&C) allowance or plan allowance;
- Cosmetic surgery necessary to correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease;

- Vision care expenses, such as eye exams, contact lenses, and glasses not covered by health insurance;
- Hearing care, including hearing exams and hearing aids not covered by health insurance;
- Premiums for a Medicare Supplement or Medicare Advantage Plan;
- Premiums for a dental insurance plan;
- Dental expenses not fully covered by a dental insurance plan;
- Hospital services not fully covered by health insurance (but not personal items, such as telephone or television);
- Eligible drugs prescribed to you by a health care provider not fully covered under health insurance;
- Smoking cessation programs and drugs used to fight nicotine addiction that require a prescription;
- Certain over-the-counter drugs/medications prescribed and submitted with a health care provider's prescription related to medical care (eg, pain relievers, cold, flu and fever remedies, antibiotic ointments, allergy medications);
- Certain over-the-counter items that do not require a physician's prescription, as long as they are for medical care, and not merely beneficial to overall general health. Examples of these include contact lens solution, first aid bandages and diabetes glucose monitors and related equipment, masks, hand sanitizers, and sanitizing wipes purchased for the primary purpose of preventing the spread of COVID-19, and menstrual care products;
- Travel and parking expenses for necessary medical care;
- Foreign claims; and
- Medically required supplies and equipment, if not covered by health insurance.

Currently, the following expenses <u>cannot</u> be reimbursed through your HRA. However, the list of ineligible expenses may change if the tax laws are revised.

- Expenses of a domestic partner unless he or she qualifies as a dependent under Section 152 of the Internal Revenue Code;
- Amounts reimbursed by health insurance or other coverage;
- Cosmetic surgery, procedures, or drugs that are directed at improving appearance and do not meaningfully promote the proper function of the body or treat an illness or disease;
- Teeth whitening;
- Electrolysis (hair removal);
- Hair transplant operations;
- Medical expenses for which you take an itemized tax deduction on your federal tax return;
- Payments to domestic help who render primarily nonmedical services;
- Charges for a nurse to care for a healthy infant;
- Over-the-counter health aids that do not treat a specific medical condition, including those recommended by your physician;
- Personal use items and over-the-counter drugs that are merely beneficial to good health (eg, vitamins, minerals, weight loss aids, dietary supplements, deodorants, cosmetics, skin care, hair care, routine dental care (toothpastes, brushes, floss, mouthwashes));
- Expenses for recreation, health clubs, and nutrition for general health and wellbeing, even if prescribed by a physician;
- Weight loss programs if the purpose is for the improvement of appearance, general health, or sense of wellbeing. You cannot include amounts you pay to lose weight unless the weight loss is a treatment for a specific disease diagnosed by a physician;

- Prepaid expenses that will be incurred after the current plan year;
- Nonprescription drugs and medicine, except for those that are prescribed to you by a health care provider or that is insulin; and
- Nutritional supplements unless obtained with a physician's prescription, diet food and beverages.

How do I get Reimbursed from My HRA?

In general, when you incur a qualifying health-related expense, or pay premiums for voluntary supplemental health insurance or Medicare, you must pay the bill first and then claim reimbursement with tax-free dollars. The HRA Plan administrator, Alight's Your Spending Account ("**YSA**"), will process all claims for reimbursement and send you a check for eligible expenses.

Note: Any reimbursement checks not cashed within 1 year of the date of issue will be considered void and will not be reissued.

Reimbursement forms are available from YSA by calling the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252). Return completed forms, with the appropriate documentation attached, directly to:

Your Spending Account
P.O. Box 661147
Dallas, TX 75266-1147

If you have questions about a claim, you can call YSA at 1-844-358-0600 (or 1-312-843-5252).

Submitting Claims for Health-Related Expenses if you Have Supplemental Health Insurance

If you have health care coverage under a voluntary supplemental health insurance plan or another group health plan, when you have a qualifying health-related expense you should first submit it to your health insurance plan. Once your claim has been processed and settled, you may submit any unreimbursed, qualifying amount for payment under your HRA Plan.

