



Staples, Inc.

**UnitedHealthcare Choice Plus HSA
Summary Plan Description**

For Active Associates

Effective July 1, 2018

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About the Plan

This Summary Plan Description (SPD) summarizes the Staples Medical Plan (the “Plan”), with details about your UnitedHealthcare (UHC) Choice Plus HSA (Health Savings Account) plan benefits in effect July 1, 2018. If you enroll in a different plan, you may access an SPD for that option. The information in this booklet supersedes information communicated in prior booklets.

This Plan is self-insured. There is no insurance company to collect premiums or underwrite coverage. Instead, contributions from you and Staples pay all benefits. Prior claims experience and forecasted expenses are used to determine the amount of money needed to pay future benefits. These options are governed by federal laws, not by state insurance laws.

The HSA option includes a network of physicians, hospitals, and other health care providers whose credentials have been reviewed by UnitedHealthcare, and who have agreed to provide their services at negotiated rates. Pharmacy benefits are also included and provided by CVS Caremark. You can generally reduce your out-of-pocket expenses by using network providers. However, you may choose to go out-of-network and pay more.

 **Note:** UnitedHealthcare is the network manager and Claims Administrator for this coverage option unless you live in the state of Minnesota, North Dakota, or South Dakota, or the county of Polk, Pierce, St. Croix, Burnett, Douglas, Bayfield, Ashland, Washburn, Sawyer, Barron, Dunn, Chippewa, or Eau Claire in Wisconsin. Then your Claims Administrator for purposes of arranging for network providers is through the Medica Choice Network, administering the payment of claims, and conducting related activities is Medica Self-Insured.

Eligibility

Associate Eligibility

Generally, you are eligible to participate in this Plan if you are an active:

- Full-time exempt associate,
- Full-time non-exempt associate,
- Part-time exempt associate, or
- Part-time ACA non-exempt associate.

You are not eligible if you are a(n):

- Associate whose employment is subject to the terms of a collective bargaining agreement, unless the agreement states inclusion in the Plan,
- Casual or temporary associate,
- Associate classified as an independent contractor,
- Intern,
- Retired associate, or
- Leased associate.

You will be considered in active service:

- On any of your scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Staples place of business or at some location to which you must travel to for your Staples business, or
- On a day that is not one of your scheduled work days if you were in active service on the preceding scheduled work day.

Part-Time ACA Non-Exempt Associate


To be eligible for a Staples' qualified medical plan, you must work an average of at least 30 hours per week during the measurement period.

You will be notified if you meet the eligibility requirements during the measurement period. You will be eligible for medical for a minimum of 12 months from the beginning of your stability period, unless you separate from Staples. Certain rules apply for a rehire, or resumption of service, when a break in service occurs. A break in service occurs when a continuous unpaid leave of absence or termination meets or exceeds 13 weeks.

- After a minimum of 13 weeks where no hours of service are being paid to an associate, an employer can consider the associate to have experienced an employment break, reset the ACA status and treat the associate as a new hire if they should return to work beyond 13 weeks.

- If the associate has unreported hours of service for less than 13 weeks and returns to work, the associate should be treated as a rehire where the offer of medical coverage is based on the ACA status when the unreported hours of service began. Refer to the *Rehire* section contained in this document for medical eligibility timeframes.

IMPORTANT: If you are in a Marketplace plan, your eligibility for the Staples medical plan may have an impact on the cost of your Marketplace plan if you choose to remain in the Marketplace plan. Contact your Marketplace plan directly for information about your rates and any other questions. If you do not know the contact information, you may find it at www.healthcare.gov or call 1-800-318-2596.

 **Note:** Part-time non-exempt associates remain eligible for all Staples part-time benefits.

Eligible Family Members

You may also elect coverage for your eligible family members, including:

- **Your spouse (excluding common law spouse).** A “spouse” will be defined as an individual to whom you are legally married. Former spouses are not eligible for coverage through Staples, except on a temporary basis as required by COBRA.
 - **Your dependent children under age 26.** Coverage ends on the last day of the month in which the child reaches age 26.

The term child is a person under the age of 26 who is your:

- Natural child,
- Stepchild,
- Legally adopted child,
- Child placed for adoption, or
- Child for whom legal guardianship has been awarded to you or your spouse.
- **Dependent child(ren) age 26 and older who are unable to care for themselves because of physical or mental disability.** Proof of the child’s condition and dependence must be submitted to the Claims Administrator within 30 days after the date the child reaches this category (must be prior to age 26). The Claims Administrator may ask, from time to time, for proof of continuation of such condition.

Dependent eligibility is subject to the following additional conditions and limitations:

- A dependent also includes a child for whom health care coverage is required through a “Qualified Medical Child Support Order” (QMCSO) or other court or administrative order. Staples is responsible for determining if an order meets the criteria of a QMCSO.

- A dependent does not include anyone who is also enrolled as an associate. No one can be a dependent of more than one associate. If your spouse is a Staples associate, he/she may enroll for “single” coverage or may be enrolled as a dependent under your coverage, but not both. Also, if you have children, each child can only be covered by one of you. A child who is an associate cannot be a dependent covered under you and also have his or her own coverage; he or she must choose one or the other.

Dependent Verification


You will be asked to provide documents to prove that the family members you enrolled are eligible (e.g., marriage certificate, birth certificate). All dependents must meet the definition of an eligible dependent and it is your obligation to ensure the accuracy of your dependent data. Should you enroll ineligible dependents and the Plan is made aware, any ineligible dependents will be removed from the applicable plans retroactively to the initial date of coverage and you will be refunded any premiums. You may be responsible for any expenses incurred and paid for this individual. In this case, expenses would be required to be reimbursed to the Plan and your employment may be terminated as a result of violating our Code of Ethics Policy.

Filing an Appeal for Dependent Verification

If the documentation you provided for a dependent is denied, you may appeal the decision to the appropriate Claims Fiduciary in writing. Your request should include the following:

- 1) the name of the dependent(s) that you are requesting reinstatement for
- 2) an explanation of the reason you believe coverages should be reinstated and any extenuating circumstances that you would like considered
- 3) any required documentation must be included with the signed claim initiation form.

Log on to the Dependent Verification website (Staples Benefits Connection at staples.com/benefits) for a list of required documentation.

 **Note:** If documentation is not received with your signed claim form, your request may be delayed.

You will receive a response no later than 30 calendar days from the receipt of your claim. To check on the status of your request and the estimated completion date visit Staples Benefits Connection (staples.com/benefits) and click on the Dependent Verification link, then click on the **Claims and Appeals** tab.

Please note that if approved, coverages will be retroactively reinstated, and retroactive deductions will apply.

As part of health care reform, Staples is required to request and provide the IRS with Social Security numbers for all dependents covered by a Staples medical plan. As of **January 1, 2009**, all plan administrators, third-party administrators or insurers must provide the Centers for Medicare and Medicaid Services (CMS) with Social Security numbers (SSN) for those members covered under the health plan. Reporting dependent SSNs to CMS is mandatory, and the failure to provide information subjects plans and insurers to significant penalties. The federal government may assess a financial penalty on your dependent for not having medical insurance if the IRS cannot confirm that he/she has minimum essential coverage. Please verify that the correct Social Security numbers for your covered dependents are provided.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't live with you. However, children who are no longer eligible (e.g., due to their age) cannot be added under a QMCSO.

Eligibility for Coverage under a QMCSO

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order and will not be considered a late entrant for dependent insurance.

When Staples is notified that a QMCSO has been issued for your eligible child, we will enroll your child and you, if you are not enrolled, per the instructions on the QMCSO. If you feel that the QMCSO has been issued in error, you must work with the issuing court or competent jurisdiction to provide Staples with the appropriate documentation to stop the deductions.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits discrimination in group health plan coverage based on genetic information. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and is effective for plan years beginning after October 9, 2009. HIPAA prevents a plan from imposing a pre-existing condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

GINA prohibits group health plans from:

- **Basing premiums on genetic information.** However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.
- **Asking or requiring you to undergo a genetic test.** However, your health care provider may request a genetic test. In addition, genetic testing information may be requested to determine payment of a claim for benefits. However, the plan may request only the minimum amount of information necessary to determine payment. There is a research exception that permits a plan to request (but not require) that you or a covered family member undergo a genetic test.

- **Collecting genetic information (including family medical history) before or in connection with enrollment, or for underwriting purposes.** Plans are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a health risk assessment. There is an exception for incidental collection, provided the information is not used for underwriting. The incidental collection exception is not available if it is reasonable for the plan to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

Enrollment Guidelines

New Hires

A personalized enrollment notice will be sent via email to your Staples email address. If you do not have a valid Staples email address, the notice will be mailed to your home address on file. The options you may choose from are determined by your home and work zip code. You make your election choices using Staples Benefits Connection (staples.com/benefits).

You must make an election on or before the deadline shown on your enrollment notice. If you fail to do so, you will be considered to have waived participation for the current plan year and will have no coverage unless you make a new election as a result of a qualifying life event or during the next annual enrollment period (whichever occurs first).

Annual Enrollment

Each spring, Staples offers an annual enrollment period for the plan year: July 1 through June 30. During this time, you may elect coverage, switch from your current option to another available option or drop coverage. This is also the time to add or remove family members. Eligible family members may be added or deleted for any reason during annual enrollment.

Important: If a family member is no longer eligible, you must remove him/her from coverage.

When you elect coverage, you are automatically enrolled in the Pre-Tax (Section 125) Plan. This enables you to pay your premium contributions on a pre-tax basis. In return for this tax advantage, you may only enroll or change coverage during the annual enrollment period or if you experience a qualifying life event (defined in the *Changes in Family Status* section).

- If you fail to make an election before the annual enrollment deadline, your default election will be your previous election (if already enrolled assuming the previously elected coverage remains available) or no coverage (if there was no previous election). If your previous election is no longer available, Staples may enroll you in an option of its choice or may require you to make another election. In the latter case, if you fail to make an election before the deadline, you will not have coverage.

📖 Note: For the health savings bank account, your participation will stop if you do not make a new election each year (regardless of your previous election).

Special Enrollment Rules

If you decline enrollment for yourself or your dependents (including your spouse) because of other health coverage and you later lose that other coverage, you may be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 or 60 days (whichever is applicable; see the *Changes in Family Status* section for details) after the marriage, birth, adoption or placement for adoption by submitting your elections through the Life Events tab on Staples Benefits Connection (staples.com/benefits). Also, if you or your dependents become ineligible for

Medicaid or CHIP (Children's Health Insurance Program) and lose coverage, or if you or your dependents become eligible for a state's premium assistance program, you will have 60 days from the qualifying life event date to submit your elections through the Life Events tab on Staples Benefits Connection (staples.com/benefits).

Cafeteria Plan Rules

Because this Plan is administered through a cafeteria plan arrangement in accordance with Section 125 regulations of the Internal Revenue Code, your current premium contributions will be made on a pre-tax basis. Any contributions taken in arrears will be made on a post-tax basis. Also, per this regulation, you are allowed to enroll or change coverage only during the annual enrollment period. Exceptions are allowed if you experience a qualifying life event and enroll or change your coverage due to the special enrollment rules.

Spousal Surcharge

If you enroll your spouse and he/she has access to subsidized medical coverage through his/her employer, you will be assessed a \$23.08 per week surcharge in addition to your medical premium. Subsidized coverage is defined as any medical coverage that is partially paid for by an employer or government-sponsored plan. You will be prompted when you enroll on Staples Benefits Connection (staples.com/benefits) to attest to the employment status of your spouse and the availability of subsidized medical coverage. If you are adding a spouse as a result of a qualifying life event (e.g., marriage, spousal loss of coverage), these questions are part of the online enrollment process. If you do not answer these questions, you will be assessed the spousal surcharge.

Changes in Family Status (Qualifying Life Event)

This section explains which events are considered qualifying life events and what changes you may make as a result. If you have a qualifying life event, you must submit your elections through the Life Events tab on Staples Benefits Connection (staples.com/benefits) within 30 days (60 days for birth, adoption or placement for adoption, or guardianship). If you do not, your changes to your coverage may be limited.

If you elect not to participate, you will not be able to enroll again until the next annual enrollment period unless you experience a qualifying life event (as defined under Section 125 of the tax code) or qualify under the Health Insurance Portability and Accountability Act (HIPAA) "special enrollment rules." *Any changes in coverage due to "special enrollment rules" or qualifying life event will take effect on the date that correlates to the special enrollment.*

The following is a quick reference guide for qualifying life events and how your coverage is affected.

Important: You must submit your elections through the Life Events tab on Staples Benefits Connection (staples.com/benefits) **WITHIN 30 DAYS FROM THE QUALIFYING LIFE EVENT** (unless noted differently).

If This Qualifying Life Event Occurs...	How Coverage Is Affected
Marriage	You may elect or waive coverage, add or drop dependent(s) and/or change your Plan.
Divorce (You are enrolled)	Your ex-spouse is no longer eligible for Staples group coverage on the date of divorce. Note: You may not drop coverage for yourself or other covered eligible family members.
Divorce (You lose coverage under your spouse's plan)	You may enroll yourself and other family members who might have lost eligibility for your spouse's plan.
Gain of a Dependent (through birth, adoption or placement for adoption, or guardianship)	You may enroll yourself and other family members and/or enroll him or her. You will have 60 days from the qualifying life event date to submit your elections through the Life Events tab on Staples Benefits Connection (staples.com/benefits).
Dependent Becomes Ineligible	If your child is covered, coverage for your child ends on the last day of the month in which he/she reaches age 26.
Death of a Dependent	You may elect or waive coverage, drop dependent(s) and/or change your elections.
Dependent Becomes Ineligible or Eligible for Medicaid or CHIP	If you or your dependent(s) become eligible or ineligible for Medicaid or CHIP and gain or lose coverage, you will have 60 days from the qualifying life event date to submit your elections through the Life Events tab on Staples Benefits Connection (staples.com/benefits).

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, you may change your election for yourself and any eligible family member within **60 days** of either (1) termination of Medicaid or CHIP coverage due to loss of eligibility, or (2) becoming eligible for a state premium assistance program under Medicaid or CHIP coverage. In either case, coverage is effective no later than the first of the month after submittal of your elections through the Life Events tab on Staples Benefits Connection (staples.com/benefits).

Coordination with Medicare

If you cancel coverage or drop your dependent(s) due to entitlement to Medicare, or if you enroll in or increase the dependent(s) covered under this Plan due to the loss of Medicare entitlement, you will have a qualifying life event.

Note: If you are enrolled in a plan with a Health Savings Account (HSA) bank account, you, as the associate, may not be enrolled in Medicare and contribute to the HSA; however, if you are eligible for Medicare *but have not filed an application for either Social Security retirement benefits or Medicare*, you are still eligible to contribute. You can continue to contribute to your HSA after age 65 if you choose to postpone applying for Social Security and Medicare.

Coordination with Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

When Coverage Begins

Once you elect coverage, it will become effective (provided your initial eligibility period was met):

	New Hire	Annual Enrollment Effective Date	Employment Status Change (Part- to Full-time) *Special Rules apply regarding ACA eligibility	Family Status Change Qualifying Life Event
Exempt; also includes <ul style="list-style-type: none"> • Non-exempt retail management associates 	First day of the month following or concurrent with 30 days of service	July 1	Effective the date of the status change	Effective the date of the Qualifying Life Event
Non-exempt	First day of the month following or concurrent with 60 days of service	July 1	Effective the date of the status change	Effective the date of the Qualifying Life Event

Judgment, Decree, or Order, Including QMCSOs (Court Order)

If a judgment, decree, or order (including a QMCSO) requires the Plan to provide coverage to your child, then Staples may automatically change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of such judgment, decree or order, if you desire. If the judgment, decree or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to Staples HR Services that such other person actually provides the coverage for the child.

Changes in Coverage Under Another Employer Plan

You may make a coverage election change if the plan of your spouse or dependent:

- Incurs a change such as adding or eliminating a benefit option,
- Allows election changes due to special enrollment, change in status, court order or Medicare eligibility/entitlement, or
- Has a different plan year than Staples.

Change in Cost or Coverage

If the cost of benefits increases or decreases during the plan year, Staples may, in accordance with the Plan's terms, automatically change your election contribution.

When the change in cost is significant, you may either increase your contribution or elect less costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit is added, you may change your election to the new benefit option.

You may be permitted to revoke and/or make new benefit elections, subject to the appropriate consistency rules, if one of certain specified events permitted by the Plan and IRS regulations occurs.

Rehires

If you are a rehire:

- And rehired within 30 days of separation provided your initial eligibility period was met*, you are considered reinstated. Your coverage (plan & tier) will be reinstated to the same coverage as when you separated from the company. It will be effective the day you are reinstated.
- And rehired between 31 and 180 days of separation, you must enroll within 30 days of your rehire date provided your initial eligibility was met*. Coverage will be effective the 1st day of the month following or concurrent with your rehire date.
- And rehired more than 180 days after separation, you must enroll within 30 days of your rehire date. Coverage will be effective in accordance with the new hire guidelines stated previously.

*If your initial eligibility period was not met prior to separation, you must enroll within 30 days of your rehire date and coverage will be effective in accordance with the new hire guidelines stated previously.

Information Sources

UnitedHealthcare's Toll-Free Care Line and Website

You may contact UHC at any time as follows:

Phone Number:	Mailing Address:	Web Address:
UHC Member Services 1-877-440-5984 Available 365 days 24/7	<u>Medical Claims:</u> UnitedHealthcare PO Box 30555 Salt Lake City, UT 84130-0555	www.myuhc.com

Medica's Toll-Free Care Line and Website

(For Minnesota, North Dakota, South Dakota and certain counties in Wisconsin)

Phone Number:	Mailing Address:	Web Address:
Medica Self-Insured 1-877-440-5984 Available 365 days 24/7	<u>Medical Claims:</u> Medica PO Box 30990 Salt Lake City, UT 84130-0990	www.mymedica.com

Phone Services

For benefit questions, finding providers, preauthorization, claims status and forms, ID cards and other health information, contact the UHC Healthcare 24-Hour Health Information LineSM at 1-877-440-5984.

24-Hour Nurseline

The main number can also get you to a UHC registered nurse for guidance – available 24 hours a day, 7 days a week.

The Nurseline can help you navigate the health care system, including:

- Helping you decide on the right place for care,
- Finding a doctor or hospital,
- Understanding treatment options that you can discuss with your doctor,
- Finding answers to medication questions, and
- Locating available resources.

