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Siemens Energy, Inc. Group Insurance and Flexible Benefits Program

Summary Plan Description

Part 2 – Retiree Coverages

including

Summaries of Material Modifications

The Summary Plan Description for the **Retiree Coverages** provided under the Siemens Energy, Inc. Group Insurance and Flexible Benefits Program dated September 28, 2020, was modified by and includes the Summaries of Material Modifications dated January 1, 2024, January 1, 2023, January 1, 2022 as follows:

If you have questions about this document, call the Siemens Energy Benefits Service Center (SEBSC) at **844-950-0359**.

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What's Inside

2024 Annual Enrollment begins October 16 and ends October 27

Siemens Energy knows that your well-being is important to you and your loved ones. That's why Siemens Energy provides you, and your eligible dependents, with benefits that can help keep you healthy and protected in the year ahead.

Be sure to access the health care you need throughout the year, including preventive care, which is generally covered at 100% when visiting an in-network provider. It's also important that you see your provider annually, or more often, if needed. Remember that early detection can help you and your doctor focus on health issues before they become more serious.

Take time to review this newsletter, which provides information on your 2024 benefits.

Contributions

Medical and vision plans

For 2024, medical and vision plan premiums will change.

Medical plan changes and reminders

Due to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA):

- Visit limits for any procedure (including physical/occupational/speech therapy) that has a primary diagnosis of Mental Health/Substance Use Disorder (including autism), will no longer be capped, effective October 1, 2023.
- **Autism Spectrum Disorder** will be defined as a Mental Health condition, effective October 1, 2023.
- Visit limits on **nutritional counseling** for Mental Health/Substance Use Disorder conditions will no longer be capped, effective October 1, 2023.

Coverage for over-the-counter (OTC) hearing aids—*New*

To provide you with less expensive hearing aid options, OTC hearing aids will be covered by the Siemens Energy medical plans. Please contact your medical plan for more information.

- **UnitedHealthcare**: United Healthcare Hearing at **1-855-523-9355** or go to **uhchearing.com**

Retiree Health Savings Medical Plan

The Health Savings Account (HSA) individual contribution maximum amount will increase from $3,850 to $4,150, and the family contribution maximum will increase from $7,750 to $8,300 in 2024. If you are age 55 or older, you can continue to contribute an additional $1,000 to your HSA in 2024. All HSA contributions must be made directly through Optum Bank.

The advantages of contributing to your HSA

The money in your HSA is available to help you pay for eligible expenses. But did you know that there are several tax advantages to contributing to your HSA?

- **Tax-free distribution:** Money used on eligible health care expenses is not taxed.
- **Tax-free earnings:** Interest and investment earnings on your account are not taxed.

Retiree Health Reimbursement Medical Plan

Your Health Reimbursement Account (HRA) is a great way to help you pay for your health care expenses. Siemens Energy will continue to provide an automatic contribution to your account of $400 for you and $800 if you cover yourself and a spouse or domestic partner.

Your HRA is there for you to use to pay for eligible medical expenses. The maximum HRA balance that can roll over from year to year is $4,000.

Keep in mind that throughout the year, your HRA balance can be greater than the maximum carryover. Just be sure to use any amounts over $4,000 by the end of each year.

Any future out-of-pocket medical expenses will automatically be paid to your provider. If you turn off the automatic payment option, you choose how and when to access your account. For example, you can use your HRA to pay for a medical claim expense, or you can pay out of pocket. If you've turned off the automatic payment option, you will need to submit your claims for eligible expenses incurred in 2023 by March 31, 2024.

Vision plan reminder

If you want vision coverage, you must be enrolled in a medical plan through Siemens Energy.

Prescription drug coverage changes and reminders

CVS/caremark will continue to be the prescription drug administrator.

New PrudentRx Specialty Drug Copay Program

If you are enrolled in the **Health Reimbursement Medical Plan**, you will be eligible to enroll in the PrudentRx Copay Program, a third-party (manufacturer) copay assistance program that may help you save money on your specialty prescription(s).