Any qualifying health-related expenses that are not paid by insurance can be reimbursed by your HRA Plan. Fill out a reimbursement form and attach your receipt and the medical Explanation of Benefits you received from the insurance company. Send the material to YSA, as described above under "**How do I get Reimbursed from my HRA?**."

Claims for qualifying health care expenses will be paid up to the unused amount in your HRA. Please note that you may not submit claims for services until they have been incurred. Expenses are considered incurred when the service is rendered and not when you are billed, are charged, or pay for these services. Requests for reimbursement for services to be performed in the future will be returned to you for resubmission in the appropriate enrolled plan year(s).

Direct Deposit

With direct deposit, you can have your reimbursements from the HRA automatically deposited into your bank account. Instead of a check, you receive an Explanation of Payment stating the amount deposited.

How Can I Keep Track of My HRA Balance?

The Explanation of Payment ("**EOP**") that YSA issues with each reimbursement is a good source of information. The EOP details the amount reimbursed. You can also access information about the status of your HRA balance 24 hours a day, 7 days a week from the GSK Benefits Center portal at http://digital.alight.com/gsk.

Whom to Call for Help

Questions about:	Contact:
Eligibility, dependent verification and HRA funding	**GSK Benefits Center:** 1-844-358-0600 (or 1-312-843-5252) http://digital.alight.com/gsk
Claims status	**GSK Retiree Medicare HRA Plan**: 1-844-358-0600 (or 1-312-843-5252) Your Spending Account P.O. Box 661147 Dallas, TX 75266-1147

APPENDIX I - GSK Retiree Medicare Benefit (closed plan)

The GSK Retiree Medicare Benefit ("**Retiree Medicare Benefit**") is closed to new participants and is available only to eligible retirees and dependents currently enrolled in this benefit. It includes the GSK Medicare Plan and the GW Retiree Medicare Plan, and it is provided under the GSK Medical Plan.

Please note: Anyone who retired on or after January 1, 2014 or anyone who became eligible for Medicare on or after January 1, 2014 is not eligible for this closed plan. If you have questions regarding your eligibility, you should contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

How Does the GSK Retiree Medicare Benefit Work?

The GSK Retiree Medicare Benefit provides Medicare Maintenance of Benefits. This means that the GSK Retiree Medicare Benefit considers Medicare to be your primary coverage and the GSK Retiree Medicare Benefit coverage to be secondary, whether or not you are actually enrolled in Medicare. Because Retiree Medicare Benefit payments assume that you and/or your dependents are enrolled for both Medicare Parts A and B, **you must be enrolled in Medicare to ensure that you receive all benefits to which you may be entitled.**

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

If you are enrolled in the GSK Retiree Medicare Benefit but are not enrolled in Medicare, the Retiree Medicare Benefit will only pay 20% of the Medicare allowed amount and you will be responsible for the remaining 80% out-of-pocket amount in addition to any amount over the Medicare allowed amount. The amount that you pay over the Medicare allowed amount will not be applied toward your GSK Retiree Medicare Benefit annual out-of-pocket maximum. Failure to enroll in Medicare when you are first eligible will result in your paying more out-of-pocket for your health care. In addition, you may be subject to a penalty that will result in an increase to your monthly Medicare Part B premium payment.

Coordination of Medical Benefits with Medicare

After you meet your out-of-pocket maximum or your deductible under Medicare, GSK will pay benefits for the following under the GSK Retiree Medicare Benefit:

- **When Medicare benefits are assigned.** Your GSK coverage pays the difference between the actual dollar amount paid and the "Amount Approved for Payment" as shown on the Medicare Part B "Explanation of Benefits" form.
- **When Medicare benefits are not assigned.** Your GSK coverage pays the difference between the "Amount Billed" and the "Amount Approved for Payment" as shown on the Medicare Part B "Explanation of Benefits" form.
- After you meet your individual out-of-pocket maximum under the GSK Retiree Medicare Benefit, claims for the rest of the year will generally be reimbursed at 100%.