Online Services

To register:

- Go to www.myuhc.com or www.mymedica.com and click on the “Register Now” button.
- Enter information from your health plan ID card or register using your Social Security number and date of birth.
- Enter or confirm your email address. Or if you do not already have an email address, you can sign up for a free personal email address with Google, Yahoo or AOL.
- Create a username and password, select a security question, and agree to the website policies.

Once registered, visit www.myuhc.com to better understand this Plan and make informed decisions on doctors, hospitals and your health and wellbeing. You can:

- Find a doctor or service,
- Look up your current bank account balance, past transactions and claim status,
- Track your account balance and estimate your out-of-pocket expenses,
- Compare average medical costs by location,
- Learn about other UnitedHealthcare products and services — what they are and how you can use them,
- Find answers to frequently asked questions – about health care in general and UnitedHealthcare specifically,
- Find savings on health and wellness products and services, and
- Take advantage of a number of convenient, helpful tools such as:

UnitedHealth Premium Program

UnitedHealthcare has designated network physicians and facilities as UnitedHealth Premium Program physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels: quality and efficiency of care. For details on the UnitedHealth Premium Program, log on to www.myuhc.com.

Treatment Decision Support Program

UHC’s Treatment Decision Support Program helps you make informed decisions about specific conditions as well as the treatments and procedures for those conditions.

This program offers access to accurate, objective and relevant health care information. It provides coaching by a nurse through decisions in your treatment, information on high quality providers and programs and expectations of treatment for your condition. Participation in the Treatment Decision Support Program is voluntary and free of charge.

Healthwise®

Find medical content on more than 5,000 health conditions, health and wellness, first aid and medical exams.

Health Record

Record and store personal health information in a central and secure location including current conditions, medications, allergies, surgeries, immunizations and emergency contacts.

CVS Caremark Toll-Free Care Line and Website

CVS Caremark is your contact (and claims processor) for outpatient prescription drugs provided through mail order for long-term prescriptions (90 day) or a local retail pharmacy for short-term prescriptions (30 day).

Phone Number:	Mailing Address:	Web Address:
CVS Caremark Member Services 1-877-876-7215	CVS Caremark PO Box 52196 Phoenix, AZ 85072-2196	www.caremark.com

Online Services

To register:

- Go to www.caremark.com/register
- Enter the required information and click "Continue"
- Create a username and password

Once registered, visit www.caremark.com to:

- Check drug cost and discover easy ways to save on your medications,
- Order new prescriptions with FastStart® ,
- Locate retail network pharmacies,
- Check drug interactions,
- Order prescription refills,
- Sign up for automatic refills and renewals,
- View prescription history,
- Get details about your prescription drug benefit,
- Learn more about your health conditions and medicines,
- Ask a pharmacist a question,
- View prescription history, and
- Receive alerts by email, phone or text message.

Staples HR Services Toll-Free Line and Website

The Staples HR Services team provides an easy, single point of contact for your human resources and benefits questions, including payroll, HR policies and procedures, compensation, and taxes. Staples HR Services team members are available year-round to help.

Phone Number:	Mailing Address:	Web Address:
1-888-490-4747 Monday - Thursday 8:30 a.m. to 6:00 p.m. Friday 8:30 a.m. to 5:00 p.m. EST (Eastern Standard Time) (except certain holidays)	Staples, Inc. Attn: HR Services 500 Staples Drive Framingham, MA 01702	Staples Benefits Connection (staples.com/benefits)

Online Services

Access to plan-related information including all Staples benefits, forms, guides and information for you and your family members is available at Staples Benefits Connection (staples.com/benefits).

Basic Plan Features

The basic features of this Plan are:

- Only covered health services are covered.
- Preventive care that meets specific guidelines is free because it helps to detect conditions before they become serious. (See the *Preventive Care* sections for more details.)
- Inpatient hospital stays must be pre-certified to receive the maximum benefits allowed by the Plan.
- The HSA Choice Plus network of participating providers offers you savings of both time and money.

Out-of-Network Providers at a Network Facility

Covered Health Services that are provided at an in-network facility by an out-of-network facility-based Physician are reimbursed as part of the in-network facility benefit. Refer to the *Benefits Schedule Emergency & Urgent Care Services* section for details.

Covered Health Services

Expenses are covered under this Plan only if they are covered health services. Care is considered a covered health service (as defined in the *Key Terms* section of the SPD) if it is a therapeutic procedure, service or supply used in the medical treatment of an injury, disease, or pregnancy, which is generally recognized by the United States medical community as appropriate. Claims are reviewed as submitted and some or all of any claim or series of services could be denied as not being medically necessary. It also means that experimental or investigational procedures, drugs, devices or biological products not proven by long-term clinical studies are generally not covered.

When determining medical necessity, the Plan Administrator may consider the Clinical Policy Bulletins (CPBs) published by the Claims Administrator. CPBs are based on established, nationally accepted governmental and/or professional society recommendations, as well as other recognized sources.

Personal Health Support – Prior Authorization Requirement

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, some network benefits require you to obtain prior authorization from Personal Health Support before receiving those services.


Prior authorization is required for certain Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine and Nuclear Cardiology procedures (“Advanced Outpatient Imaging Procedures”) if a member’s benefit document requires that services be medically necessary in order to be covered. If prior authorization is required, a clinical coverage review will be

conducted to determine whether a service is medically necessary based on evidence-based clinical guidelines, prior to the service being rendered to an individual member. Prior authorization is a process that must be completed before rendering the service, with administrative claim denial for failure to comply with the requirement.

When you receive certain covered health services from non-network providers you are responsible for obtaining Prior authorization before you receive those services, or your benefits will be reduced.

The services that require prior Authorization from Personal Health Support are:

- Ambulance – non-emergency air,
- Chemotherapy,
- Congenital heart disease services,
- Clinical Trials,
- Durable medical equipment for items that will cost more than \$1,000 to rent or purchase including diabetes equipment for the management and treatment of diabetes,
- Gender Identity Disorder Treatment,
- Genetic Testing – BRCA,
- Home health care,
- Hospice care – inpatient,
- Hospital inpatient stay – all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery,
- Infertility services,
- Manipulative treatment as described in rehabilitative services,
- Obesity surgery,
- Outpatient sleep studies,
- Prosthetic devices for items that will cost more than \$1,000 to purchase or rent;
- Reconstructive procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery,
- Skilled nursing facility/inpatient rehabilitation facility services,
- Surgery – sleep apnea surgeries and orthognathic surgeries,
- Therapeutics –all outpatient therapeutics (such as dialysis, chemotherapy and radiation therapy),
- Transgender surgery, and
- Transplant services.

 **Note:** For the services listed above, please remember that, for out-of-network benefits, you must notify Personal Health Support five business days before receiving services or as soon as

reasonably possible. If Personal Health Support is not notified, benefits will be reduced by 50% of eligible expenses.

HealthNotes

UnitedHealthcare provides a service called HealthNotesSM. HealthNotesSM provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealthNotesSM report may include health tips and other wellness information.

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine

If your Physician identifies any concerns after reviewing his or her HealthNotesSM report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the information UnitedHealthcare provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Maternity Support Program

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

This program offers:

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

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free Member Services number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services (NRS)

The Plan pays benefits for neonatal intensive care unit (NICU) services provided by designated facilities participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions.

To receive benefits under this program, the network provider must notify NRS or Personal Health Support if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- Call Personal Health Support, or
- Call NRS toll-free at 1-888-936-7246 and select the NRS prompt.

Disease and Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program, at no cost to you, which are designed to support you. This means that you will receive free educational information through the mail and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications,
- Access to educational and self-management resources on a consumer website,
- An opportunity for the disease management nurse to work with your physician to ensure that you are receiving the appropriate care (for certain conditions),
 - **Personal Health Support**
 - Case Management
 - HealthNotes and HealthNote Reminder Mailings
 - **Complex Medical Conditions**
 - Transplant Resource Services
 - Congenital Heart Disease
 - Cancer Support Program
 - **Women's Health**

- Fertility Solutions Program
- Maternity Support Program
- Neonatal Resource Program
- **Decision Support**
 - Emergency Room Decision Support
 - Decision Support
- Toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - Education about the specific disease and condition,
 - Medication management and compliance,
 - Reinforcement of on-line behavior modification program goals,
 - Preparation and support for upcoming physician visits,
 - Review of psychosocial services and community resources,
 - Caregiver status and in-home safety, and
 - Use of mail order pharmacy and network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, contact Member Services at 1-877-440-5984.

Prior authorization for Mental Health and Substance Use Disorder Services

You are not required to provide pre-service notification when you seek the following services from network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.

For benefits to be provided for any of the following services, prior authorization is required:


- **Mental health services** – inpatient services (including partial hospitalization/day treatment and residential treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management,
- **Neurobiological disorders** – mental health services for autism spectrum disorders – inpatient services (including partial hospitalization/day treatment and residential treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management, and
- **Substance use disorder services** – inpatient services (including partial hospitalization/day treatment and residential treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to admission or as soon as reasonably possible for non-scheduled admissions (including emergency admissions). If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, the benefits will be subject to a reduction.

Medical Plan Network

The network includes a group of physicians, hospitals, and other providers who have met standards for licensing, academic background and service. If you use network providers, the Plan pays a larger portion of the covered expenses and some services are only covered in-network. Network providers have agreed to negotiated charges, which may save you and the Plan money. Other advantages to using network providers for medical care are:

- Your deductible and plan year out-of-pocket maximum are significantly lower.
- Network providers file claims and handle the hospital pre-admission review process for you.
- All negotiated charges are within usual, customary and reasonable (UCR) limits.
- Certain services such as preventive care visits, infertility treatment, bariatric surgery and transplants are only covered if you use a network provider.
- UnitedHealthcare Choice Plus networks are located throughout the United States and some are designated as Centers of Excellence (COE). A COE is designated as such because of the high-quality rating they receive for certain procedures.

 **Note:** It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of *Shared Savings Program* section for details about how the Shared Savings Program applies.

Show Your ID Card

When you visit a physician or other health care provider, present your Plan identification card. This helps the provider confirm your eligibility and understand your benefits coverage.



Tip: Also present your pharmacy card in the event a prescription is needed.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

When You Use Out-of-Network Providers

- Your out-of-pocket costs will be higher. The Plan's reimbursement level is 140% of the Medicare reimbursement rate vs. usual, customary and reasonable after you meet the deductible.
- If your provider's charges are above the Medicare reimbursement rate, you are responsible for paying those amounts and they do not accumulate toward your deductible or out-of-pocket maximum.


For Emergency Medical Care

Certification must be made within 24 hours after an emergency admission. If the admission is on a weekend or holiday, notification must be made within 72 hours.

- If you are using a network provider, your provider will obtain certification for you.
- You or someone acting on your behalf must call to certify care if you are in an out-of-network hospital.

Care While Traveling

For non-emergency care, call UHC to identify a nearby network provider or check **Find a Doctor** on www.myuhc.com. If you are traveling outside the United States and need care, you would be covered at the out-of-network benefit level.

 **Note:** For emergency care, refer to the *For Emergency Medical Care* section.

Fast Facts

If you choose to see a UnitedHealthcare participating provider, the cost is based on discounted rates, so your costs will be lower. If you visit a provider not in the network, you may still use UnitedHealthcare Choice Plus to pay for the cost of those services, but you will pay a higher rate and you may have to file claims.

If you need hospital care, there are several tools to help you make informed decisions about quality and cost.

- Visit the provider directory for UHC's Centers of Excellence, which provides hospital scores for specific procedures/conditions, such as cardiac care, hip and knee replacement and bariatric surgery. Scores are based on cost and effectiveness in treating the procedure/condition, based on publicly available data.
- To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.
- For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium Physician, log onto www.myuhc.com or call the number on your ID card.

Important Terms to Know

Accumulation of Deductibles and Out-of-Pocket Maximums

Deductibles and out-of-pocket maximums will not cross-accumulate between in- and out-of-network. All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted.

Copayments/Deductibles

Copayments and deductibles are expenses to be paid by you or your dependent for the services received.

Coinsurance

Coinsurance means the percentage of charges for covered services that you must pay under the Plan.

Maximum Reimbursable Charge

In-network services are paid based on the fee agreed upon between UnitedHealthcare and the provider. Out-of-network services are paid based on the maximum reimbursable charge (MRC). For this Plan, the MRC is calculated at 140% of the Medicare reimbursement rate. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge.

Out-of-Pocket Expenses

Out-of-pocket expenses are covered expenses incurred for in-network and out-of-network charges that are not paid by the Plan because of any deductible or coinsurance.

Charges will not accumulate toward the out-of-pocket maximum nor will they be payable at 100% by the Plan for covered expenses incurred for:

- Prescription drug benefits subject to the 50% mail order penalty,
- Noncompliance penalties, or
- Provider charges over the maximum reimbursable charge (MRC).


Plan Year


The plan year is defined as July 1 – June 30. Each July 1, your deductible and out-of-pocket maximum are reset and begin to accumulate again.

How Your UnitedHealthcare Choice PlusSM – Health Savings Account (HSA) Works

The Basics

The Health Savings Account option combines traditional medical coverage with a bank account that you may contribute to on a pre-tax basis and includes contributions from Staples if you complete certain incentive criteria. Upon your enrollment, UHC’s banking partner, Optum Bank attempts to open a health savings account on your behalf and once successfully opened, your contribution as well as Staples are deposited, and you may use the funds to pay for IRS qualified health care expenses which may include medical expenses not covered under the Staples Plan design.

 **Note:** The health savings account is an individually owned account and is not considered part of this Plan or subject to ERISA.

Before Annual Deductible	1	<p>HSA wellness rewards, if available, may be used to pay for your covered health care expenses. These payments also go toward your annual deductible and out-of-pocket maximum.</p> <p>Staples contributes wellness rewards to your bank account (provided you have completed the requirements – see <i>How to Earn Staples Wellness Rewards</i>)</p> <p>Up to \$400 – Associate Up to \$600 – Family</p>
	2	<p>If you use all the wellness rewards available in your HSA bank account, you pay the rest of the deductible amount out of your own pocket.</p> <p>The in-network plan year deductible is:</p> <p>\$1,500 – Associate \$3,000 – Family</p> <p>The out-of-network plan year deductible is:</p> <p>\$3,000 – Associate \$6,000 – Family</p>
Your Contribution	3	<p>You may also contribute to your account. Your annual contribution limits are:</p> <p>\$3,450 – Associate \$6,900 – Family</p> <p>You must contribute a minimum of \$100 annually if you want to participate. Also, if you are age 55 or older, you may add an additional \$1,000 per year.</p> <p> Note: You must manage the contributions to ensure that your contribution plus any Staples Wellness Rewards do not exceed the annual calendar year limit set by the IRS.</p>

After Annual Deductible	4	After meeting your plan year deductible, you and Staples share expenses. This is called coinsurance. Staples pays 80% in-network and 50% out-of-network (except for emergency use).	
	5	You are protected from major expenses with an out-of-pocket maximum.	
		Associate	Family
	Out-of-Pocket Maximum (includes deductible) Once you reach the maximum, all eligible expenses are covered up to 100% for the rest of the plan year.	In-network: \$3,000 Out-of-network: \$6,000	In-network: \$6,000 Out-of-network: \$12,000

Important: Your in-network and out-of-network deductibles and out-of-pocket maximums do not cross-accumulate. This means you have to meet each individually.

Important Information About Your HSA Bank Account:


There are many rules and tax implications with the bank account, so it is important that you consult with a tax advisor to ensure you are compliant. Below are highlights of some of the considerations to take into account when using your HSA bank account.

- For any contributions to be made to your HSA, you must satisfy the following HSA eligibility requirements:
 - You cannot be claimed as another person’s tax dependent.
 - You must not be enrolled in Medicare.
 - You must not participate in a full Health Care Flexible Spending Account (FSA).
 - You must not be covered under any other health care coverage other than qualifying high deductible coverage like the UHC Choice Plus option. This means that if you are covered under your spouse’s non-highly deductible health plan coverage, including a health flexible spending account, you are not eligible for an HSA.
- For a list of services for which HSA funds may be used, visit www.myuhc.com.
- Under IRS rules, HSA funds can be used to cover qualified health care expenses incurred by:
 - You and your spouse (an individual to whom you are legally married),
 - Any individual you claim as a dependent on your Federal tax return,
 - A child of parents who are divorced, separated or living apart for the last six months of a calendar year is treated as the dependent of both parents whether or not the custodial parent releases the claim to the child’s exemption.
 - If you change plans or leave Staples, any funds remaining in your HSA bank account are yours.

- You have discretion on when and how you use your bank account.
- You may make changes to your pre-tax contribution amount up to one time per month. The change will be reflected in your first paycheck of the following month.
- You do not pay federal income or FICA taxes on your contributions.
- You do not pay state income taxes on your contributions, except in Alabama, California and New Jersey. Each state can decide to follow the federal tax guidelines for HSAs or establish its own. Please consult a tax advisor regarding your state's rules or visit your state's Department of Revenue office for more information.

HSA Fund Covered Services

Under federal law, HSA funds can be used for anything, however, to avoid penalties and taxes, the funds must be used on qualified medical, dental, vision and prescription expenses for you and your tax dependents.

 **Note:** Not all HSA qualified expenses count towards your deductible and/or out-of-pocket maximum.

What an HSA Is

An HSA is a tax-advantaged account participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- Accumulate over time with interest or investment earnings,
- Are portable after employment, and
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

How the HSA Bank Account Works

You and Staples may contribute, and contributions are tax-free up to federal limits. You choose how to pay for qualified medical expenses:

- You may pay claims on your own using a debit card or checkbook that draws from your savings bank account.
- You may choose the automatic claim forwarding option, allowing claims to be paid directly to your doctor, hospital, or other facility. So you don't have to do a thing; your claims are paid automatically while there is money in your savings account.



Tip: You may change your pre-tax election amount up to one time per month (effective as of the first pay period of the following month) at any time during the plan year by submitting your elections through the Life Events tab (click on the *Change Your Health Savings Account Contribution Amount* tile) on Staples Benefits Connection (staples.com/benefits).

- You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for qualified medical expenses in future years or at retirement. The account earns interest and once your balance reaches \$2,000.00, you can invest the funds in mutual funds.
- Any money left in your HSA at the end of the plan year will be rolled over to use for future medical expenses.
- If you leave Staples or change medical plans with funds remaining in your account, the money is still yours to pay for eligible medical expenses.
- If you withdraw money from your account for non-eligible expenses before age 65, you will be subject to income tax and a tax penalty on those funds. The money will be treated as ordinary income and will be subject to taxes.

 **Note:** If you become disabled, the 20% penalty will not apply.

Services Paid Out of My Own Pocket

This summary plan description details covered services, but if you are still not sure, call UHC to get an answer about your specific need. In addition to the premiums deducted from your paycheck, you'll be responsible for paying:

- Your deductible,
- Copayments or coinsurance, and/or
- Costs for any services that are not covered by the Plan.

Services Covered When Using Out-of-Network Doctors

You can use your HSA bank account to pay for visits to any licensed doctor or facility. However, if you choose a provider who participates in UnitedHealthcare Choice Plus network, your costs will be lower.

UHC does not insure the benefits described in this section. Further, note that it is the Plan's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by Staples. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

How to Earn Staples Wellness Rewards

An important part of this Plan is your HSA bank account. Staples deposits wellness rewards into your bank account during the plan year when you meet the following requirements. To be eligible, you must be actively employed and have an open bank account at the time the rewards are funded.

Activity	Reward Amount	How
Take the Personal Health Assessment (PHA).	The PHA is required to earn the medical premium discount and Wellness Rewards. (applies to associate and covered spouse)	Access the Wellness Rewards tile on Staples Benefits Connection (staples.com/benefits) to take the PHA. To earn any discounts or rewards, your covered spouse must complete this step too.
Be a non-tobacco user, or complete an approved alternative if you use tobacco.	Save \$18.46/week on your medical plan premium. * (applies to associate and covered spouse)	Indicate you are a non-tobacco user on the PHA, OR If you use tobacco: Complete three coaching calls with a trusted WebMD Health Coach. OR Work with your doctor on a smoking cessation plan and have him/her complete the Health Consult Form. ** To earn the non-tobacco user discount on your medical premium, your covered spouse must complete this step too.
Complete one Healthy Habits activity	\$100 (applies to associate only).	Complete a preventive screening, such as getting your annual physical, a dental cleaning or an annual vision exam.
Complete one Healthy Minds activity	\$100 (applies to associate only).	Complete an activity to challenge your mind such as, completing two Health Topic evaluations, participating in a Life Services webinar or achieving a Digital Health Assistant goal.
Complete two Healthy	\$200 for single coverage.	Complete two healthy actions, such as

Activity	Reward Amount	How
Actions activities	<p>\$400 if covering a child or children only.</p> <p>Earn an additional \$200 if your covered spouse completes activities too.</p>	participating in a challenge, enrolling in WW (formerly known as Weight Watchers) or achieving a Digital Health Assistant goal.

*The non-tobacco user discount reduces the cost of your medical premium – whether you’re enrolled in the HSA plan or the HRA plan.

**You can find the full details by accessing the Wellness Rewards tile on Staples Benefits Connection (staples.com/benefits).

How your HSA Wellness Rewards and Deductible Work

Any HSA wellness rewards you earn through the Wellness Rewards program will help you pay for eligible medical expenses that you would otherwise pay out of your own pocket (such as your deductible). Let’s look at a few examples to see how this works. We’ll assume you have single coverage and have earned the full \$400 in Wellness Rewards.



Tip: When you use in-network providers, you do not have to file claim forms.



Tip: You have flexibility on how and when you use your HSA bank account. If you prefer to have the claim paid automatically from your account, you may select to do so by going to www.myuhc.com.

Example 1 (in-network with funds available):

You go to a network doctor in January and have not met your deductible for the plan year. The total cost of your exam is \$200, and your discounted portion is \$120. Your portion (\$120) of the cost of the exam is paid using your HSA dollars so you pay nothing out of your pocket. The balance in your HSA is \$280.

Example 2 (in-network with no funds available):

Now, let’s say that you have already used all of the dollars in your HSA before the end of the plan year. In this case, you pay any additional costs out of your own pocket. This includes any deductible you have not met and applicable coinsurance.

If we use the example above, but you don’t have any HSA dollars available, you have to pay the discounted portion of \$120 out of your own pocket.

Example 3 (out-of-network):

If you see an out-of-network doctor, you may have to pay for the exam at the time of the service and file a claim for reimbursement from your HSA. Claim forms and instructions for filing it are available at www.myuhc.com.

In this example, let's say you have the exam and it costs \$200. You may have to pay \$200 at the time of the service and then file the claim. Once the claim has been processed, UHC will let you know how much the service cost after they apply the out-of-network benefit (140% of the Medicare reimbursement rate). Then you can request to have that amount taken out of your HSA and sent to you as a check.

2018-2019 Benefits Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Staples annual contribution (with completion of Wellness Rewards criteria)	Individual \$400 / Family \$600	Individual \$400 / Family \$600
Plan year combined medical and prescription drug deductible – collective <i>Individual (associate only; no covered dependents)</i> <i>Family maximum (associate + dependent(s))</i>	<u>Maximums do not cross-accumulate</u> \$1,500 \$3,000	<u>Maximums do not cross-accumulate</u> \$3,000 \$6,000
Family deductible – collective: The expenses of all family members count towards the family deductible. The total family deductible must be satisfied before the Plan starts paying a portion of eligible expenses (coinsurance) for any individual.		
Important: There is shared accumulation of deductibles and out-of-pocket maximums, when applicable, between medical and mental health/substance use disorder benefits		
Plan year medical and prescription drug out-of-pocket maximum – collective <i>Individual (associate only; no covered dependents)</i> <i>Family maximum (associate + dependent(s))</i>	<u>Maximums do not cross-accumulate</u> \$3,000 \$6,000	<u>Maximums do not cross-accumulate</u> \$6,000 \$12,000
Family out-of-pocket maximum – collective: The expenses of all family members count towards the family out-of-pocket maximum. An individual cannot have claims covered at 100% until the total family out-of-pocket maximum has been satisfied.		
Reimbursement Level	100% of usual, customary and reasonable	140% of the Medicare reimbursement rate
Coinsurance	Plan pays 80% of eligible expenses after deductible. You pay 20% of eligible expenses after deductible.	Plan pays 50% of eligible expenses after deductible. You pay 50% of eligible expenses after deductible.
Personal Health Support (Required for all inpatient admissions and for selected outpatient procedures and diagnostic testing)	Coordinated by your physician unless otherwise noted	You must obtain approval for inpatient admission and selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
Lifetime maximum	Unlimited	Unlimited
Pre-existing condition limitation	No	No

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician Services		
Preventive care Routine preventive care – Well baby, well child care, adult and well woman Unlimited maximum per plan year Immunizations	No charge, no deductible	Covered in-network only
Primary care physician (PCP) Office visit Specialty physician office visit Office visits, consultant and referral physician services Allergy treatment/injections – PCP or specialty physician Allergy serum (dispensed by physician in office) Second opinion consultations (provided on voluntary basis) Surgery performed in the physician’s office – PCP or specialty physician	80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed 80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed 80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible	50% of eligible expenses after deductible 50% of eligible expenses after deductible 50% of eligible expenses after deductible 50% of eligible expenses after deductible 50% of eligible expenses after deductible
Mammograms*, PSA, Pap test Outpatient facility (includes the associated preventive outpatient professional services)	No charge, no deductible Note: No charge, no deductible per office visit for associated wellness exam	Covered in-network only
Note: Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services; based on place of service * 3D Mammograms covered effective April 1, 2017		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Inpatient hospital services including:</p> <ul style="list-style-type: none"> • Semi-private Room and board • Diagnostic/therapeutic lab and x-ray • Drugs and medication • Operating and recovery room • Radiation therapy and chemotherapy • Anesthesia and inhalation therapy • MRIs, MRAs, CAT scans, PET scans 	80% of eligible expenses after deductible	50% of eligible expenses after deductible Prior authorization required
<p>Inpatient hospital doctor visits/consultations</p> <p>Inpatient hospital professional services (surgeon, radiologist, pathologist, anesthesiologist)</p>	<p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p>
<p>Outpatient facility services includes:</p> <p>Operating room, recovery room, procedure room and treatment room and observation room including:</p> <ul style="list-style-type: none"> • Diagnostic/therapeutic lab and x-rays • Anesthesia and inhalation therapy • Physician and outpatient professional services (surgeon, radiologist, pathologist, anesthesiologist) 	80% of eligible expenses after deductible	50% of eligible expenses after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Laboratory and radiology Services (includes pre-admission testing)</p> <ul style="list-style-type: none"> • Physician's office • Outpatient hospital facility • Emergency room/urgent care facility (billed by facility as part of the emergency room/urgent care visit) • Independent lab facility • Independent lab facility (in conjunction with an emergency room/urgent care visit) 	<p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>
<p>Advanced Radiological Imaging (MRIs, MRAs, CAT scans, PET scans)</p> <ul style="list-style-type: none"> • Outpatient facility • Emergency room/urgent care facility (billed by facility as part of the emergency room/urgent care visit) • Physician's office 	<p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p>
<p>Short-term rehabilitative therapy and chiropractic care (includes physical, speech, occupational, chiropractic and cognitive therapy) 30 days maximum per plan year[#] for all therapies combined</p>	<p>80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed</p>	<p>50% of eligible expenses after deductible</p>
<p>[#]In-network and out-of-network services apply to the same treatment or dollar maximum. Note: Therapy sessions provided as part of home health care accumulate to the short-term rehabilitation therapy maximum.</p>		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient cardiac rehabilitation – office visit Unlimited days maximum per plan year	80% of eligible expenses after deductible	50% of eligible expenses after deductible
Pulmonary rehabilitation – office visit Unlimited days maximum per plan year	80% of eligible expenses after deductible	50% of eligible expenses after deductible
Emergency and Urgent Care Services Physician’s office – PCP or specialty physician Hospital emergency room Outpatient professional services (radiology, pathology and emergency room physician) Urgent care facility or outpatient facility Ambulance * Emergency room physician charges may be balanced billed for out-of-network physician affiliations.	80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed 80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible	80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Maternity care services Initial office visit to confirm pregnancy</p> <p>All subsequent prenatal visits, postnatal visits and physician's delivery charges (total maternity fee)</p> <p>Office visits not included in the total maternity fee performed by OB or specialty physician</p> <p>Delivery – facility (inpatient hospital/birthing center charges)</p> <p>Note: A deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>	<p>80% of eligible expenses after deductible for initial visit, including when only x-ray and laboratory services are performed and billed</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p> <p>Prior-authorization required for extended maternity care</p>
Inpatient Services at Other Health Care Facilities		
<p>Skilled nursing, rehabilitation and sub-acute facilities 120 days maximum per plan year[#]</p>	<p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible, prior authorization required</p>
<p>Home health services 90 days maximum per plan year[#]; 8 hour maximum per day[#]</p>	<p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible, prior authorization required</p>
<p>Hospice Inpatient Outpatient</p>	<p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p>
<p>[#] In-network and out-of-network services apply to the same treatment or dollar maximum. Note: Amounts paid toward the annual deductible for services subject to a visit or day limit will apply to the maximum benefit limit.</p>		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Human organ and tissue transplants Prior authorization required Inpatient services Physician's services</p>	<p>100% at Centers of Excellence after deductible 100% at Centers of Excellence after deductible</p>	<p>Not covered Not covered</p>
Family Planning Services (as defined by ACA)		
<p>Men's services Office visits (tests, counseling) Vasectomy (excludes reversals)</p> <ul style="list-style-type: none"> • Inpatient facility • Outpatient facility <p>Physician's services – inpatient or outpatient</p>	<p>80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible 80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible 50% of eligible expenses after deductible, prior authorization required 50% of eligible expenses after deductible 50% of eligible expenses after deductible</p>
<p>Women's services Office visits (tests, counseling) Tubal ligation (excludes reversals)</p> <ul style="list-style-type: none"> • Inpatient facility • Outpatient facility <p>Physician's services – inpatient or outpatient</p>	<p>100% of eligible expenses 100% of eligible expenses 100% of eligible expenses 100% of eligible expenses</p>	<p>50% of eligible expenses after deductible 50% of eligible expenses after deductible, prior authorization required 50% of eligible expenses after deductible 50% of eligible expenses after deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Infertility Services Lifetime maximum: \$10,000 per member Note: All the services outlined below contribute to this lifetime maximum; there is a separate \$10,000 lifetime maximum for prescription drug coverage.</p>		
<p>Office visit (lab and radiology tests, counseling) -- PCP or specialty physician</p> <p>Treatment/surgery (includes artificial insemination, in-vitro fertilization, GIFT, ZIFT)</p> <ul style="list-style-type: none"> • Inpatient facility • Outpatient facility <p>Physician's services – inpatient or outpatient</p>	<p>80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p>
<p>TMJ – surgical and non-surgical case-by-case basis Note: Always excludes appliances and orthodontic treatment. Subject to medical necessity.</p> <p>Physician's office</p> <p>Inpatient facility</p> <p>Outpatient facility</p> <p>Physician's services – inpatient or outpatient</p>	<p>80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p> <p>50% of eligible expenses after deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Bariatric surgery Prior authorization required</p> <p>Physician's office</p> <p>Inpatient facility</p> <p>Outpatient facility</p> <p>Physician's services – inpatient or outpatient</p>	<p>80% of eligible expenses after deductible, including when only x-ray and laboratory services are performed and billed</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p>
<p>Mental health – inpatient Unlimited maximum per plan year</p> <p>Mental health – outpatient</p> <ul style="list-style-type: none"> • Includes individual, group therapy and intensive outpatient • Applies to physician's office and outpatient facility services <p>Unlimited maximum per plan year</p>	<p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible, prior authorization required</p> <p>50% of eligible expenses after deductible</p>
<p>Neurobiological and autism spectrum disorders</p>	<p>Covered same as mental health services</p>	
<p>Substance use disorder – inpatient Unlimited maximum per plan year</p> <p>Substance use disorder – outpatient</p> <ul style="list-style-type: none"> • Includes individual and intensive outpatient • Applies to physician's office and outpatient facility services <p>Unlimited maximum per plan year</p>	<p>80% of eligible expenses after deductible</p> <p>80% of eligible expenses after deductible</p>	<p>50% of eligible expenses after deductible, prior authorization required</p> <p>50% of eligible expenses after deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Durable medical equipment and speech generative devices Unlimited maximum per plan year if considered a covered health service	80% of eligible expenses after deductible	50% of eligible expenses after deductible Prior authorization required for items that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes
External prosthetic appliances Unlimited maximum per plan year	80% of eligible expenses after deductible	50% of eligible expenses after deductible Prior authorization required for items that will cost more than \$1,000 to purchase or rent
Wigs (<i>for hair loss due to chemotherapy, alopecia, radiation therapy or surgery</i>) Limited to one per person per plan year	80% of eligible expenses after deductible	50% of eligible expenses after deductible
Acupuncture Unlimited maximum per plan year	80% of eligible expenses after deductible	50% of eligible expenses after deductible
Biofeedback Unlimited maximum per plan year	80% of eligible expenses after deductible	50% of eligible expenses after deductible
Transgender surgery <u>\$75,000 lifetime maximum</u> <ul style="list-style-type: none"> • Transgender surgery must be performed by qualified provider • Physician must pre-certify with health plan before surgery • Treatment plan must conform to Harry Benjamin International Gender Dysphoria standards • Associated behavioral health treatments are covered, but do not apply towards the \$75,000 Lifetime Maximum 	80% of eligible expenses after deductible	Covered in-network only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Fitness reimbursement	Reimbursement of 100% up to \$300 per family, per plan year	
Qualifying fitness programs include the use of a full-service fitness center or the purchase of specific home fitness equipment (treadmill, stair master, elliptical, rowing machine or stationary bike)		
Weight loss program reimbursement	Reimbursement of 100% up to \$300 per family, per plan year	
<p>Qualifying weight loss programs include: traditional Weight Watcher meetings, the WW (formerly known as Weight Watchers) at Work program, and hospital-based weight loss programs.</p> <p><i>Excludes:</i> The WW Online and WW at Home programs, fees paid for any other weight loss programs and fees paid for individual nutrition counseling.</p>		

Prescription Drugs – Provided by CVS Caremark	CVS Caremark Retail Pharmacy Network		Maintenance Choice® CVS Caremark Mail Service Pharmacy or a CVS/pharmacy store
	<i>For short-term medications (Up to a 30-day supply)</i>		<i>For long-term medications (Up to a 90-day supply)</i>
Refill limit Specialty medications are limited to up to a 30-day supply per refill	One initial fill plus two refills for long- term medications	N/A	None
After the annual deductible is met, you pay:			
Generic medications	20% up to refill limit*	50% after refill limit*	20%*
Preferred brand name medications	20% up to refill limit*	50% after refill limit*	20%*
Non-preferred brand- name medications	20% up to refill limit*	50% after refill limit*	20%*
Generic contraceptives	\$0 up to the refill limit	50% after refill limit*	\$0
Preventive maintenance medications	Prescriptions on the preventive drug listing are not subject to the deductible.		

* Once your deductible is satisfied. If you don't move to Maintenance Choice for long-term medications after three 30-day refills at retail (including preventive medications), you pay 50% of the total cost of the drug. This 50% will not count toward your medical plan out-of-pocket maximum. Maintenance medications that are on the preventive drug list would always be subject to the penalty if the associate did not move a 30 day to a 90 day on the 4th fill and greater, because these drugs do not count or apply toward the deductible.

Vision Benefits – Provided by VSP	IN-NETWORK	OUT-OF-NETWORK
Eye exam – <i>Adult</i> – one every 24 months	\$30 copay per exam	Up to \$35 reimbursement per exam
Eye exam – <i>Child</i> – one every 12 months	\$30 copay per exam	
Contact lens and supplies, eyeglasses, laser eye surgery	Reimbursable from the HSA fund	

Covered Expenses – Medical

The term covered expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred while covered for these benefits. Expenses incurred for such charges are considered covered expenses to the extent that the services or supplies provided are recommended by a physician, and are covered health services for the care and treatment of an injury or a sickness, as determined by the Plan Administrator. Any applicable copayments, deductibles, coinsurance or limits are shown in the *Benefits Schedule*.

Also see the *Key Terms* section for more information.