Determining the Allowable Expense for the GSK Retiree Medicare Benefit

Because the GSK Retiree Medicare Benefit is secondary to Medicare, the Medicare allowed amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, they can charge you more than the Medicare allowed amount, but there's a limit called the 'limiting charge' (the most a provider can charge you if they don't accept Medicare), and the limiting charge will be the allowable expense. Medicare payments, combined with Retiree Medicare Benefits, will not exceed 100% of the Medicare allowed amount.

If you are eligible for, but not enrolled in, Medicare, benefits payable under the Retiree Medicare Benefit will be reduced by the amount that would have been paid if you had been enrolled in Medicare. If you choose to receive care from a health care provider who does not participate in Medicare, your claims will be paid as if they were participating in Medicare.

To receive the highest level of benefits, you must be enrolled in Medicare Parts A and B and obtain care from a Medicare participating provider.

Prescription Drug Coverage

Prescription drug coverage is included in the GSK Retiree Medicare Benefit. It is provided through a Medicare Part D prescription drug plan (PDP) called **SilverScript Employer PDP sponsored by GSK ("SilverScript")**.

What is SilverScript?

SilverScript is a group Medicare Part D prescription drug plan (PDP), sponsored by GSK. It combines a standard Medicare Part D prescription drug plan with additional coverage provided by GSK. This means you will have more prescription drug coverage than the standard Medicare Part D plan.

SilverScript is offered by SilverScript® Insurance Company which is affiliated with CVS Caremark®. SilverScript Insurance Company has a contract with Medicare.

Who is Eligible for SilverScript?

To be eligible for SilverScript, you must meet all of the criteria below:

- Be a current participant in the GSK Retiree Medicare Benefit, which includes the GSK Medicare Plan and the GW Retiree Medicare Plan, and
- Be enrolled in Medicare Part A and/or Medicare Part B, and
- Be eligible for Medicare Part D, and
- Live in the SilverScript service area, which is the United States and its territories, and
- Continue to meet the eligibility requirements for GSK benefits as defined in this Summary Plan Description.

What if I Declined SilverScript Coverage or I am not Eligible for SilverScript?

GSK Retiree Medicare Benefit participants who declined SilverScript coverage, or who are otherwise ineligible as described above, will have no prescription drug coverage through GSK. Opting out of or being ineligible for SilverScript will have no impact on your medical coverage under the GSK Retiree Medicare Benefit, and your monthly premium will not be reduced. You will pay the same premium whether or not you choose to opt out of SilverScript.

GSK Retiree Medicare Benefit Summary and Covered Services

Following is a summary chart of covered medical benefits for participants in the GSK Medicare Plan and the GW Retiree Medicare Plan.

Plan Information	GSK Medicare Plan [a]	GW Retiree Medicare Plan
Annual Deductible	$1,484 - Part A Medicare Deductible $203 - Part B Medicare Deductible	
Note: Part A deductible reflects inpatient deductible for days 1-60. Additional Medicare coinsurance amounts may apply for stays beyond 60 days.		
Annual Out-of-Pocket Maximum [a]	$2,000 individual $5,000 family	$100 individual Note: Each covered member must meet the annual $100 out-of-pocket maximum.
After annual out-of-pocket maximum is met, eligible expenses will be covered at 100% for the remainder of the year. The following will be applied to your annual out-of-pocket maximum: • Medicare Part A and B deductibles • Eligible charges not paid by Medicare Not applied to annual out-of-pocket maximum: Pre-authorization penalties, amounts exceeding the allowable amount and non-covered expenses		
Prescription Drug Coverage: SilverScript Employer PDP sponsored by GSK (SilverScript) if eligible		
Coinsurance	10% (min $5/max $75)	
GSK Drugs - Maintenance or Acute Medications	$0	
Preventive Services (Coverage based carrier guidelines and provider coding) [a]		
Physical exam (adult and well-child)	100%	
OB/GYN exam, Pap smear and HPV screening	100%	
Mammography screening	100%	
Immunizations	100%	
Laboratory tests	100%	
Prostate screening (PSA)	100%	
Colonoscopy/sigmoidoscopy - excludes virtual colonoscopies	100%	
Hearing exam/screening	100%	
Vision exam/screening - excludes lenses, frames, contacts	100%	
Inpatient/Outpatient Services		
Office visit (PCP & Specialist)	100% after annual out-of-pocket is met	
Inpatient hospital [b]	100% after annual out-of-pocket is met	
Inpatient surgery [b]	100% after annual out-of-pocket is met	
Outpatient hospital facility [b, c]	100% after annual out-of-pocket is met	
Outpatient surgery	100% after annual out-of-pocket is met	
Emergency room facility	100% after annual out-of-pocket is met	
Non-emergency ER care	Not covered	