Covered expenses include:

- Charges made by a hospital, on its own behalf, for bed and board and other necessary services and supplies, except that for any day of hospital confinement, covered expenses will not include that portion of charges for bed and board, which is more than the bed and board limit shown in the *Benefits Schedule*,
- Charges for licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided,
- Charges made by a hospital, on its own behalf, for medical care and treatment received as an outpatient,
- Charges made by a free-standing surgical facility, on its own behalf, for medical care and treatment,
- Charges made on its own behalf, by another health care facility, including a skilled nursing facility, a rehabilitation hospital or a subacute facility for medical care and treatment, except that for any day of other health care facility confinement, covered expenses will not include that portion of charges which are over the other health care facility daily limit shown in the *Benefits Schedule*,
- Charges made for emergency services and urgent care,
- Charges made by a physician or a psychologist for professional services,
- Charges made by a nurse, other than a member of your family or your dependent's family, for professional nursing service,
- Charges made for anesthetics and their administration, diagnostic x-ray and laboratory examinations, x-ray, radium, and radioactive isotope treatment, chemotherapy; blood transfusions, oxygen and other gases and their administration,
- Charges made for an annual Papanicolaou (Pap) laboratory screening test,
- Charges made for an annual prostate-specific antigen test (PSA),
- Charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation, excluding procedures to reverse sterilization,
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures,

- Charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives,
- Office visits, tests and counseling for family planning services are subject to the preventive care maximum shown in the *Benefits Schedule*,
- Charges made for routine preventive care. Routine preventive care means health care assessments, wellness visits and any related services as defined in the *Preventive Care* sections of this document,
- Charges made for visits for routine preventive care of a dependent child during the first two years of that dependent child's life, including immunizations,
- Charges made for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction,
- Surgical or nonsurgical treatment of TMJ dysfunction,
- Charges made for or in connection with acupuncture,
- Phase II cardiac rehabilitation provided on an outpatient basis after diagnosis of a qualifying cardiac condition when medically necessary. Phase II is a hospital-based outpatient program after an inpatient hospital discharge. The Phase II program must be physician directed with active treatment and EKG monitoring,
- Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase II which includes more active participation and weight training, and
- Charges made for biofeedback.

Cancer Resource Services (CRS)

The Plan pays benefits for oncology services provided by designated facilities participating in the Cancer Resource Services (CRS) Program. A designated facility is defined the *Key Terms* section.

For oncology services and supplies to be considered covered health services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive benefits for cancer-related treatment, you are not required to visit a designated facility. If you receive oncology services from a facility that is not a designated facility, the Plan pays benefits depending upon where the covered health service is provided. Benefits will be the same as those stated under each category in this section.

Note: The services described under the *Travel and Lodging* section are covered health services only in connection with transplant services received at a designated facility or Center of Excellence.

To receive benefits under the CRS Program, you must contact CRS before obtaining covered health services. The Plan only pays benefits under the CRS Program if CRS provides the proper notification to the designated facility provider performing the services (even if you self-refer to a provider in that network).

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered health services for which Benefits are typically provided absent a clinical trial,
- Covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications, and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

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

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

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

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

- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration,
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application,
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial, or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

Durable Medical Equipment

The purchase or rental of durable medical equipment is covered if it is ordered or prescribed by a physician and provided by a vendor approved by the Claims Administrator for use outside a hospital or other health care facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for durable medical equipment is limited to the lowest-cost alternative as determined by the utilization review physician.

Durable medical equipment is defined as items that are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of injury or sickness, are appropriate for use in the home and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable medical equipment items that are not covered include but are not limited to those that are listed below:

- Bed-related items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses,
- Bath-related items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas,
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs,
- Fixtures to real property: ceiling lifts and wheelchair ramps,
- Car/van modifications,

- Air quality items: room humidifiers, vaporizers, air purifiers and electrostatic machines,
- Aids or devices that assist with nonverbal communications, including, but not limited to, communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books, with the exception of speech generating devices, which are covered as described elsewhere,
- Blood/injection related Items: blood pressure cuffs, centrifuges, nova pens and needleless injectors, and
- Other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

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


External Prosthetic Appliances and Devices

The initial purchase and fitting of external prosthetic appliances and devices ordered or prescribed by a participating physician available only by prescription and necessary for the alleviation or correction of illness, injury or congenital defect are covered.

Coverage for external prosthetic appliances and devices is limited to the most appropriate and cost-effective alternative as determined by the utilization review physician and includes:

- Prostheses/prosthetic appliances and devices: Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts and include but are not limited to:
 - Basic limb prostheses,
 - Terminal devices such as a hand or hook, and
 - Speech prostheses.
- Orthoses and orthotic devices: Orthoses and orthotic devices are defined as orthopedic appliances or apparatus used to support, align, prevent or correct deformities.
 - Foot orthotics: Custom foot orthoses are covered as follows:

- For members with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease),
- As integral part of a leg brace and necessary for the proper functioning of the brace; for use as a replacement or substitute for missing parts of the foot (e.g., amputation), and
- Necessary for the alleviation or correction of illness, injury or congenital defect; for members with neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment or pathological positioning of the foot and there is reasonable expectation of improvement.
- Non-foot orthotics: ONLY the following non-foot orthoses are covered:
 - Rigid and semi-rigid pre-fabricated and flexible orthoses, and
 - Rigid pre-fabricated orthoses including preparation, fitting and basic additions such as bars and joints.
 - Braces: A brace is defined as an orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

 **Note:** Excludes specifically “Copes” scoliosis braces (other scoliosis braces may be covered if deemed medically necessary).

- Splints: A splint is defined as an application for preventing movement of a joint or for the fixation of displaced or movable parts. Replacement of external prosthetic appliances and devices is limited to:
 - Regular wear and tear,
 - Anatomical change that has rendered the external prosthetic appliance or device ineffective (anatomical change includes significant weight gain or loss, atrophy and/or growth),
 - No more than once every 24 months for members 19 years of age and older,
 - No more than once every 12 months for members 18 years of age and under, and
 - Due to surgical alteration or revision of the site.

The Plan specifically excludes:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; non-power components of prosthetic limb may be covered, subject to medical necessity,
- Myoelectric prostheses peripheral nerve stimulators,
- Prefabricated foot orthoses; cranial banding/cranial orthoses/other similar devices except when used postoperatively for synostic plagiocephaly, and
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; orthoses primarily for improved athletic performance or sports participation.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically necessary repair, maintenance or replacement of a covered appliance is also covered.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease and are covered only if:

- A person has symptoms or signs of a genetically-linked inheritable disease,
- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome, or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing and genetic diagnosis before embryo transfer are covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three visits per plan year for both pre- and post-genetic testing.

Nutritional Evaluation

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease are covered.

Home Health Services

Charges made for home health services are covered when you:

- Require skilled care,
- Are unable to obtain the required care as an ambulatory outpatient, and
- Do not require confinement in a hospital or other health care facility.

Home health services are those skilled health care services that can be provided during visits by other health care professionals. The services of a home health aide are covered when provided in direct support of skilled health care services provided by other health care professionals. Necessary consumable medical supplies and home infusion therapy administered or used by other health care professionals in providing home health services are covered. Home health services do not include services by a person who is a member of your family or your dependent's family or who normally lives in your house or your dependent's house even if that person is another health care professional. Skilled nursing services provided in the home are subject to the home health services benefit terms, conditions and benefit limitations. Physical, occupational, and other short-term rehabilitative therapy services provided in the home are not subject to the home health services benefit limitations in the *Benefits Schedule*, but are subject to the benefit limitations described under short-term rehabilitative therapy maximum shown in the *Benefits Schedule*.

Hospice Care Services

If you have been diagnosed as having six months or less to live, the Plan will cover services provided:

- By a hospice facility for bed, board, services and supplies, up to the daily hospice bed and board limit shown in the *Benefits Schedule*,
- By a hospice facility for services provided on an outpatient basis,
- By a physician for professional services,
- By a psychologist, social worker, family counselor or ordained minister for individual and family counseling,
- For pain relief treatment, including drugs, medicines and medical supplies,
- By another health care facility for:
 - Part-time or intermittent nursing care by or under the supervision of a nurse,
 - Part-time or intermittent services of another health care professional,
 - Physical, occupational and speech therapy, and
 - Medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been confined in a hospital or hospice facility.

Services must be provided as part of a formal hospice care program.

The following charges for hospice care services are not included as covered expenses:

- For the services of a person who is a member of your family or your dependent's family or who normally lives in your house or your dependent's house,
- For any period when you or your dependent is not under the care of a physician,
- For services or supplies not listed in the hospice care program,
- For any curative or life-prolonging procedures,

- To the extent that any other benefits are payable for those expenses under the policy, or
- For services or supplies that are primarily to aid you or your dependent in daily living.

Infertility Services

Infertility is defined as the inability of a woman to achieve pregnancy or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

Benefits are limited to \$10,000 for medical and \$10,000 prescription drug per lifetime.

Fertility Services and Fertility Solutions Program

To receive the highest level of benefits, infertility services must be ordered by a network provider, received at a fertility solutions designated facility and coordinated through fertility solutions.

Fertility Solutions

Fertility Solutions is a program administered by the UnitedHealthcare or its affiliates. The Fertility Solutions program provides:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on fertility treatment options.
- Access to specialized Network facilities and Physicians for fertility services.

The Plan pays Benefits for the fertility services described below when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions program provides education, counseling, Infertility management and access to a national Network of premier Infertility treatment clinics.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Eligibility Requirements

To be eligible for benefits, the covered person must:

- Meet all eligibility requirements specified in the Plan.
- Be under age 44, if female.

What Benefits are Available as Covered Health Services?

Infertility Services

Therapeutic services for the treatment of Infertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- ICSI - (intracytoplasmic sperm injection).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Embryo transportation related network disruption.
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty.
- Electroejaculation.
- Pre-implantation Genetic Diagnosis (PGD) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the *SPD*. Benefits for diagnostic tests are described under, *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits*.

Benefits for certain Pharmaceutical Products, including specialty Pharmaceutical Products, for the treatment of Infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under *Injections in a Physician's Office*.

However, the following are specifically excluded infertility services:

- Reversal of male and female voluntary sterilization,
- Infertility services when the infertility is caused by or related to voluntary sterilization,
- Donor charges and services,
- Cryopreservation of donor sperm and eggs, and
- Any experimental, investigational or unproven infertility procedures or therapies.

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [or in a Physician's office] include:

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per plan year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per plan year.

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

Mental Health and Substance Use Disorder Services

Mental health services are services that treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Substance use disorders (also known as substance-related and addictive disorders) are defined as psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance use disorders.

Inpatient Mental Health Services

Services that are provided by a hospital while you or your dependent is confined in a hospital for the treatment and evaluation of mental health. Inpatient mental health services include partial hospitalization and mental health residential treatment services.

Partial hospitalization sessions are services that are provided for not less than four hours and not more than 12 hours in any 24-hour period.

Mental health residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.

Mental health residential treatment center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians; (c) provides 24-hour care, in which a person lives in an open setting;

and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a mental health residential treatment center when she/he is a registered bed patient in a mental health residential treatment center upon the recommendation of a physician.

Outpatient Mental Health Services

Outpatient mental health services include the services of providers who are qualified to treat mental health when treatment is provided on an outpatient basis, while you or your dependent is not confined in a hospital, and is provided in an individual, group or mental health intensive outpatient therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning, emotional adjustment or concerns related to chronic conditions, such as psychosis or depression, emotional reactions associated with marital problems or divorce, child/adolescent problems of conduct or poor impulse control, affective disorders, suicidal or homicidal threats or acts, eating disorders or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental health intensive outpatient therapy program services are exchanged with outpatient mental health services at a rate of one visit of mental health intensive outpatient therapy being equal to one visit of outpatient mental health services.

Neurobiological Disorders –Autism Spectrum Disorder Services

The Plan pays benefits for psychiatric services for autism spectrum disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider, and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These benefits describe only the psychiatric component of treatment for autism spectrum disorders. Medical treatment of autism spectrum disorders is a covered health service for which benefits are available.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment,
- Treatment planning,
- Referral services,
- Medication management,

- Individual, family, therapeutic group and provider-based case management services, and
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial hospitalization/day treatment, and
- Services at a residential treatment facility.

Benefits include the following services provided on an outpatient basis:

- Intensive outpatient treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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

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

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your dependent is confined in a hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs include partial hospitalization sessions and residential treatment services.

Partial hospitalization sessions are services that are provided for not less than four hours and not more than 12 hours in any 24-hour period.

Substance use disorder residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance use disorder conditions.

Substance use disorder residential treatment center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of a substance use disorder; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a substance use disorder residential treatment center when she/he is a registered bed patient in a substance use disorder residential treatment center upon the recommendation of a physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your dependent is not confined in a hospital include outpatient rehabilitation in an individual, or a substance use disorder intensive outpatient therapy program.

A substance use disorder intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder program. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Substance use disorder intensive outpatient therapy program services are exchanged with outpatient substance use disorder services at a rate of one visit of substance use disorder intensive outpatient therapy being equal to one visit of outpatient substance use disorder rehabilitation services.

Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where

the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Plan Administrator will decide, based on the medical necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Mental Health and Substance Use Disorder Exclusions

The following are specifically excluded from mental health and substance use disorder services:

- Any court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this policy or agreement,
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain,
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders,
- Counseling for activities of an educational nature,
- Counseling for borderline intellectual functioning,
- Counseling for occupational problems,

- Counseling related to consciousness raising,
- Vocational or religious counseling,
- I.Q. testing,
- Custodial care, including but not limited to geriatric day care,
- Psychological testing on children by or for a school system,
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline,
- Intensive behavioral therapies such as applied behavioral analysis for autism spectrum disorders,
- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association,
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions,
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental,
 - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time, or
 - Not clinically appropriate for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Reconstructive Surgery

Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery after a mastectomy, benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed, (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance, (c) postoperative breast prostheses, and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) are covered, provided that: (a) the surgery or therapy restores or improves function, (b) reconstruction is required as a result of medically

necessary, noncosmetic surgery or (c) the surgery or therapy is performed before age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review physician.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

A federal law, the Women's Health and Cancer Rights Act of 1998, was enacted requiring group health plans that provide coverage for mastectomies to provide the following mastectomy-related benefits to plan participants:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas.

These benefits will be subject to the same deductibles and coinsurance or co-payment provisions consistent with those established for other benefits under your health plan. Coverage for these benefits or services will be provided in a manner determined in consultation with your attending physician.

Short-term Rehabilitative Therapy and Chiropractic Care Services

Charges made for short-term rehabilitative therapy provided by a licensed therapy provider, under the direction of a Physician (when required by state law) that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic and manipulative rehabilitation therapy is covered, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic physician when provided in an outpatient setting as well as behavioral therapy for autism.

Services of a chiropractic physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is provided to restore motion, reduce pain and improve function. There is a combined maximum of 30 visits allowed per plan year.

Benefits are also available for orthoptic (eye exercise) therapy and for cardiac and pulmonary rehabilitation services.

The following limitations apply to short-term rehabilitative therapy and chiropractic care services:

- To be covered, all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved before the injury or sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an injury or sickness.

Short-term rehabilitative therapy and chiropractic care services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy, treatment of dyslexia, behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder,
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury, and
- Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrences or to maintain the patient's current status.

The following are specifically excluded from chiropractic care services:

- Services of a chiropractor which are not within his scope of practice, as defined by state law,
- Charges for care not provided in an office setting, and
- Vitamin therapy.

Transplant Services

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

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


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

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


Benefits are also available for cornea transplants. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a designated facility.

Donor costs that are directly related to organ removal are covered health services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding benefits for transplant services. Contact United Resource Networks at 1-888-936-7246 or Health Support at 1-877-440-5984 for information about these guidelines.

 **Note:** The services described under the *Travel and Lodging* section are covered health services only in connection with transplant services received at a designated facility or Center of Excellence.

Transplant Travel Services

 **Note:** Payments for travel and related expenses associated with transplants may be subject to IRS taxable income regulations. Ask your personal tax advisor about the tax consequences of these payments.

Congenital Heart Disease (CHD) Surgeries

The Plan pays benefits for congenital heart disease (CHD) services ordered by a physician and received at a CHD Resource Services program Center of Excellence. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- Outpatient diagnostic testing,
- Evaluation,
- Surgical interventions,
- Interventional cardiac catheterizations (insertion of a tubular device in the heart),
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology), and
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at 1-888-936-7246 or Personal Health Support at 1-877-440-5984 for information about CHD services.

Travel and Lodging

United Resource Networks will assist the patient and family with travel and lodging arrangements related to:

- Congenital heart disease (CHD), and
- Transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a designated facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up,
- Eligible expenses for lodging for the patient (while not a hospital inpatient) and one companion,
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the designated facility or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- Airfare at coach rate,
- Taxi or ground transportation, or
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the designated facility.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

A maximum benefit of \$10,000 per covered person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

Lodging

- A per diem rate, up to \$50.00 per day, for the patient (when not in the Hospital) or the caregiver.
- Per diem is limited to \$100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

Groceries.

Alcoholic beverages.

Personal or cleaning supplies.

Meals.

Over-the-counter dressings or medical supplies.

Deposits.

Utilities and furniture rental, when billed separate from the rent payment.

Phone calls, newspapers, or movie rentals.

Preventive Care

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

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

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

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

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

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

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

Certain medications are covered as preventive care items and are paid at 100% per the Affordable Care Act:

- Aspirin to prevent cardiovascular disease in men and strokes in women over the age of 45,
- Iron supplements for children at risk for iron deficiency anemia,

- Fluoride for children up to age six,
- Folic acid for pregnant women or those planning to become pregnant,
- Tobacco-cessation products,
- Generic women's contraceptive agents, and
- Vitamin D for prevention of falls in people over age 65.

Transgender Surgery

The Plan provides benefits to covered associates for many of the charges incurred for transgender surgery (also known as gender reassignment surgery). Not all charges are eligible, and some are only eligible to a limited extent. Transgender or gender reassignment surgery is a covered benefit under this Plan.

Transgender surgery must be performed at a facility designated and approved by the Claims Administrator for the type of transgender surgery to be performed and must be authorized before being performed.

Surgery must be performed by qualified provider. A physician must pre-certify with the Plan before surgery. The treatment plan must conform to Harry Benjamin International Gender Dysphoria standards. Associated behavioral health treatments are covered through your regular medical benefits. Behavioral health treatments do not apply towards the \$75,000 lifetime maximum.

Treatment of Gender Identity Disorder/Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services in your SPD.
- Cross-sex hormone therapy,
- Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under Pharmaceutical Products – Outpatient in your SPD,
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting,
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy,

Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)

- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

- The Covered Person must provide documentation of the following for breast surgery:
- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must be 18 years or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must 18 years or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
 - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Medical Benefit Exclusions, Expenses Not Covered and General Limitations

Additional coverage limitations determined by the Plan or provider type are shown in the *Benefits Schedule*. Payment for the following is specifically excluded from this Plan:

- Any service or supply not described as covered in the *Covered Expenses* section of the plan.
- Any medical service or device that is not medically necessary.
- Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35–39 with comorbidities. The patient must be 18 years or older, have gone through a 6 month weight loss program with a physician within the last 24 months, psychological evaluation performed and received nutritional counseling. The following are specifically excluded: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, court-ordered, forensic, or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered under this Plan.
- Infertility donor services and charges.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
- Medical and hospital care and costs for the child of a dependent, unless this infant child is otherwise eligible under the Plan.

- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
- Consumable medical supplies other than ostomy supplies and urinary catheters.
- Private hospital rooms except as provided under the home health services provision.
- Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- Refractive eye surgery is excluded from coverage. Refractive eye surgery is intended to allow the patient to see better without glasses or other vision correction. This includes, but is not limited to: radial keratotomy, laser, and other refractive eye surgical procedures.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the Plan.
- Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
- Genetic screening or pre-implantation genetic screening.
- Fees associated with the collection or donation of blood or blood products.
- Cost of biologicals to protect against occupational hazards and risks.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.
- The following services are excluded from coverage regardless of clinical indications: massage therapy; cosmetic surgery and therapies; rhinoplasty; blepharoplasty; acupressure; dance therapy, movement therapy; applied kinesiology; rolfing; non-medical counseling or ancillary services; assistance in the activities of daily living; cosmetics; personal or comfort items; dietary supplements; health and beauty aids; dental implants for any condition; telephone consultations; email and internet consultations; telemedicine; reversal of male and female voluntary sterilization procedures; and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions.
- To the extent that you or any one of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person lives when the expenses are incurred.

- Charges that you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review physician to be:
 - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed,
 - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use,
 - The subject of review or approval by an institutional review board for the proposed use except as provided in the *Clinical Trials* section, or
 - The subject of an ongoing Phase I, II or III clinical trial, except as provided in the *Clinical Trials* section.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an injury or sickness.
- Medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that covered expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- All noninjectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this Plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.

- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism. Enteral nutrition is covered if it is the sole source of nutrition or if necessary due to inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
- Medical treatment when payment is denied by a primary plan because treatment was received from a nonparticipating provider.
- Telephone, email, internet consultations and telemedicine.
- Massage therapy.
- To the extent that they are more than maximum reimbursable charges.
- Expenses incurred outside the United States or Canada, unless you or your dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- Charges made by any covered provider who is a member of your family or your dependent's family.
- To the extent of the exclusions imposed by any certification requirement shown in this Plan.
- For charges that would not have been made if the person had no coverage.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).

Alternative Treatments

- Acupressure,
- Aromatherapy,
- Hypnotism,
- Massage therapy,

- Rolwing,
- Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided.

Gender Dysphoria

- 1. Cosmetic Procedures, including the following:
- 2. Abdominoplasty,
- 3. Blepharoplasty,
- 4. Breast enlargement, including augmentation mammoplasty and breast implants,
- 5. Body contouring, such as lipoplasty,
- 6. Brow lift,
- 7. Calf implants,
- 3. Cheek, chin, and nose implants,
- 9. Injection of fillers or neurotoxins,
- 10. Face lift, forehead lift, or neck tightening,
- 11. Facial bone remodeling for facial feminizations,
- 12. Hair removal,
- 13. Hair transplantation,
- 14. Lip augmentation,
- 15. Lip reduction,
- 16. Liposuction,
- 17. Mastopexy,
- 18. Pectoral implants for chest masculinization,
- 19. Rhinoplasty,
- 20. Skin resurfacing,
- 21. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple),
- 22. Voice modification surgery,
- 23. Voice lessons and voice therapy.

Personal Care, Comfort or Convenience

- Television,
- Telephone,

- Beauty/barber service,
- Guest service.

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

- Air conditioners, air purifiers and filters and dehumidifiers,
- Batteries and battery chargers,
- Car seats,
- Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners,
- Exercise equipment and treadmills,
- Hot and cold compresses,
- Hot tubs,
- Humidifiers,
- Jacuzzis,
- Medical alert systems,
- Motorized beds, non-Hospital beds, comfort beds and mattresses,
- Music devices,
- Personal computers,
- Pillows,
- Power-operated vehicles,
- Radios,
- Safety equipment,
- Saunas,
- Stair lifts and stair glides,
- Strollers,
- Treadmills,
- Vehicle modifications such as van lifts,
- Video players,
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. Examples include:

- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple,
- Pharmacological regimens, nutritional procedures or treatments,

- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures),
 - Hair removal or replacement by any means,
 - Treatments for skin wrinkles or any treatment to improve the appearance of the skin,
 - Treatment for spider veins,
 - Skin abrasion procedures performed as a treatment for acne,
 - Treatments for hair loss,
 - Varicose vein treatment of the lower extremities, when it is considered cosmetic.
2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
 3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.
 4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.
 5. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Types of Care

1. Custodial Care,
2. Domiciliary Care,
3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain,
4. Private Duty Nursing,
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care*,
6. Rest cures,
7. Services of personal care attendants,
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Medical — Payment of Benefits — To Whom Payable

All medical benefits are payable to you. However, at the option of the Plan Administrator, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical benefits are not assignable unless agreed to by the Plan Administrator. The Plan Administrator may, at its option, make payment to you for the cost of any covered expenses received by you or your dependent from a non-participating provider even if benefits have been assigned. When benefits are paid to you or your dependent, you or your dependent are responsible for reimbursing the provider. If any person to whom benefits are payable is a minor or, in the opinion of the Plan Administrator, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If his legal guardian does not ask for payment, the Plan Administrator may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, the Plan Administrator may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters or to the executors or administrators of your estate.

Payment as described above will release the Plan Administrator from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by the Plan Administrator when it receives due proof of loss within 12 months from the date of service.

Calculation of Covered Expenses

The Plan Administrator, in its discretion, will calculate covered expenses after evaluation and validation of all provider billings in accordance with the following methodologies:

- In the most recent edition of the current procedural terminology, and
- As reported by generally recognized professionals or publications.

Medical Benefits Extension During Hospital Confinement

If the medical benefits under this Plan cease for you or your dependent, and you or your dependent is confined in a hospital on that date, medical benefits will be paid for covered expenses incurred in connection with that hospital confinement. However, no benefits will be paid after the earliest of:

- The date you exceed the maximum benefit, if any, shown in the *Benefits Schedule*,
- The date you are covered for medical benefits under another group plan,
- The date you or your dependent is no longer hospital confined, or
- Three months from the date your medical benefits cease.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy that exists when your medical benefits cease, or your dependent's medical benefits cease.

Recovery of Overpayment

When an overpayment has been made by UnitedHealthcare, they will have the right at any time to:

- Recover that overpayment from the person to whom or on whose behalf it was made, or
- Offset the amount of that overpayment from a future claim payment.

Prescription Drug Benefits

If you enroll in medical coverage, you automatically receive prescription drug benefits administered by CVS Caremark.

How Prescription Drug Benefits Work

To be eligible for coverage, a prescription drug must be:

- Necessary for the treatment of a disease or illness and widely accepted as effective, appropriate and essential – based on the recognized standards of the medical community,
- Prescribed by a licensed physician and
- Prescribed in accordance with type, frequency and duration-of-treatment guidelines of national medical, research and governmental agencies.

Visit the CVS Caremark website (www.caremark.com) or call CVS Caremark at 1-877-876-7215 for the generic, brand, preferred or non-preferred listing that describes those prescription drugs that are eligible and ineligible for reimbursement under the Staples prescription drug program. If you have any questions about a particular prescription, call CVS Caremark. The fact that your physician prescribes, orders, recommends, or approves a prescription or supply does not automatically mean it is an eligible expense. Always call CVS Caremark to confirm coverage.

To receive prescription drug benefits, you and your covered dependents may pay a portion of the covered expenses for prescription drugs and related supplies for each 30-day supply at a retail pharmacy or each 90-day supply at a mail order pharmacy. That portion is the copayment, deductible or coinsurance.

Medications that have over-the-counter (OTC) equivalents such as ibuprofen, hydrocortisone creams, as well as non-sedating antihistamines are not covered by this Plan.

The program offers coverage for both your short-term and long-term prescription needs. When you have prescriptions filled at a retail pharmacy, benefits are payable for up to a 30-day supply. If you are taking a prescription on a long-term basis, you should have your prescription filled through the mail order drug program. When you use the mail order drug program, you can have prescriptions filled for up to a 90-day supply.

The *Benefits Schedule* includes a brief outline of your prescription drug benefits payable under your HSA plan.

Understanding the Different Types of Medications

Under the prescription drug program, you have access to a wide range of covered prescriptions. Your share of the cost is based on the actual cost of the medication to the plan, which depends on the type of drug: generic, preferred brand or non-preferred brand.

Generic vs. Brand Name Drugs

A generic medication is a copy of its brand name equivalent; they are identical in dosage, safety, strength, how they are taken, effectiveness and intended use. Each brand name drug and its generic equivalent share the same active ingredients and are often made by the same manufacturer. For most patients, the generic drug works just as well as the brand name drug because the active ingredients are the same. Brand name drugs are more expensive because their prices include the cost of research and development as well as marketing and advertising. The price is lowered once the generic version is available.

Preferred Brand vs. Brand Name

CVS Caremark's physician and pharmacist advisors have approved a list of specific preferred brand name drugs called the Formulary Drug List. Preferred brand name drugs are selected based on their success in effectively treating certain conditions as well as their relative cost-effectiveness. You have access to brand drugs that are not on the preferred brand list, but your share of the cost is greater because they are not as cost-effective for you or the Plan.

If you currently have a prescription for a brand name drug that is not on the preferred brand name list, there may be an alternative preferred brand name drug that may work just as well for you. Check with your doctor and share the CVS Caremark Formulary list of preferred drugs with him or her. You can view the Formulary List at www.caremark.com.

Note: The utilization of generic products is encouraged with this Plan. Generic medications offer the lowest cost options for you and your dependents. If you or a family member are taking a brand drug with a generic equivalent (multi-source drug) and do not switch to the generic equivalent, you may be subject to a penalty. The penalty associated with multi-source brand drugs, is the cost differential between the brand and generic medication plus the generic co-insurance/co-payment. This penalty will apply even if dispense as written (DAW) penalties are included on the prescription. If you have a medical reason to be on the multi-source brand, you can request a medical exceptions review. Contact Caremark Customer Care at **1-877-876-7215** to learn how to initiate the process.

Specialty Medications

Certain specialty medications may require prior authorization. Contact Caremark Customer Care representatives at **1-800-237-2767** to initiate this review. Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the Member shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Over-the-Counter Medications

An over-the-counter medication is one that you can obtain without a prescription. The prescription drug program does not cover over-the-counter medications, including those that previously required a prescription (for example: Claritin, Zantac and Tagamet).

Preventive Medication Coverage

Preventive care benefits are an integral part of this Plan. Under this HSA Plan, you don't have to meet your deductible for certain medications*, you are only responsible for your copay or coinsurance. Medications on the preventive list may be maintenance and thus, subject to Incentivized Maintenance Choice fill restrictions regardless if your deductible has been satisfied.

*Visit caremark.com for most up to date drug list

If you have any questions about this prescription drug provision or want to confirm that your medications are included, please contact Caremark Customer Care at 1-877-876-7215.

CVS Caremark Participating Pharmacies

The CVS Caremark network includes many retail pharmacies, including major chain pharmacies and independent community pharmacies. To locate a participating pharmacy either call CVS Caremark directly at 1-877-876-7215. To find the pharmacy closest to you, go to www.caremark.com.

Retail Pharmacy Program

When you need a short-term medication, such as an antibiotic, take your prescription to a retail pharmacy in the CVS Caremark network. You will receive up to a 30-day supply of the medication depending upon your prescription.

When you use a CVS Caremark participating pharmacy:

- Ask your doctor to write a prescription for up to a 30-day supply of your medications, plus refills if appropriate.
- Take your prescription to a participating pharmacy.
- Show your CVS Caremark ID card to the pharmacy.
- Keep your receipt.

CVS Caremark Mail Service

If you take any prescriptions on a regular basis—such as medications for high blood pressure or diabetes—you can save time and money by using the CVS Caremark Mail Service program. When you purchase prescriptions from the CVS Caremark Mail Service Program, you pay the appropriate copayment or coinsurance and receive up to a 90-day supply of your medication.

If you are receiving a medication on a monthly basis, once you have filled that medication three times at a retail pharmacy you should move to mail order. Once you have satisfied your deductible, if you fail to change to a mail order prescription after your third fill at a retail pharmacy, you will pay 50% of the cost of the prescription and your costs will not apply to your medical out-of-pocket maximum.

There are two ways to receive up to a 90-day supply:

- If you are using a CVS pharmacy, talk to your pharmacist about moving to “mail at retail” a specialized program CVS has in place for you to receive your 90-day prescription at the CVS retail pharmacy location of your choice.
- If you are not using a CVS pharmacy, you can move to mail order and have the prescription conveniently delivered to your home. Ask your doctor to write two prescriptions; one for immediate short-term use to be filled at a local network pharmacy, and one for up to a 90-day supply plus refills to be filled through the CVS Caremark mail service pharmacy. You can send in a mail order form found at www.caremark.com or use the FastStart tool at www.caremark.com or call FastStart at 1-800-875-0867. How to order refills from CVS Caremark in the future:

Once you have received your first prescription from CVS Caremark Mail Service Pharmacy, you can choose one of the following ways to request a refill:

- Online: Log on to www.caremark.com and register if you haven’t already done so. Then click on “Refill a Prescription.”
- Mail: Simply complete the enclosed mail order form or find one online at www.caremark.com.
- Phone: Call Customer Care toll-free at 1-877-876-7215.

Medications that Cannot Be Transferred

Some medications (e.g., controlled substances) cannot be transferred to CVS Caremark Mail Service Pharmacy. If you or a covered dependent are receiving medications that cannot be transferred to mail order, you will not be charged the higher coinsurance amount.

Limitations

Each prescription order or refill will be limited as follows:

- Up to a consecutive 30-day supply, at a retail pharmacy, unless limited by the drug manufacturer's packaging, or
- Up to a consecutive 90-day supply at a mail order participating pharmacy, unless limited by the drug manufacturer's packaging, or
- Up to a 30-day supply for any specialty medication, or
- To a dosage and/or dispensing limit as determined by the CVS Caremark Pharmacy & Therapeutics (P&T) Committee.

Coverage for certain prescription drugs and related supplies requires your physician to obtain authorization before prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your physician wishes to confirm coverage for prescription drugs or related supplies for which prior authorization is required, your physician may call or complete the appropriate prior authorization form and fax it to CVS Caremark to get prior authorization for coverage of the prescription drugs or related supplies. Your physician should make this request before writing the prescription.

If the coverage is approved, your physician will receive confirmation. The authorization will be processed in the CVS Caremark claim system to allow you to have coverage for those prescription drugs or related supplies. The length of the authorization will depend on the diagnosis and the prescription drugs or related supplies. When your physician advises you that coverage for the prescription drugs or related supplies has been approved, you should contact the pharmacy to fill the prescription(s).

If the coverage is denied, your physician and you will be notified that coverage for the prescription drugs or related supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Plan, by submitting a written request stating why the prescription drugs or related supplies should be covered.

If you have questions about a specific prior authorization, you should call Customer Care at 1-877-876-7215.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-preferred or non-prescription drug list drugs until the P&T Committee clinically evaluates the prescription drug for a different designation.

Prescription drugs that represent an advance over available therapy according to the FDA will be reviewed by CVS Caremark within six months after FDA approval. Prescription drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by CVS Caremark for at least six months after FDA approval.

Your Payments

Coverage for prescription drugs and related supplies purchased at a pharmacy is subject to the deductible, copayment or coinsurance shown in the *Benefits Schedule*. Please refer to the *Benefits Schedule* for any required coinsurance or maximums if applicable.

Prescription Drug Benefit Exclusions

No payment will be made for the following expenses:

- Drugs available over the counter that do not require a prescription by federal or state law,
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin,
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee,
- Any drugs that are experimental or investigational as described under the *Medical Benefit Exclusions, Expenses Not Covered and General Limitations* section of this summary plan description,

- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal,
- Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than related supplies,
- Dietary supplements and fluoride products,
- Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as fade cream products,
- Biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis,
- Replacement of prescription drugs and related supplies due to loss or theft,
- Drugs used to enhance athletic performance,
- Drugs that are to be taken by or administered to you while you are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution that operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the original date of issue,
- Other limitations are shown in the *Medical Benefit Exclusions, Expenses Not Covered and General Limitations* section.

Reimbursement/Filing a Prescription Drug Claim

When you or your dependents purchase your prescription drugs or related supplies through a retail participating pharmacy, you pay any applicable coinsurance shown in the *Benefits Schedule* at the time of purchase. As long as you present your CVS Caremark ID card, you do not need to file a claim form.



Tip: In the event you need to submit for reimbursement for a prescription drug claim, contact CVS Caremark for assistance.

To purchase prescription drugs or related supplies from a mail order participating pharmacy, see your mail order drug introductory kit for details, or contact CVS Caremark for assistance.

Coordination of Benefits (COB)

If you are eligible for benefits under another group health plan (such as a plan sponsored by your spouse's employer), the two plans will coordinate their benefit payments, so the combined payments do not exceed your actual expenses. This provision is called coordination of benefits (COB).

How COB Works

Under COB provisions, one group plan has primary responsibility and pays first. The other group plan has secondary responsibility and considers any additional benefits not covered by the primary carrier. Therefore, if the Plan is:

- Primary: It pays expenses as if no other insurance were involved.
- Secondary: It pays benefits only if you have not already received the full amount the Plan would pay if it were primary.