Plan Information	GSK Medicare Plan [a]	GW Retiree Medicare Plan
Urgent care facility	100% after annual out-of-pocket is met	
Ambulance (life-threatening situations)	100% after annual out-of-pocket is met	
Diagnostic x-ray and laboratory [b, c] CAT, MRI, PET Scans & other nuclear imaging tests must be pre-authorized or 20% penalty will apply.	100% after annual out-of-pocket is met	
Home healthcare/private duty nursing [b]	100% after annual out-of-pocket is met	
Hospice care [b]	100% after annual out-of-pocket is met	
Skilled nursing facility [b]	100% after annual out-of-pocket is met	
Other Services		
Allergy serum/injections	100% after annual out-of-pocket is met	
Chiropractic services/acupuncture 20 visit combined limit per calendar year	100% after annual out-of-pocket is met	
Durable medical equipment [b] approval required for equipment over $5,000	100% after annual out-of-pocket is met	
Hearing Aids $5,000 per year; one per ear every three calendar years	100% after annual out-of-pocket is met	
Occupational/physical/speech therapy up to 60 visits per calendar year per type of therapy	100% after annual out-of-pocket is met	
Radiation/chemotherapy	100% after annual out-of-pocket is met	
Mental Health/Substance Abuse administered by Medical Carrier (Aetna or UHC)		
Inpatient mental health [b]	100% after annual out-of-pocket is met	
Inpatient substance abuse [b]	100% after annual out-of-pocket is met	
Outpatient mental health/substance abuse	100% after annual out-of-pocket is met	

[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 deductible or 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] 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.

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

If you have any questions about whether or not a medical service is covered, contact Aetna at 1-800-345-5463 or United Healthcare at 1-866-649-4867.

For more information about SilverScript, please refer to your Confirmation of Coverage booklet mailed to your home address. If you have questions, contact SilverScript at 1-888-970-0864, 24 hours a day, 7 days a week. TTY users should call 711.

How Much Does Coverage Under the GSK Retiree Medicare Benefit Cost?

Your cost for retiree coverage under the GSK Retiree Medicare Benefit is based on the full annual premium and depends on your years of Eligible Service and the dependents you cover (ie, your coverage units).

What is a Coverage Unit?

In most cases, a coverage unit is the same as a covered person:

- You are considered one unit,
- Your spouse or certified domestic partner is considered another unit,
- Your dependent children are considered one unit regardless of the number of children you cover.

The maximum number of coverage units is three if you cover yourself, a spouse or partner, and child(ren).

What is My Share of the Premium?

Your cost for coverage under the GSK Medicare Plan is available by calling the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

You will be billed for this retiree coverage on a monthly basis, as applicable. If you do not pay your premium by the due date on the bill, your coverage will be terminated, and you will cease to be an Eligible Retiree. All dependents' participation in GSK retiree benefits will also end if you, the GSK Retiree, are no longer an Eligible Retiree.

Will My Share of the Cost Increase?

The annual premium for GSK Retiree Medicare Benefit may change year to year, which means that your share of the cost may change. In addition, you may pay a higher share of the cost if the annual premium exceeds the **GSK Retiree Medicare Benefit Premium Cap**.

You will be informed of your monthly premium for the upcoming year in the fall of each year.

What is the GSK Retiree Medicare Benefit Premium Cap?

There is an annual cap (or limit) on the amount that GSK will recognize in determining its share of the contribution for the GSK Retiree Medicare Benefit. This cap applies separately to each coverage unit. This premium cap is $10,000. This means that GSK will pay its percentage of the annual premium only up to $10,000.

If the annual premium exceeds the cap of $10,000, you will be responsible for your share of the Retiree Medical Premium **plus** 100% of all increases in the cost of coverage above the premium cap, regardless of your contribution schedule.

Required Notices Relating to Medical Coverage

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 your Retiree Health Benefit Plan. If you would like more information on WHCRA benefits, contact the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

Pursuant to GINA, Retiree Health Benefits protect against discrimination based on genetic information and, unless otherwise permitted, your Retiree Health Benefit Plan will not 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 your Retiree Health Benefit Plan, 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.

Whom to Call for Help

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

Questions about:	Contact:
Eligibility and billing	**GSK Benefits Center:** 1-844-358-0600 (or 1-312-843-5252) http://digital.alight.com/gsk
Coverage, 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 **United Healthcare:** 1-866-649-4867 https://www.whyuhc.com/gsk or www.myuhc.com
Prescription drug coverage	**SilverScript**: 1-888-970-0864 (TTY: 711) https://www.caremark.com/

APPENDIX II - GSK Retiree Dental Benefit (closed plan)

The GSK Retiree Dental Benefit ("**Retiree Dental**") is closed to new participants and is available only to eligible retirees and dependents currently enrolled in this benefit.

If you have questions regarding your eligibility for Retiree Dental, please contact the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

How Does the GSK Retiree Dental Benefit Work?

Individuals who retired prior to December 1, 2013 may have been eligible to receive Retiree Dental benefits under the GSK Dental Plan or the GSK Preventive Dental Plan.

Both Retiree Dental plan options use the MetLife Dental PDP Plus network. There are two levels of benefits - in-network and out-of-network - that determine your total annual Retiree Dental expense.

- **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.

  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.
- **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

The GSK Preventive Dental Plan option provides benefits for preventive and diagnostic dental services only. This plan 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

The GSK Dental Plan option 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, and orthodontic services up to a lifetime maximum of $2,000 per person.

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.

Comparison of GSK Dental Plan Options and Covered 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
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

Plan Information	GSK Dental Plan		GSK Preventive Dental Plan
	In-Network	Out-of-Network	
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.

How Much Does Coverage Under the GSK Retiree Dental Benefit Cost?

Your cost for retiree coverage under the GSK Retiree Dental Benefit is available by contacting the GSK Benefits Center at 1-844-358-0600 (or 1-312-843-5252).

You will be billed for this retiree dental coverage on a monthly basis, as applicable. If you do not pay your premium by the due date on the bill, your coverage will be terminated.

Important Information Relating to Dental Coverage Under the Plan

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.

Whom to Call for Help

Provider directories, claim forms, or information about a claim, along with detailed information about coverage is available from your dental provider.

Questions about:	Contact:
Eligibility and billing	GSK Benefits Center 1-844-358-0600 (or 1-312-843-5252) http://digital.alight.com/gsk
Coverage, pre-treatment estimates, coordination of benefits	MetLife 1-888-330-3444 http://www.metlife.com/mybenefits

Appendix III - Survivor Coverage

This section is applicable to all participants in GSK Retiree Health Benefits.

Are My Dependents Eligible for Survivor Coverage if I Die?

If you die while you are enrolled in Retiree Health Benefits, your survivors are eligible for retiree survivor coverage under Retiree Health Benefits if they:

- Were enrolled in Retiree Health Benefits at the time of your death; and
- Don't enroll in continued coverage under COBRA for medical coverage (if applicable).

After meeting the retiree survivor eligibility requirements (stated above), your surviving spouse or certified domestic partner and children who continue to meet the dependent eligibility requirements may continue this retiree survivor coverage as long as they continue to meet the eligibility criteria and pay any required premium in a timely manner.

New dependents cannot be added to retiree survivor coverage. However, your surviving spouse or certified domestic partner can add your eligible child to retiree survivor coverage if the child is born after your death and the request is made by contacting the GSK Benefits Center within 30 days of the child's birth. If your surviving spouse or certified domestic partner remarries, his or her new spouse is not eligible for coverage.

How Much Does Survivor Coverage Cost?

The cost for retiree survivor coverage is based on the plan for which your survivors are eligible, your years of Eligible Service and the rate structure on which your dependent benefit contributions were based.