If the benefit is for...	Then this Plan is...
You as an active associate	Primary
You as a COBRA participant with benefits under another plan	Secondary, except for limits and exclusions under the other plan, in which case this Plan is primary
Your spouse	Secondary, if he or she is covered as an active employee through another employer's plan
Your dependent children	Primary or secondary as determined by the COB Birthday Rule

If the other group benefit program does not have a COB provision, these rules will not apply. In that case, the other group program is automatically primary.

You should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the secondary plan. This will avoid delays in claims processing and will ensure that you are reimbursed for the full amount to which you are entitled.

COB "Birthday Rule"

Under this rule, primary coverage for your dependent children will be the plan of the parent whose birthday occurs first in the calendar year, regardless of which parent is older. For example, if your spouse's birthday is in March and your birthday is in October, your spouse's plan will provide primary coverage for your children. If the decision cannot be made based on the birthday rule, the plan that has covered the individual the longest will be primary.

Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order, without regard to the birthday rule:

- The plan of the parent with custody of the child,
- The plan of the stepparent whose spouse has custody of the child, and
- The plan of the parent not having custody of the child.

If a court decree declares one parent responsible for a child's health care expenses, payment will be made first under that parent's plan.

When This Plan Is Secondary

If this Plan is secondary, it determines the amount it will pay for a covered health service by following the steps below:

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid less than the primary plan paid, the Plan pays no benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any coinsurance or deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense if This Plan Is Secondary

If this Plan is secondary and the expense meets the definition of a covered health service under this Plan, the allowable expense is the primary plan's network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate.

When the provider is a network provider for the primary plan and a non-network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-network provider for the primary plan and a network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will

be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

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

When calculating the Plan's Benefits in these situations, for administrative convenience the Claims Administrator in its sole discretion may treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and durable medical equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

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

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

Right to Recover

If the Plan makes larger payments than are necessary under the COB provision or under any other provision, the Plan Administrator has the right to recover the excess payments from any insurance company, any organization, and/or any persons for whom those payments were made.

The Claims Administrator also may pay another organization an amount that it determines is warranted, if the other organization or group plan pays benefits that should have been paid under the Plan.

The Plan also has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. By participating in this Plan, the participant agrees to authorize the release of information the Plan Administrator requires to enforce these provisions.

Integrating Benefits with Medicare

If you are eligible for benefits under Medicare, your benefits under the Plan are dependent upon which coverage is primary.

When the Plan Is Primary to Medicare

The Plan is primary for you and your family members when you are actively employed and:

- Eligible for Medicare because of your age, or
- Disabled.

When the Plan is primary, benefits are determined first – before Medicare’s benefits.

When Medicare Is Primary to the Plan

Medicare is primary for you if you retire at or after age 65 and are either on Medicare or become eligible for Medicare even when on COBRA. Medicare also is primary when your eligibility for Medicare is due to disability and you are not currently employed and on COBRA. The same rules apply to your spouse when they become Medicare eligible.

If you are eligible for, but not enrolled in Medicare, and this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Medical Coverage for Disabled Individuals

If you or your eligible dependents are totally disabled and do not have current employment status, Medicare will provide primary medical coverage.

Medical Coverage for Individuals with End-Stage Renal Disease

In all situations involving End-Stage Renal Disease (ESRD)—regardless of age or Medicare status—the Plan will be the primary payer of medical benefits during the first 30 months the individual is eligible for Medicare. Thereafter, Medicare will be primary payer of the medical benefits for the individual and the Plan will be secondary payer.

Health Savings Account and Medicare

If you have applied for, or are receiving, Social Security benefits—which automatically entitles you to Part A—no contributions to your HSA are allowed, including employer wellness rewards. This IRS rule affects only employees age 65 or older who have HSAs through their employment, because they are the ones who contribute to HSAs from their before-tax earnings at work. They can continue to spend the existing HSA funds but cannot contribute additional money to the account. The rule does not affect covered spouses over age 65, who can continue to use funds from the working spouse’s HSA for approved medical purposes.

No-Fault Motor Vehicle Coverage

If you (or your dependent) has coverage available to you under any no-fault motor vehicle coverage required by law, the no-fault motor vehicle coverage is primary. If you are covered for loss of earnings by both this Plan and any no-fault motor vehicle coverage required by law, any benefits the Plan pays because of a disability are reduced by the benefits available to you for loss of earnings according to the no-fault motor vehicle coverage.

Workers' Compensation

This Plan does not provide benefits if expenses are covered by workers' compensation or occupational disease law. This Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered by a workers' compensation or occupational disease law. Under those circumstances and before any payment from the Plan is made, the Plan Administrator may ask that you execute a subrogation and reimbursement agreement.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. Subrogation applies when the Plan has paid benefits on your behalf (for a Participant or Beneficiary) for a sickness or injury for which a third party is alleged to be responsible. In the event that these sicknesses or injuries are caused by the act or omission of another person or entity, the Participant or Beneficiary may have a claim against that other person or entity, or against a third party, for payment of the medical or other charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Participant or Beneficiary may have to recoveries from any third party up to the full amount of such benefits.

The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is alleged to be responsible. This subrogation right allows the Plan to pursue any claim that the Participant or Beneficiary has against any third party, whether or not the Participant or Beneficiary chooses to pursue that claim.

Subrogation – Example

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

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury. The Plan may make a claim directly against a third party, but in any event, the Plan has an equitable lien on any amount of the recovery of the Participant or Beneficiary, whether or not designated as payment for medical expenses. In addition, each Participant and Beneficiary agrees to hold such covered amounts in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan

is repaid in full. In the event that the Participant or Beneficiary dies as a result of his or her sickness or injuries, the Plan's subrogation and refund rights shall still apply.

The Plan will be subrogated to all rights the Participant may have against that other person or third party and will be entitled to reimbursement of benefits paid or to be paid to the Participant or Beneficiary relating to such injuries, whether by insurance, litigation, settlement or other proceeding, and whether or not the Participant has been "made whole." The Plan shall not be responsible for any expenses or fees incurred in connection with any recovered sums (including, among others, attorney fees).

Reimbursement – Example

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages,
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages,
- The Plan Sponsor (for example, workers' compensation cases),
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators, and
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
- subrogate to the Plan his or her rights to recovery when this provision applies;
- authorize the Plan to sue, compromise and settle in the Participant's or Beneficiary's name to the extent of the amount of medical or other benefits paid for the sickness and/or injuries under the Plan and its expenses incurred by the Plan in collecting this amount;
- reimburse the Plan out of any recovery made from the other person, the other person's insurer, or the third party for the amount of medical or other benefits paid for the sicknesses and/or injuries under the Plan and the expenses incurred by the Plan in collecting this amount;

- notify the Plan in writing immediately of any instance in which a third party may be liable for his or her sickness or injury;
- cooperate with the Plan, or any representatives of the Plan, in protecting the Plan's rights, including discovery, attending depositions, and cooperating at trial;
- provide the Plan with pertinent information regarding the sickness or injury, including accident reports, settlement information, and any other requested additional information;
- take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- do nothing to prejudice the Plan's rights of subrogation and reimbursement; and
- notify the Plan in writing immediately of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement.

Amounts Subject to Subrogation or Reimbursement

- All amounts recovered will be subject to subrogation or reimbursement. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or other benefits paid or to be paid for the sicknesses or injuries under the Plan and the expenses incurred by the Plan in collecting this amount.

Make Whole and Common Fund Doctrines Inapplicable

- This Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan from receiving a recovery unless a Participant or Beneficiary has been "made whole" with regard to sickness or injury that is the responsibility of a third party. This Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan to pay a portion of the attorney fees and costs expended in obtaining a recovery. These doctrines have no application to this Plan, since the Plan's recovery rights apply to the first dollars payable by a third party.

Plan's Right to Offset if:

- A Participant or Beneficiary fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this section, or
- Payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then, in addition to all other remedies and rights of recovery that the Plan may have, the Plan shall have the right to terminate or suspend benefit payments and/or recover the reimbursement due to the Plan by withholding, offsetting and recovering such amount out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Participant or Beneficiary.

- The provisions of this section shall apply to all Self-Insured Benefits, and, to the extent not inconsistent with applicable state insurance law or the terms of the applicable insurance policy, to all Insured Benefits. Should any portion of this section be inconsistent with state insurance law applicable to an Insured Benefits delivered under a Benefit Program, or with the insurance policy applicable to such Benefit Program, then only such portion not apply, and all other portions shall apply.

If you incur a covered expense for which, in the opinion of the Plan or Claims Administrator, another party may be responsible or for which you may receive payment from a third party:

- **Subrogation:** The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Plan. You or your representative shall execute such documents as may be required to secure the Plan's subrogation rights.
- **Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted above, but only to the extent of the benefits provided by the Plan.
- Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable,
- Providing any relevant information requested by the Plan,
- Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
- Responding to requests for information about any accident or injuries,
- Making court appearances,
- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of expenses, and
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

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

- Made in error,
- Due to a mistake in fact,
- Advanced during the time period of meeting the plan year deductible, or
- Advanced during the time period of meeting the out-of-pocket maximum for the plan year.

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

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

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

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan, and
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

Prohibitions on Assignment

All rights to benefits under the Plan are personal to the Participant or Beneficiary. A Participant's or Beneficiary's rights and benefits under the Plan with respect to Self-insured Benefits cannot be assigned, sold, pledged, or transferred to a third party, including to a health care provider. This includes the right to payment or reimbursement for benefits under the Plan and the right to file a lawsuit to recover benefits due under the Plan.


Any purported assignment of rights or benefits is void and will not be recognized by the Plan. A Benefit Program that offers Insured Benefits may also prohibit assignments of rights or benefits with respect to the Insured Benefits under the Benefit Program. An Insured Benefit Program may also prohibit assignments. The Plan prohibits assignments of any other rights a participant or beneficiary may have under ERISA, including, without limitation, the right to request documents under Section 104 of ERISA and the right to file a lawsuit to:

- enforce rights under the terms of the Plan,
- to clarify rights to future benefits under the terms of the Plan,
- obtain relief for a breach of fiduciary duty; enjoin any act or practice which violates ERISA or the terms of the Plan or to obtain other equitable relief to redress such violations or enforce any provisions of ERISA or the Plan,
- and obtain relief based on the Plan Administrator's failure to provide information or other documentation to which a participant or beneficiary may be entitled under ERISA.

When Coverage Ends

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits for you and your family include:


- You and your family members no longer meet the eligibility requirements,
- Your employment ceases,
- You are on an approved leave of absence for greater than six months over the course of a 12-month rolling calendar,
- You fail to make any required contributions due to leave of absence, or
- Staples terminates the Plan.

 **Note:** If you or any of your dependents lose coverage under a plan, certain rights to continue health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) are outlined in the *How to Continue Coverage Under COBRA* section.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent, or
- You commit an act of physical or verbal abuse that imposes a threat to Staples staff, the Claims Administrator's staff, a provider or another covered person.

 **Note:** Staples has the right to demand that you pay back benefits Staples paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

How to Continue Coverage Under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your dependents may be eligible to continue health coverage (called “COBRA coverage”) at group rates. This COBRA coverage is available in certain instances (called qualifying life events) where coverage under the Plan would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have ends. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers offering benefits. For more information, contact Staples HR Services at 1-888-490-4747.

COBRA coverage is provided subject to your eligibility for coverage as described below. Staples reserves the right to terminate your coverage retroactively if it’s determined that you’re ineligible under the terms of the Plan.

You will pay the entire cost of coverage—your share and Staples—plus a 2% administrative fee. There’s a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

The following table provides an overview of available COBRA coverage. See the sections after the table for more details.

COBRA at a Glance

Who Is Affected	Qualifying Life Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	You leave employment for reasons other than gross misconduct	You and your dependents	Up to 18 months
	You experience a reduction in hours below the level required for benefit eligibility	You and your dependents	Up to 18 months
	You are disabled (for purposes of Social Security disability benefits) when you become eligible for COBRA or you become disabled within the first 60 days after an 18-month COBRA continuation coverage period begins	You and your dependents	Up to 29 months*
Your Spouse or Dependent Child	You die	Your dependents	Up to 36 months
	You and your spouse become divorced or legally separated	Your dependents, including your former spouse	Up to 36 months
	You become enrolled in Medicare (Part A, Part B, or both) *	Your dependents	Up to 36 months
	Your spouse and/or dependent child is disabled when he/she becomes eligible for COBRA or becomes disabled within the first 60 days after an 18-month COBRA continuation coverage period begins	You and your dependents	29 months*
Your Dependent Child	Your dependent child is no longer an eligible dependent (for example, due to age)	Your dependent child	36 months

* You must provide proof of eligibility for Social Security disability benefits to be eligible for the additional 11 months of COBRA coverage.

** Only if this would cause your spouse or child to lose coverage under the Plan.

Who Is Eligible for COBRA Coverage

If you are covered by the Plan on the day before a qualifying life event, you have the right to choose COBRA coverage if you lose coverage because of a reduction in your hours of employment or the termination of your employment (unless you are terminated because of gross misconduct on your part).

If you are enrolled in the Plan and terminate employment after a leave of absence qualifying under the Family and Medical Leave Act (FMLA), the qualifying life event that will trigger COBRA coverage is the date that you indicate you will not be returning to work after the leave or the last day of the FMLA leave period, whichever is earlier.

If your spouse is covered by the Plan on the day before the qualifying life event, he or she is considered a qualified beneficiary. That means he or she has the right to choose COBRA coverage if he or she loses group health coverage under the Plan for any of the following reasons:

- You die,
- Your employment is terminated (for reasons other than your gross misconduct) or your hours of employment are reduced,
- You divorce from your spouse, or
- You become entitled to Medicare.

If your dependent children are covered under the Plan on the day before the qualifying life event, they are also considered qualified beneficiaries. This means they have the right to COBRA coverage if their coverage under the Plan is lost for any of the following reasons:

- You die,
- Your employment is terminated (for reasons other than your gross misconduct) or your hours of employment are reduced,
- You divorce,
- You become entitled to Medicare, or
- Your child ceases to be a dependent child under the Plan.

If you elect continuation of coverage and then have a child (either by birth, adoption or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, a new child who is a qualified beneficiary can be added to COBRA coverage. Contact Staples HR Services at 1-888-490-4747 to add the dependent. Staples HR Services may ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

If you fail to notify Staples HR Services in a timely fashion (in accordance with the terms of the Plan), you will not be offered the option to elect COBRA coverage for the new child. Newly acquired eligible dependents (other than children born to, adopted by or placed for adoption) won't be considered qualified beneficiaries, but may be added to your COBRA coverage as dependents, according to the Plan's rules that apply to active associates.

Your Duties

Under the law, you or a family member have the responsibility to inform Staples HR Services, of a divorce or child's loss of dependent status under the Plan. This notice must be provided within 60 days from the latest of the:

- Date of divorce or loss of dependent status,
- Date coverage would normally be lost because of the qualifying life event, or
- Date on which you were informed of the responsibility to provide the notice and of the Plan's procedures for providing such notice to Staples HR Services.

Notice must be provided to Staples HR Services, 500 Staples Drive, Framingham, MA 01702 or faxed to 508-305-1300. Notice must include information about you or your qualified beneficiary needing COBRA coverage and the qualifying life event that gave rise to the individual's right to COBRA coverage. In addition, you or your qualified beneficiary may be asked to provide Staples HR Services with documentation supporting the occurrence of the qualifying life event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

- **Divorce:** A copy of the divorce decree

If you or your family member fails to notify Staples HR Services during this 60-day notice period, any family member who loses coverage will not be given the option to elect COBRA coverage.

When Staples HR Services is notified that this qualifying life event has happened, Staples will notify the COBRA Administrator, Alight, to send out notification with your rights to elect COBRA coverage.

Your Employer's Duties

Qualified dependents will be notified of the right to elect COBRA coverage automatically (without any action required by you or your family member) if any of the following qualifying life events that results in a loss of coverage occurs:

- You die,
- Your employment is terminated (for reasons other than your gross misconduct) or your hours of employment are reduced, or
- You become entitled to Medicare.

Electing COBRA

To elect COBRA coverage, visit Staples Benefits Connection (staples.com/benefits). For any questions, contact Staples HR Services at 1-888-490-4747.

Under the law, you must elect COBRA coverage within 60 days from the date you are provided with notice of your right to elect COBRA coverage. If you or a covered dependent do not choose COBRA coverage within the time period described above, you will lose the right to elect COBRA coverage. You and your family members must reimburse the Plan for any claims mistakenly paid after the date coverage would normally have been lost.

If you choose COBRA coverage, Staples must give you coverage that, as of the time coverage is being provided, is made available under the Plan to similarly situated beneficiaries. “Similarly situated” refers to a current associate or dependent who hasn’t had a qualifying life event. You’ll have the same opportunity to change coverage as active associates have. This also means that if the coverage for similarly situated or family members is modified, your coverage will be modified in the same way. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate Elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a spouse or dependent child who is a qualified beneficiary is entitled to elect COBRA coverage even if you don’t make that election. However, you or your spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA Coverage

If elected, COBRA coverage begins on the day after your coverage as an active associate ends. For dependents who no longer meet the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends. However, coverage won’t take effect unless COBRA coverage is elected as described above and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If you lose group health coverage because of a termination of employment or reduction in hours, COBRA coverage may continue for you and your covered dependents for up to 18 months.

COBRA coverage for your covered dependents may continue for up to 36 months if coverage would otherwise end because:

- You die,
- You divorce,
- You become covered by Medicare, or
- Your dependent child loses eligibility for coverage.

Additional Qualifying Life Events

Additional qualifying life events (such as a death, divorce or Medicare entitlement) may occur while COBRA coverage is in effect. These qualifying life events may result in an extension of an 18-month continuation period to 36 months for your covered dependents, but in no event will coverage last beyond 36 months from the date of the first qualifying life event that originally made a qualified dependent eligible to elect coverage. The COBRA coverage period for your spouse and dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer, but not to exceed 36 months.

Under the law, in order to receive an extension of COBRA coverage, a qualified beneficiary must notify the COBRA Administrator, Staples HR Services at 1-888-490-4747, of the death of

an associate, a divorce, a child's losing dependent status under the Plan, or the associate's entitlement to Medicare. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying life event or (2) the date on which the qualified beneficiary is informed of the responsibility to provide the notice and of the Plan's procedures for providing such notice to Staples HR Services.

Notice of the additional qualifying life event must be provided to Staples HR Services. The notice must include information about you or your qualified beneficiary needing additional COBRA coverage and the qualifying life event that gave rise to the individual's right to additional COBRA coverage. In addition, you or your qualified beneficiary must provide the COBRA Administrator with documentation supporting the occurrence of the qualifying life event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

- **Death:** A copy of the death certificate,
- **Divorce:** A copy of the divorce decree

If a former associate or family member fails to provide the appropriate notice and supporting documentation to the COBRA Administrator during the 60-day notice period, the family member will not be entitled to extended COBRA coverage.

Special Rules for Disability

The 18 months of COBRA coverage may be extended to 29 months if you or your covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. This applies even to family members who are not disabled.

To benefit from the extension, the qualified beneficiary must provide Staples HR Services, with the disability determination within 60 days after the latest of (1) the Social Security Administration's determination of disability, (2) the date on which a qualifying life event occurs, (3) the date coverage would normally be lost because of the qualifying life event, or (4) the date on which the qualified beneficiary is informed of the responsibility to provide the notice, and the Plan's procedures for providing such notice to Staples HR Services. This notice must be furnished to Staples HR Services before the end of the original 18-month COBRA coverage period. If a child is born to you or is placed for adoption with you while you're continuing coverage and the child is determined to be disabled within the first 60 days of COBRA coverage, the child and all family members with COBRA coverage arising from the same qualifying life event may be eligible for a total of up to 29 months of COBRA coverage. If, during COBRA coverage, the Social Security Administration determines that the qualified dependent is no longer disabled, the individual must inform Staples HR Services of this re-determination within 30 days of the date it is made or the date on which the qualified beneficiary is informed of the responsibility to provide the notice, and the Plan's procedures for providing such notice to Staples HR Services. Coverage will terminate no earlier than the first of the month following the month that is 30 days after receipt of the notice that the individual is no longer disabled (if the 18 months provided to all COBRA eligible participants has been used).

Notice by the Social Security Administration of a determination of disability or a determination that you or a covered family member is no longer disabled must be provided to Staples HR Services. The notice must include information about you or your covered family member

needing a disability COBRA coverage extension or notifying Staples HR Services that he/she is no longer disabled.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and another qualifying life event occurs within the 29-month continuation period, then the COBRA coverage period is 36 months after the termination of employment or reduction in hours. The qualified beneficiary must provide the appropriate notice to Staples HR Services as described under the *Additional Qualifying Life Events* section.

Early Termination of COBRA Coverage

The law provides that your COBRA coverage may be cut short before the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- Staples no longer provides group health coverage to any of its associates,
- The premium for COBRA coverage isn't paid on time (within the applicable grace period),
- The qualified dependent becomes covered—after the date COBRA coverage is elected—under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual,
- The qualified dependent first becomes entitled to Medicare after the date COBRA coverage is elected, or,
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early because of your participation in that other plan.

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying life event that would make you eligible for COBRA coverage. However, a COBRA qualifying life event occurs if:

- You or your dependent is covered by the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave), and
- You do not return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- When you definitively inform Staples HR Services (1-888-490-4747) that you are not returning to work, or
- The end of the leave, assuming you do not return to work.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you may be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of at least 30 days.

Contacting Staples HR Services/COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact Staples HR Services at 1-888-490-4747.

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Also, you must notify Staples HR Services at 500 Staples Drive, Framingham, MA 01702, if:

- Your marital status has changed,
- You, your spouse or a dependent has changed address, or
- A dependent loses eligibility for dependent coverage under the terms of the Plan.

Key Terms

These terms are referenced throughout the summary plan description (SPD). To help you understand your benefits, they are defined below.

Active Service

You will be considered in active service:

- On any of your employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your employer's place of business or at some location to which you must travel to for your employer's business.
- On a day that is not one of your employer's scheduled work days if you were in active service on the preceding scheduled work day.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon – The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon before any reductions due to coinsurance or deductible amounts.)

Co-Surgeon – The maximum amount payable will be limited to charges made by co-surgeons will be limited to the amount specified in UHC reimbursement policies.

Associate (Employee)

Associate means all exempt and full-time non-exempt employees of the employer who is currently in active service. The term does not include associates who are part-time non-exempt or temporary.

Bed and Board

Bed and board includes all charges made by a hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Cellular Therapy

Administration of living whole cells into a patient for the treatment of disease.

Chiropractic Care

Chiropractic care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment of specific joints to restore motion, reduce pain and improve function.

Coinsurance

The percentage of charges you pay for expenses covered by the Plan.

Congenital Anomaly/Congenital Defect

A physical developmental defect that is present at birth and is identified within the first 12 months of birth.

Copayment

Copayments are expenses to be paid by you or your covered dependent for covered services.

Cosmetic Procedures

Cosmetic procedures are services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a cosmetic procedure because appearance would be improved, but there would be no improvement in function like breathing.

Covered Health Services

Those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

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

If your Claims Administrator is Medica Self-Insured, covered health services are those services determined by Medica Self-Insured to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms,
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below,
- Not provided for the convenience of the Covered Person, Physician, facility or any other person,
- Included as covered, as described in this document,
- Provided to a Covered Person who meets the Plan's eligibility requirements,

- Not identified as an exclusion.

In applying the above definition, “scientific evidence” and “prevailing medical standards” mean:

- Scientific evidence means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- Prevailing medical standards and clinical guidelines means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

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

Custodial Services

Custodial services are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial services also can provide medical services, given mainly to maintain the person’s current state of health.

These services are intended to provide care while the patient cannot care for himself or herself. Custodial services include but are not limited to services:

- Related to watching or protecting a person,
- Related to performing or helping a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self-administered, and
- That do not need to be performed by trained or skilled medical or paramedical personnel.

Deductible

The deductible is the amount you pay out of your pocket for covered expenses each plan year (including medical expenses and prescription drugs) before Staples shares in the costs. There are separate deductibles for in- and out-of-network care. If you enroll eligible dependents, you and your dependents must meet the higher family deductible before Staples shares in the cost of non-preventive care.

Definitive Drug Test

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

Dependent

See the *Eligibility and Enrollment* section for the definition of dependent.

Designated Facility

A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area. The fact that a hospital is a network hospital does not mean that it is a designated facility.

Eligible Expenses

Eligible expenses mean the actual billed charges, except when the provider has contracted directly or indirectly with the Plan Administrator for a different amount.

Emergency Services

Emergency services are medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which must treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention.

Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Employer

Employer means the plan sponsor who self-insures the benefits described in this booklet and on whose behalf the Plan Administrator is providing claim administration services. (The Plan Sponsor is Staples.)

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided, unless otherwise noted.

Experimental or Investigational Services

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational).
- The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Free-Standing Surgical Facility

Free-standing surgical facility means an institution which:

- Has a medical staff of physicians, nurses and licensed anesthesiologists,
- Maintains at least two operating rooms and one recovery room,
- Maintains diagnostic laboratory and x-ray facilities,
- Has equipment for emergency care,
- Has a blood supply,
- Maintains medical records,
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis, and
- Is licensed in accordance with the laws of the appropriate legally authorized agency.

Gene Therapy

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

Hospice Care Program

A hospice care program is:

- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families,
- A program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness, and
- A program for persons who have a terminal illness and for the families of those persons.

Hospice Care Services

Hospice care services are services provided by:

- A hospital,
- A skilled nursing facility or a similar institution,
- A home health care agency,
- A hospice facility, or
- Any other licensed facility or agency under a hospice care program.

Hospice Facility

Hospice facility means an institution or part of it which:

- Primarily provides care for terminally ill patients,
- Is accredited by the National Hospice Organization,
- Meets standards established by the Plan Administrator, and
- Fulfills any licensing requirements of the state or locality in which it operates.

Hospital

Hospital means an institution:

- Licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment, (b) provides such treatment on an inpatient basis, for compensation, under the supervision of physicians and (c) provides 24-hour service by registered graduate nurses,
- That qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations, or
- That: (a) specializes in treatment of mental health and substance use disorder or other related illness, (b) provides residential treatment programs, and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

A hospital will not include an institution that is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered confined in a hospital if he is:

- A registered bed patient in a hospital upon the recommendation of a physician,
- Receiving treatment for mental health and substance use disorder services in a partial hospitalization program, and
- Receiving treatment for mental health and substance use disorder services in a mental health or substance use disorder residential treatment center.

Injury

Injury means an accidental bodily injury.

Maintenance Treatment

Maintenance treatment means treatment provided to keep or maintain the patient's current status.

Maximum Reimbursable Charge – Medical

In-network services are paid based on the fee agreed upon between UHC and the provider. Out-of-network services are paid based on the maximum reimbursable charge. For this Plan, the maximum reimbursable charge is calculated at 140% of the Medicare reimbursement rate. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge.

Medicaid

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity

Health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, [Mental Illness,][[mental illness,] substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical

policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or www.mymedica.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

Medicare

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Health Services

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

Mental Illness

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

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in a payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Necessary Services and Supplies

Necessary services and supplies include any charges:

- Except charges for bed and board, made by a hospital on its own behalf for medical services and supplies actually used during hospital confinement,
- For licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided, and
- For the administration of anesthetics during hospital confinement.

Necessary services and supplies will not include any charges for special nursing fees, dental fees or medical fees.

New Pharmaceutical Product

A Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Nurse

Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Other Health Care Facility

Other health care facility means a facility other than a hospital or hospice facility. Examples of other health care facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and subacute facilities.

Other Health Professional

Other health professional means an individual other than a physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other health professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other health professionals do not include providers such as certified first assistants, certified operating room technicians, certified surgical assistants/technicians, licensed certified surgical assistants/technicians, licensed surgical assistants, orthopedic physician assistants and surgical first assistants.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in a plan year for covered expenses. Your deductible and coinsurance count toward your out-of-pocket maximum. Once you meet it, the plan pays 100% for covered services for the rest of the plan year. There are separate maximums for in- and out-of-network care. If you enroll eligible dependents, you and your dependents must meet the higher family out-of-pocket maximum before Staples pays 100% for covered services.

Participating Provider

Participating provider means a hospital, a physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with UHC to provide covered services with regard to a particular plan under which the participant is covered.

Participating provider can also mean a dentist, or a professional corporation, professional association, partnership, or other entity that is entered into a contract with UHC to provide dental services at predetermined fees.

Personal Health Support

Personal Health Support is a service provided through a review organization, which helps individuals with treatment needs that extend beyond the acute care setting. Participation is voluntary. The goal of Personal Health Support is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. The Personal Health Support nurse will help coordinate the treatment program and arrange for necessary resources.

A Personal Health Support nurse trained in the appropriate clinical specialty area will be assigned to you or your covered dependent. While the Personal Health Support nurse recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care. Personal Health Support services work as follows:

- You, your covered dependent or an attending physician can call UHC's Customer Service at 1-877-842-3210 during normal business hours, Monday through Friday. In addition, Staples, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Personal Health Support.
- The review organization assesses each case to determine whether Personal Health Support is appropriate.
- You or your covered dependent is contacted by an assigned case manager who explains in detail how the program works.
- The Personal Health Support nurse works with you, your family and physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care instead of an extended hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Personal Health Support nurse arranges for alternate treatment services.
- The Personal Health Support nurse also acts as a liaison between the insurer, the patient, his or her family and physician as needed.
- Once the alternate treatment program is in place, the Personal Health Support nurse continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

Pharmacy

Pharmacy means a retail pharmacy, or a mail order pharmacy.

Pharmaceutical Product(s)

U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Pharmacy & Therapeutics (P&T) Committee

A committee of the Plan Administrator including participating providers, Medical Directors and Pharmacy Directors which regularly reviews prescription drugs and related supplies for safety and efficacy. The P&T Committee evaluates prescription drugs and related supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on prescription drugs and related supplies.

Patient Protection and Affordable Care Act of 2010 (“PPACA”)

PPACA means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Physician

Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services must be covered by law in the locality where the policy is issued if he is:

- Operating within the scope of his license, and
- Performing a service for which benefits are provided under this Plan when performed by a physician.

Plan Year

Plan year means the 12-month period beginning on each July 1st.

Prescription Drug

Prescription drug means: (a) a drug that has been approved by the Food and Drug Administration for safety and efficacy, (b) certain drugs approved under the Drug Efficacy Study Implementation review or (c) drugs marketed before 1938 and not subject to review, and which can, under federal or state law, be dispensed only with a prescription order.

Prescription Drug List

Prescription Drug List means a listing of approved prescription drugs and related supplies. The prescription drugs and related supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order

Prescription order means the lawful authorization for a prescription drug or related supply by a physician who is duly licensed to make such authorization within the course of such physician's professional practice or each authorized refill thereof.

Presumptive Drug Test

Test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Preventive Care

Preventive care includes routine physical exams and health screenings (such as routine blood tests, immunizations, Pap smears, prostate screenings and other age-appropriate health screenings). In-network services coded by your doctor as preventive care are generally covered at 100% in-network. If the same tests are done to diagnose an illness or treat a known condition, they are not considered preventive care and the deductible and coinsurance apply.

Primary Care Physician

Primary care physician means a physician who qualifies as a participating provider in general practice, internal medicine, family practice or pediatrics and who has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your covered dependents.

Psychologist

Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services must be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this Plan when performed by a psychologist. Any psychotherapist while he is providing care authorized by the provider organization if he is state licensed or nationally certified by his professional discipline and performing a service for which benefits are provided under this Plan when performed by a psychologist.

Reconstructive Procedure

A reconstructive procedure is performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a reconstructive procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures that are associated with an injury, sickness or congenital anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a reconstructive procedure.

Related Supplies

Related supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under prescription drug benefits, and spacers for use with oral inhalers.

Review Organization


Review organization refers to an affiliate of the Plan Administrator or another entity to which the Plan Administrator has delegated responsibility for performing utilization review services. This organization has a staff of clinicians that may include physicians, registered graduate nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

Shared Savings Program

A program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness – For Medical Coverage

Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine hospital and pediatric care of a newborn child before discharge from the hospital nursery will be considered to be incurred as a result of sickness.

 **Note:** According to the Newborns' and Mothers' Health Protection Act (NMHPA) of 1996 - Newborn children are only covered for the first 60 days after birth, if not enrolled as a dependent in medical coverage.

Skilled Nursing Facility

A skilled nursing facility is a licensed institution (other than a hospital, as defined) which specializes in:

- Physical rehabilitation on an inpatient basis, or
- Skilled nursing and medical care on an inpatient basis but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment, (b) provides such treatment, for compensation, under the supervision of physicians and (c) provides nurses' services.

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance-Related and Addictive Disorders Services

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

Terminal Illness

A terminal illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a physician.

UnitedHealthcare Network

UnitedHealthcare Network refers to a designation given to participating providers who meet independently established criteria determining efficiency and quality.

Unproven Services

Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

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

Urgent Care

Urgent care is medical, surgical, hospital or related health care services and testing which are not emergency services, but which are determined by the Plan Administrator, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a physician's recommendation that the covered person should not travel due to any medical condition.

Situations Affecting Your Benefits

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision that provides the better benefit will apply.

Family and Medical Leave Act (FMLA) of 1993

Under FMLA, you may take up to 12 work weeks (unless the applicable state law in which you work provides for additional time) in a rolling 12-month period (measured backward from the beginning of the leave) of unpaid family or medical leave within any 12-month period to care for:

- A newborn child or newly placed adoptive or foster child (provided leave is completed within 12 months of the birth or placement),
- A spouse, parent or child who has a serious health condition,
- Your own serious health condition that prevents you from performing your job,
- For a “qualifying exigency” when a spouse, dependent or parent has been notified of an impending call to active duty status, or
- A one-time 26-week leave within a 12-month period to care for a spouse, dependent, parent, or next of kin who was injured in the line of duty during active duty status.

You are eligible for family and medical leave if you have worked for Staples for at least 12 months (need not be consecutive) and have worked at least 1,250 hours during the 12-month period preceding the start of the leave.

The way in which you may take family and medical leave depends on the qualifying circumstances:

- For a newborn, adopted or foster child, you must take leave during a continuous period unless Staples agrees to a different schedule.
- For serious health conditions, you may take a reduced workweek or intermittent leave if medically necessary.
- For illness that qualifies as short-term disability, the amount of time that you receive short-term disability benefits will count against the 12-week entitlement; if you are on unpaid family and medical leave, you may be required (or permitted) to substitute paid time off (vacation, floating holidays) to offset FMLA leave.

If you are on an approved FMLA leave, you have the option to continue active coverage as follows:

- You and your eligible family members can continue all health benefits during FMLA leave at the active associate contribution rate up to six months by paying premiums during the leave. After six months, you may continue your coverage for an additional 18 months at 102% of the total premium. If premiums are not paid while on leave, your coverage will be terminated for non-payment and re-instated upon your return to work.

- You may return to active coverage after a family or medical leave without any pre-existing condition limits or waiting periods, even if you didn't continue benefits during the leave.

Additional information about your benefits under FMLA is described in Staples Leaves Policies.

Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994

Associates performing voluntary or involuntary duty in a "uniformed service" have certain rights under USERRA.

- If you are on uniformed services leave, you are entitled to the non-seniority benefits that would be made available to other associates with similar seniority, status, and pay, if they were on furlough or leave of absence.
- You and your dependents may continue your health coverage, at the associate rate, even if you are covered by military health care programs, up to six months in the uniformed services. After six months, you may continue your coverage for an additional 18 months at 102% of the total premium.
- You must notify Staples in advance of entering uniformed service. You should also notify Staples after you have left uniformed service.
- If you choose not to continue health coverage during this period of uniformed services leave, coverage can be reinstated without a waiting period or pre-exam, upon reemployment.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty,
- Active duty for training,
- Initial active duty for training,
- Inactive duty training,
- Full-time National Guard duty, and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996 – Maternity Stays

Group health plans and health insurance issuers generally may not, under the Newborns' and Mother's Health Protection Act (NMHPA), restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours after a vaginal delivery, or less than 96 hours after a cesarean section. However, federal law generally does not prohibit the mother's or 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 and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not over 48 hours (or 96 hours).

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for workers displaced by the impact of foreign trade who, as determined by the U.S. Secretary of Labor, are eligible for a “trade readjustment allowance” or “alternative trade adjustment assistance” (“eligible TAA individuals”). Under this tax credit, if you’re an eligible TAA individual, you’re eligible for a health insurance tax credit of up to 65% of qualified health insurance premiums, including COBRA coverage. If you’re in this situation, you’ll be notified.