The HRA Plan contribution for your survivor is based on your years of Eligible Service and the dependent contribution.

When Does Survivor Coverage End?

Retiree survivor coverage ends on the last day of the month in which your spouse or dependent:

- Dies; or
- No longer meets the dependent eligibility requirements; or
- Loses eligibility for survivor coverage.

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

Coverage if a Retiree Survivor Becomes Eligible Employee

If a survivor of a retiree becomes an eligible employee of GSK, retiree survivor coverage will end. The same eligibility rules that apply to new hires apply to the survivor. When the survivor's employment with GSK ends, their eligibility for Retiree Health Benefits will be based on their own years of Eligible Service and the Retiree Health Benefits in effect at the time of their termination.

Appendix IV – Filing Claims and Appeals

This section applies to participants in the GSK Pre-Medicare Retiree Benefit, the GSK Retiree Medicare Benefit and the GSK Retiree Dental Benefit. If you or a dependent participates in the GSK Retiree Medicare HRA Plan, see "**How do I get Reimbursed from my HRA?**" for information.

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 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 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.

Payment of Claims

The Retiree Health Benefits provided under the GSK Pre-Medicare Retiree Benefit, the closed GSK Retiree Medicare Benefit, and the closed GSK Retiree Dental Benefit are self-insured, which means that GSK determines the plan provisions and pays for medical and dental 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' practices to ensure that Retiree Health Benefits 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.

Claims for covered health care expenses, including hospitalization and behavioral health, 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 coverage under GSK Retiree Health Benefits may be terminated. All dependents' participation in GSK retiree benefits will also end if you, the GSK Retiree, are no longer an Eligible Retiree.

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

Where to Submit Claims

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

Participants in the GSK Pre-Medicare Retiree Benefit

Submit claims to:

Aetna	**United Healthcare**	**CVS Caremark**
P.O. Box 981106 El Paso, TX 79998-1106 Attn: Member Services	P.O. Box 740800 Atlanta, GA 30374-0800 Attn: Claims Department	P.O. Box 52136 Phoenix, AZ 85072-2136 Attn: 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.

Claim forms are available from the Claims Administrators' websites:

- United Healthcare 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

Participants in the GSK Retiree Medicare Benefit (closed plan)

Submit claims to:

Aetna	**United Healthcare**	**SilverScript**
P.O. Box 981106 El Paso, TX 79998-1106 Attn: Member Services	P.O. Box 740800 Atlanta, GA 30374-0800 Attn: Claims Department	SilverScript Insurance Company Prescription Drug Plans Medicare Part D Paper Claim P.O. Box 52066 Phoenix, AZ 85072-2066

Claim forms are available from the Claims Administrators' websites:

- United Healthcare 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
- SilverScript: www.caremark.com

Medical claims must be received no later than one (1) year from the date of service. SilverScript claims must be submitted within three (3) years of the date you received the service, item, or prescription drug. Any claim received after this time will not be considered eligible for reimbursement.

Participants in the GSK Retiree Dental Benefit (closed plan)

Submit claims to:

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

Claim forms are available from the Claims Administrator's website:

- MetLife Dental: http://www.metlife.com/mybenefits

Dental 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.

Foreign Claims

A foreign claim is a medical expense that is incurred outside the United States. Retiree Health Benefits (excluding SilverScript) 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.

How Do I Know if My Claim is Denied (excluding SilverScript)?

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. Contact information for each Claims Administrator is shown in the "Administrative and Funding Information" chart in Appendix VII.
- 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. 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.

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) and Dental *Excluding SilverScript		
	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* *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) and Dental *Excluding SilverScript		
	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[3]	**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]Not applicable to Dental claims.

Appendix V - Continued Coverage Under COBRA

What Rights Do I Have 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. This summary is intended to inform you of your rights and obligations under COBRA.

Retirees are not eligible for coverage under COBRA. This is because as a retiree you will not experience a COBRA qualifying event, defined as a termination of employment or reduction in your hours of employment. However, your eligible dependents may be eligible if they lose coverage because of one of the "**qualifying events**" identified in the chart below.