The Trade Act of 2002 also created a special COBRA right applicable to TAA individuals. TAA individuals are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they didn’t already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the TAA individual becomes eligible for assistance under the Trade Act of 2002. Nonetheless, this election may not be made more than six months after the date the TAA individual’s group health plan coverage ends.

If you have questions about this tax credit or your extended ability to elect COBRA coverage, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact.

Use and Disclosure of Protected Health Information (PHI) Under HIPAA

This Plan will use protected health information (PHI) to the extent of and consistent with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment for Health Care includes activities undertaken by the Plan (1) to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or (2) to obtain or provide reimbursement for the provision of health care and which relate to the individuals to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim),
- Coordination of benefits,
- Adjudication of health benefit claims (including appeals and other payment disputes),
- Subrogation of health benefit claims,
- Establishing associate contributions,
- Risk adjusting amounts due based on enrollee health status and demographic characteristics,
- Billing, collection activities and related health care data processing,
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance and related health care data processing),
- Covered services reviews or reviews of appropriateness of care or justification of charges,
- Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review,
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan), and
- Reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- Quality assessment,
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions,
- Rating provider and plan performance, including accreditation, certification, licenses or credentialing activities,
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance),
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs, and
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies.

Business Management and General Administrative Activities of the Plan, including, but not limited to:

- Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements,
- Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers,
- Resolution of internal grievances, or
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, after completion of the sale or transfer, will become a covered entity. The Plan will use and disclose PHI as required by law.

In accordance with HIPAA, the Plan will disclose PHI to Business Associates for purposes related to administration of this Plan.

Disclosure of PHI to the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the requirements identified below. The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law,

- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI,
- Not use or disclose PHI for employment-related actions and decisions,
- Not use or disclose PHI in connection with any other benefit or associate benefit plan of the Plan Sponsor,
- Report to the Plan any PHI uses or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware,
- Make PHI available to an individual in accordance with HIPAA's access requirements,
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
- Make available the information to provide an accounting of disclosures,
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA, and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Limitations of PHI Access and Disclosure

In accordance with HIPAA, only associates in the following groups may be given access to PHI:

- Benefits Administration Strategy and Design Group,
- Benefits Leave of Absence Group, and
- Staples HR Services.

The persons described above may only have access to and use and disclose PHI for administration functions that the Plan Sponsor performs for the Plan.

If a person described above does not comply with this plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance as required by HIPAA.

Benefits Claim Procedures

Filing a Claim

A claim must be filed in writing to the appropriate Claims Administrator:

- UnitedHealthcare Member Services, for medical claims, or
- CVS Caremark for prescription drug claims.

The Claims Administrator is responsible for providing you an explanation of benefits and information regarding your entitlement to benefits and any amount payable to you.

The following categories of claims for benefits apply to the Plan, and according to the type of claim submitted your claim will be reviewed and responded to within a designated response time. If additional time (an extension) is needed to decide on your claim because of special circumstances, you will be notified within the claim response period.

If you have a problem with a UnitedHealthcare Choice Plus HSA benefit, contact UHC Member Services.

- **Urgent Care Claims** – Claims for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician with knowledge of your medical condition, would subject the patient to severe pain that cannot be adequately managed otherwise.
- **Pre-Service Claims** – Claims that must be decided before a patient will be afforded access to health care (e.g., preauthorization requests).
- **Post-Service Claims** – Claims involving the payment or reimbursement of costs for medical care that has already been provided.
- **Concurrent Care Claims** – Claims where the Plan has previously approved a course of treatment over a period of time or for a specific number of treatments and the Plan later reduces or terminates coverage for those treatments.

Type of Claim	Response time	Extension
Urgent claims	72 hours	Not applicable. However, if additional information is needed, the Claims Fiduciary must ask for the additional information 24 hours after receiving the claim. You must then respond with this additional information within 48 hours of the request. Failure to submit this additional information may result in a claim denial.

Type of Claim	Response time	Extension
Pre-service claims	15 days	An additional 15 days. However, if an extension is necessary due to incomplete information, you must provide the additional information within 45 days from the date of receipt of the extension notice.
Post-service claims	30 days	An additional 15 days. However, if an extension is necessary due to incomplete information, you must provide the additional information within 45 days from the date of receipt of the extension notice.

Denied Claims

If your claim for benefits is denied completely or partially, you, your beneficiary, or designated representative will receive written notice of the decision. The notice will describe:

- The specific reasons for the claim's denial,
- References to the pertinent Plan provisions on which the denial is based,
- If a medical or prescription drug claim, the date of service, name of the health care provider, and claim amount,
- If a medical or prescription drug claim, the denial code (if applicable) and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim,
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures (including any available external review process) and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal, and
- If a medical or prescription drug claim, a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and external review processes.

Depending on the type of claim, the explanation will also contain the following information:

- If the denial is based on an internal rule, guideline, or protocol, or standard, the denial will say so and state that you can obtain a copy of the rule, guideline, or protocol, free of charge upon request.

- If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge.
- If the denial involves urgent care, you will be provided an explanation of the expedited review procedures applicable to urgent claims.

You should be aware that the Claims Administrator has the right to ask for repayment if they overpay a claim for any reason.

Filing an Appeal

If your claim is denied, you, your beneficiary, or your designated representative may appeal the decision to the appropriate Claims Fiduciary in writing. Your written appeal should include the reasons why you believe the benefit should be paid and information that supports, or is relevant to, your claim (written comments, documents, records, etc.). Your written appeal may also include reasonable access to, and copies of, all documents, records and other information relevant to your claim. In the case of an urgent care claim, you may ask for an expedited appeal orally or in writing. You must submit your written appeal within 180 days from the date of the denial notice.

The review will take into account all comments, documents, records and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You will receive a response to the appeal within a designated response time as follows:

Claim Type	Response Time
Urgent care claims	72 hours
Pre-service claims	15 days
Post-service claims	30 days

If additional time is needed to decide on your claim because of special circumstances, you will be notified within the claim response period. However, you can ask for an extension, but the law stipulates that no additional time will be allowed.

If your appeal is denied, you will receive written notice of the decision. The notice will set forth:

- The specific reasons for the decision,
- Reference to the specific Plan provisions on which the decision was based,
- If a medical or prescription drug claim, the date of the service, name of the health care provider, and claim amount,
- If a medical or prescription drug claim, the denial code (if applicable) and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the appeal, including a discussion of the decision,
- If a medical or prescription drug claim or rescission of coverage (see below), a description of any available external review process and how to initiate an external review,

- A statement that you may receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim,
- A statement describing any additional appeal procedures, and a statement of your rights to bring suit under ERISA (see *Employee Retirement Income Security Act of 1974* for details), and
- If a medical or prescription drug claim, a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and external review processes.

Depending on the type of claim, the notice that you receive from the final review level will also contain the following information, to the extent required by law:

- If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the rule, etc., free of charge upon request.
- If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge.

Appealing a Rescission of Coverage

A rescission of coverage is a cancellation or discontinuance of medical and prescription drug coverage that is effective retroactively and that is not due to a failure to timely pay required contributions toward the cost of coverage. You do not need to file a claim regarding a rescission of coverage. If you are notified by the Plan Administrator or his or her delegate that your coverage under the Plan is being rescinded, that notification is considered to be a claim denial. You may appeal a rescission of coverage by writing to the Plan Administrator.

Other Information About the Appeals Process

The following rules apply to the appeal process:

- You have the opportunity to submit written comments, documents, records and other information relating to your claim for benefits.
- You will have reasonable access to and review, upon request and free of charge, copies of all documents, records and other information relevant to your claim, including the name of any medical or vocational expert whose advice was obtained in connection with your initial claim.
- All relevant information will be considered on appeal, even if it wasn't submitted or considered in your initial claim.
- The decision on the appeal will be made by a person or persons at the Claims Administrator who is not the person who made the initial claim decision and who is not a subordinate of that person.
- The decision will be made in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

- In making the decision on the appeal, the Claims Administrator will give no deference to the initial claim decision.
- If the determination is based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same individual who was consulted (if one was consulted) with regard to the initial claim decision and will not be a subordinate of that person.
- In the case of a medical or prescription drug appeal, if the Claims Administrator considers, relies upon or generates new or additional evidence in the process of considering your claim, such evidence will be provided to you as soon as possible in advance of the date by which the Claims Administrator is required to provide notice of its final decision on appeal.
- In the case of a medical or prescription drug appeal, if the Claims Administrator intends to issue an adverse final decision on appeal (deny your appeal in whole or part) based on a new or additional rationale, the Claims Administrator will provide you with the rationale as soon as possible in advance of the date by which the Claims Administrator is required to provide notice of its final decision on appeal.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review of the request by UnitedHealthcare,
- A referral of the request by UnitedHealthcare to the Independent Review Organization (IRO), and
- A decision by the IRO.

If your appeal relating to a medical or prescription drug claim is denied after the final level of appeal, you may have the right to request an external review. External review is available if the denial is based on:


- Medical judgment (such as requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness, or a determination that a treatment is experimental or investigational),
- Denials of appeals of rescissions of coverage, or
- As otherwise required by applicable law.

An external review request should include all of the following:

- A specific request for an external review,
- The covered person's name, address, and insurance ID number,
- Your designated representative's name and address, when applicable,
- The service that was denied, and
- Any new, relevant information that was not provided during the internal appeal.

External review is not available for claims that involve only contractual or legal interpretation without any use of medical judgment. Denials of claims based on a determination that you were not covered under the Plan or that you were not eligible for coverage under the Plan at the time you incurred the claim are not eligible for external review.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling 1-877-440-5984 or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

 **Note:** If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days after receiving your external review request, the Claims Administrator will complete a preliminary review to determine whether your request is complete and eligible for external review. That preliminary review will determine:

- Whether you were covered under the Plan at the time the item or service was requested or provided,
- Whether the final denial of your appeal related to your failure to meet the Plan's eligibility requirements,
- Whether you exhausted the Plan's internal appeal process (or are not required to exhaust the process), and
- Whether you have provided all the information and forms required to process an external review.

Within one business day after UnitedHealthcare completes its preliminary review, it will issue you a written notification. If your request is complete, but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review within the original four month filing period or, if later, the 48-hour period following your receipt of the notification.

If your request for external review is complete and eligible, the Claims Administrator will assign a qualified Independent Review Organization (IRO) to conduct the external review and within five business days after making the assignment will provide the IRO with the documents and information the claims administrator considered in making its final appeal denial.

The IRO will review all of the information and documents received and will not be bound by any decisions or conclusions reached by the Claims Administrator during the Plan's internal claim and appeal process. The IRO may also consider the following in reaching its decision:

- Your medical records,

- The attending health care professional's recommendation,
- Reports from the appropriate health care professionals and other documents submitted by the Claims Administrator,
- You or your treating provider,
- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan,
- Appropriate practice guidelines,
- Any applicable clinical review criteria developed and used by the Plan, and
- The opinion of the IRO's clinical reviewer(s).

The IRO will provide written notice to you and the Claims Administrator of the final external review decision within 45 days after the IRO receives the request for external review. The IRO's notice will contain, to the extent required by law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial,
- The date the IRO received the assignment and the date of the IRO's decision,
- References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards,
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision,
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the plan or you, and
- A statement that judicial review may be available to you; and, if applicable, current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

Under the following circumstances, you may be eligible to file for an expedited external review:

- If you receive a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Claims Administrator would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, or
- If you receive a final claim denial from the Claims Administrator and you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or
- If the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited external review, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After completing the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at 1-877-440-5984 for more information regarding external review rights, or if making a verbal request for an expedited external review.

Statute of Limitations

After you have received the response to the mandatory appeal, you may bring an action under Section 502(a) of ERISA. Such action must be filed within one year of the date on which your mandatory appeal was decided. The statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending.

Filing a Medical Claim (if your provider does not file your claim)

You or your beneficiary must file a claim in writing and within the time period prescribed in this Plan, (12 months from the date of service for out of network medical providers and 90 days for in network medical providers), or within a reasonable period if none is specified, to the Claims Administrator for the plan under which you are claiming benefits. Please refer to the *Information Sources* section at the beginning of this document to contact the Plan for information on filing a claim. If your claim for benefits is denied, in whole or in part, you may appeal the denial using the procedures in the *Filing an Appeal* section of this document.

The Claims Administrator has a specific amount of time to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act (ERISA) of 1974. The period of time the Claims Administrator has to evaluate and respond to a claim begins on the date the claim is first filed. Any claim made with respect to eligibility, participation, contributions, benefits or other aspects of the operation of the Plan should be made in writing to the Claims Administrator. The Claims Administrator will provide you with the necessary forms and make all determinations as to the right of any person to a disputed benefit.

How to File Your Medical Claim

The prompt filing of any required claim form will result in faster payment of your claim. Claim forms are not required for in-network care received from a participating provider.

You may get the required claim forms on www.myuhc.com. All fully completed claim forms and bills should be sent directly to the Claims Administrator.

Certain benefits require you to file your claim forms differently as described below.

Hospital Confinement

If possible, get your group medical coverage claim form before you are admitted to the hospital. This form will make your admission easier and any cash deposit usually required will be waived. If you have a benefit identification card, present it at the admission office when you are admitted. The card tells the hospital to send its bills directly to the Claims Administrator.

Doctor's Bills and Other Medical Expenses

The first medical claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

Claim Reminders

Be sure to use your UnitedHealthcare member ID and account number when you file claim forms.

- Your member ID is the ID shown on your benefit identification card.
- Your account number is the 7-digit policy number shown on your benefit identification card.
- Prompt filing of any required claim forms results in faster payment of your claims.



Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

How to File Your Fitness/Weight Loss Reimbursement Claim

You and/or your covered dependents are eligible to receive up to a plan year maximum of \$300 for both the fitness and weight loss benefit provide it meets the Plan requirements. To request reimbursement, complete a **UHC Fitness/Weight Loss Reimbursement** form available on Staples Benefits connection (staples.com/benefits) and mail it with the required documentation to the address noted on the form.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

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

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

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

UnitedHealthcare may apply a reimbursement methodology established by OptumInsight and/or a third party vendor, which is based on CMS coding principles, to determine appropriate

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

Administrative and Legal Service Information

The Staples, Inc. Health & Welfare Benefit Plan (the “Plan”) is a group health plan maintained to provide the benefits listed in the table below.

The vendors of fully insured benefit plans assume the risk for financing and providing all benefits under the contract. Staples, Inc. has no liability for any benefits due, or alleged to be due, under any such insurance contracts. Vendors that provide self-insured plans (some are referred to as third party administrators or TPAs) provide claims payments and other administrative services under an administrative services contract with Staples, but they do not assume any financial risk or obligation with respect to participant claims or the Plan.

Following is a list of current benefit vendors and administrative information for each plan.

Coverage/ Plan Type	Vendor/TPA Name	Funding Arrangem ent	Plan Year	Vendor/TPA Address	Source of Contributions
Medical: Open Access & Out-of-Area	UnitedHealthcare	Self- Insured	July 1 to June 30	185 Asylum Street Hartford, CT 06103-3408	Employer and Associate
Pharmacy	CVS Caremark	Self- Insured	July 1 to June 30	One CVS Drive Woonsocket, RI 02895	Employer and Associate
Pre-tax 125 Plan	Staples	Unfunded	July 1 to June 30	500 Staples Drive Framingham, MA 01702	N/A

Additional Information About This Plan

Plan Name

Staples, Inc. Health & Welfare Benefit Plan

Plan Number

501

Employer I.D. Number (EIN)

04-2896127

Type of Plan

This Plan is a health and welfare plan under ERISA providing medical benefits.

Plan Year

July 1 through June 30

Plan Funding

Benefits are funded through associate and employer contributions.

Plan Sponsor, Plan Administrator & Agent for Legal Service

Staples, Inc.
500 Staples Drive
Framingham, MA 01702
(508) 253-5000

Claims Administrator

The Claims Administrator provides information about claims payment. The Claims Administrator is UnitedHealthcare for medical and dental claims and CVS Caremark for prescription drug claims.

Claims Fiduciary and Appeals

The Claims Fiduciary is the person to whom all appeals are filed. The Claims Fiduciary is UnitedHealthcare for medical mandatory and voluntary appeals, and CVS Caremark for all prescription drug mandatory and voluntary appeals. You may contact the Claims Fiduciary as follows:

Medical Mandatory and Voluntary Appeals:	Prescription Drug Mandatory and Voluntary Appeals:
UnitedHealthcare 185 Asylum Street Hartford, CT 06103-3408	CVS Caremark Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196

Amendment or Termination of the Plan

While Staples expects to continue this Plan, it reserves the right, at any time and for any reason, to amend or terminate the Plan, in whole or in part. Staples right to amend or terminate the Plan includes, but is not limited to, changes in the eligibility requirements, premiums or other associate payments charged, benefits provided and termination of all or a portion of the coverage provided under the Plan. If the Plan is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination and your rights will be reduced, terminated, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered expenses you incurred prior to the plan amendment or termination. You will be notified of an amendment or termination of the Plan as may be required by law.

Loss of Eligibility

Everyone in your family may lose eligibility for coverage, and you may be subject to disciplinary action up to and including termination of employment if you commit fraud against the Plan, for instance, by filing claims for benefits to which you are not entitled. Coverage may also be terminated if you refuse to pay amounts erroneously paid by the Plan on your behalf or that you recover from a third party. Your participation may be terminated if you fail to comply with the terms of the Plan and its administrative requirements. You may also lose eligibility if you enroll persons who are not eligible, for instance, by covering children who do not meet the eligibility requirements.

Keep Staples Informed of Address Changes

To protect your and your family's rights, you should keep Staples informed of any changes in your and your family members' addresses. You should notify Staples HR Services at 1-888-490-4747, submit an eHelpdesk ticket or make the address change through Associate Connection (associateconnection.staples.com).

Notice of Provider Directory/Networks

You may obtain a list of providers who participate in the network by visiting www.uhc.com, www.myuhc.com or by calling the toll-free telephone number on your ID card.

Your participating provider networks consist of a group of local medical practitioners, and hospitals, of varied specialties as well as general practice who are employed by or contracted with UnitedHealthcare.

Your Rights Under ERISA

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

Receive Information About This Plan and Benefits

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying life event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you ask for a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the

materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have completed the administrative claim process. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. For more information, you may visit the Employee Benefits Security Administration website at www.dol.gov/ebsa.