Eligibility and Duration of Coverage

COBRA Qualifying Event	Who May Continue	How Long
Divorce/legal separation (ex-spouse is no longer an eligible dependent)[1]	Ex-spouse or legally separated spouse/your children or children of your ex-spouse	36 months
Child is no longer an eligible dependent	Children	36 months
You enroll in Medicare	Legal spouse/certified domestic partner/children	36 months

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

Qualified Beneficiaries

If your spouse/certified domestic partner or covered child(ren) has a "**qualifying event**" while you are covered by the GSK Retiree Health Benefit, they 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 retiree'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 a maximum 36 months from the date of the "**qualifying event**". Each qualified beneficiary has the right to make an individual election.

Continuation of coverage can never exceed thirty-six (36) months in total, regardless of the number of events that relate to a loss of coverage. Coverage during the continuation period will terminate if the COBRA participant fails to make timely payments or if the COBRA participant becomes covered under another employer sponsored group health plan while on COBRA (unless the new plan contains a pre-existing condition exclusion).

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 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.

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 you elect to discontinue GSK Plan coverage for your dependents when you become entitled to Medicare.

In the event of your death your dependents may be eligible for Survivor Coverage discussed in Appendix III.

After receiving notification, your qualified beneficiary must decide whether to continue 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 coverage with GSK ends. COBRA coverage is retroactive to the date your retiree coverage ends.

If your qualified beneficiary does not choose continued coverage or fails to reply within 60 days, his or her coverage will end on the date specified in the notification.

If your qualified beneficiary has requested COBRA coverage but the COBRA continuation coverage was denied, the GSK Benefits Center will send a denial notice explaining the reason for the denial.

Cost of Continued Coverage

If COBRA continuation coverage is elected, the cost of coverage is 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.

The first payment must be made within 45 days following the date of their election and must cover the number of full months from the coverage termination date to the time of election. Premium payment for the months after 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 a qualified beneficiary incurs any claims and has not paid the COBRA premium for that period, the relevant plan will not consider those claims for payment until they pay the premium. If a qualified beneficiary has not paid the premium within 30 days of the premium due date, COBRA coverage will terminate, and any claims incurred after the termination date will be ineligible.

Coverage Available

Under COBRA continued coverage, the same health care benefits will be available to qualified beneficiaries as are available to retirees under the applicable plan. Should benefit levels or costs change, both retiree and COBRA participants will experience the same change.

Changes to Continued Coverage

During annual enrollment, each qualified beneficiary may elect different coverage in the same manner as a Retiree.

When COBRA Continuation Coverage Ends

COBRA continuation coverage will automatically cease at the end of the applicable 36-month period; there is no conversion option for medical insurance available.

Coverage will end immediately if the COBRA participant:

- Fails 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);
- Enrolls 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;
- Has obtained benefits fraudulently; or
- Becomes covered under another group health care plan.

Also, coverage may end if GSK terminates its medical plan.

Certification of Coverage Under HIPAA

GSK Retiree Health Benefits do 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 a GSK Retiree Health Benefit;
- A dependent becomes entitled to elect COBRA continuation coverage; or
- Your dependent's COBRA continuation coverage ceases.

GSK will issue the Certification to the you and/or your 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).

Appendix VI- Important Information About GSK Retiree Health Benefits

Independent Contractors

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

Non-Assignability of Benefits

You may not transfer coverage and benefits of the Retiree Health Benefits to another person without the prior written consent of the Plan Administrator (except as may be delegated to UHC, Aetna, CVS Caremark or MetLife). 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, each Third Party Administrator, 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 the Third Party Administrators 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.

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 Retiree PPO, Retiree HDHP and HRA Plan (each a "**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.

A 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.

A 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.

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

Right to Recover or Withhold Benefits

A Covered 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.

A Covered 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 a Retiree Health Benefit (the "**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, certified domestic partner, and dependents. By enrolling for benefits under the Plan, you, your covered spouse 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 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 Retiree Health Benefits

GSK reserves the absolute right to interpret the 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, relating to Retiree Health Benefits. 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, and in whole or in part, Retiree Health Benefits.

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 Retiree Health Benefit at any time. In its deliberation on any proposed amendment, the Board may consider any recommendations of the Benefits Committee. Board actions are approved according to the Limited Liability Company Agreement of GSK LLC.

Appendix VII - Your Rights Under ERISA

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

Receive Information About Your Retiree Health Benefits

You have the right to:

- Review without charge all relevant documents, including insurance contracts and administrative services agreements and copies of the latest annual reports (Form 5500 Series) filed by Retiree Health Benefits, as applicable, 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 Retiree Health Benefits, 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 Retiree Health Benefits ("**fiduciaries**") to act prudently and in the sole interest of the 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 documents or the latest annual report relating to Retiree Health Benefits 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 a 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 funds relating to Retiree Health Benefits, 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 Retiree Health Benefits, 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 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
Retiree Health Benefits Includes the • GSK Pre-Medicare Retiree PPO, • GSK Pre-Medicare Retiree HDHP, • GSK Retiree Medicare Plan (closed plan)	900	Retiree Plan administration services, including network establishment, maintenance and management, pre-certification review determinations, claims processing and first-level appeal determinations ongoing case management, and other administrative services are provided by the following: **United Healthcare:** **Administrative Services:** United Healthcare Services, Inc. 9900 Bren Road East Minnetonka, MN 55343 **First-Level Appeals (Medical):** United Healthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 **Second-Level Appeals (Medical)** Claims and Appeals Management/GSK P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1832 **External Review Requests (Medical):** United Healthcare Central Escalation Unit Attn: External Review Request 4316 Rice Lake Road Duluth, MN 55811	Company and/or participant contributions	Benefits are provided through a self-funded program that is financed with Company and certain terminated 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
		First-Level Appeals & 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 **First-Level Appeals (Medical & Behavioral Health):** Aetna P.O. Box 14463 Lexington, KY 40512 **Second-Level Appeals (Medical)** Claims and Appeals Management/GSK P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1832 **External Review Requests (Medical):** Aetna and/or Aetna Life Insurance Company National External Review Unit 1100 Abernathy Road, Suite 375 Atlanta, GA 30328		
Prescription Drug Coverage (GSK Pre-Medicare Retiree Benefit only)	900	**CVS Caremark:** **Administrative Services:** CVS Caremark, Inc. 1 CVS Drive Woonsocket, RI 02895 **First-Level Appeals:** CVS Caremark Appeals Department – MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 **Second-Level Appeals (Medical)** Claims and Appeals Management/GSK P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1832		

Official Plan Name and Type of Program	Plan Number	Name of Insurer, Trustee, or Administrator of Services	Source of Contributions	Source of Benefits
		External Review Requests: CVS Caremark Appeals Department – MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172		
Prescription Drug Coverage GSK Retiree Medicare Plan (closed plan)	900	**SilverScript:** **Administrative Services:** SilverScript Insurance Company P.O. Box 30016 Pittsburgh, PA 15222-0330 **Appeals**: Refer to the SilverScript Evidence of Coverage booklet	Company and/or participant contributions	Benefits are provided through a self-funded program that is financed with Company and certain terminated employee contributions (excluding Part D)
GSK Retiree Dental Benefit (closed plan)	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 participant contributions	Dental benefits are provided through a self-funded program that is financed with Company and participant contributions.

Official Plan Name and Type of Program	Plan Number	Name of Insurer, Trustee, or Administrator of Services	Source of Contributions	Source of Benefits
GSK Retiree Medicare HRA Plan	902	**Your Spending Account (YSA)** **Administrative Services:** Your Spending Account P.O. Box 661147 Dallas, TX 75266-1147	Company contributions	Funding is provided through a self-funded program that is financed with Company contributions

Plan Administrator

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

GSK LLC ("**GSK**") sponsors and administers the Retiree Health Benefits. When the terms "**Company**" and "**GSK**" are used in this SPD, 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 Retiree Health Benefits.

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 the Pre-Medicare Retiree PPO, Pre-Medicare Retiree HDHP and HRA Plan 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 Sponsor and Administrator. Legal process may also be served on the applicable insurer listed in the above chart.