If you currently take one or more medications included on the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx in early December that provides specific information about the program as it pertains to your medication.

PrudentRx Copay Program for the Health Reimbursement Medical Plan

Siemens Energy has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx program assists members by helping them enroll in manufacturer copay assistance programs. Medications on the plan's specialty drug list and exclusively dispensed by CVS Specialty are included in the program and will be subject to 30% coinsurance. However, members enrolled in the PrudentRx Copay Program who get a copay card for their specialty medication (if applicable) or who are taking a specialty medication for which no copay card is available will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

What is copay assistance?

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost-share for select medications, in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce the cost-share for eligible medications, reducing out-of-pocket expenses. Participation in the program may require certain data to be shared with the administrators of these copay assistance programs, but be assured that this is done in compliance with HIPAA.

How am I notified that I qualify for this specialty drug program?

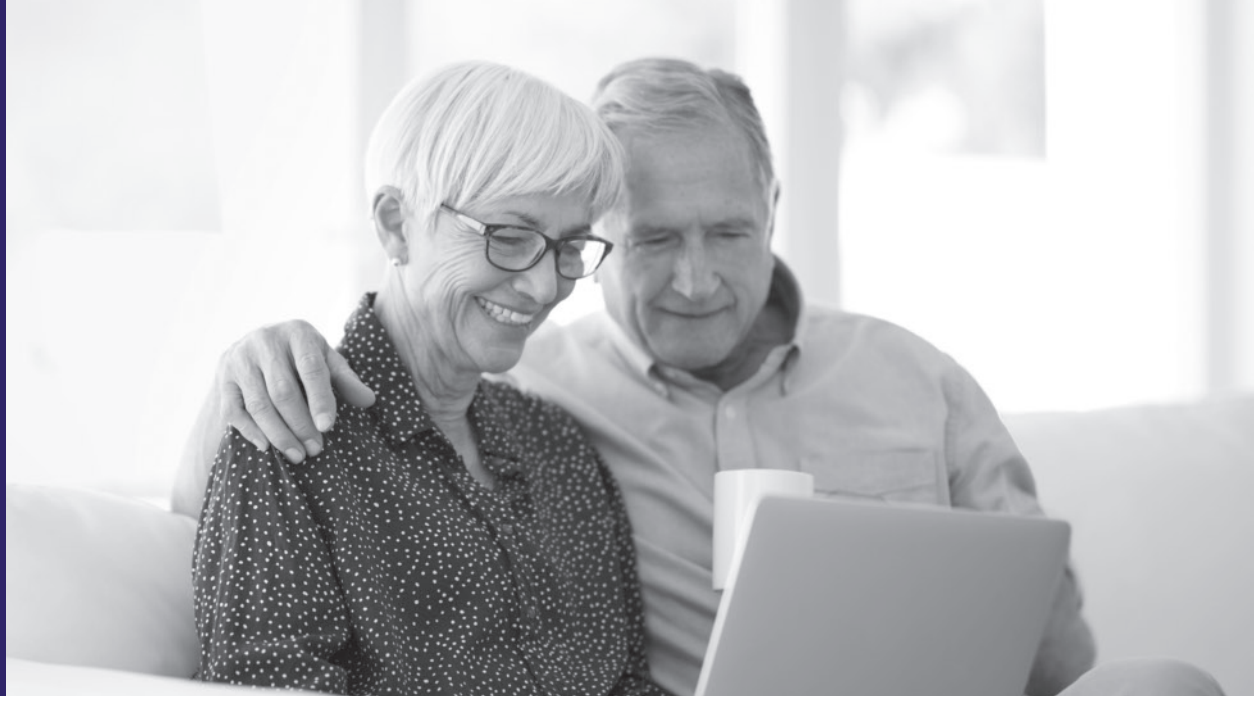
- If you currently take one or more medications included on the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx in early December that provides specific information about the program as it pertains to your medication.
- All eligible members will be automatically enrolled in the PrudentRx program, but you may call **1-800-578-4403** to opt out once you receive your welcome letter.
- Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications—in that case, you must speak to someone at PrudentRx at **1-800-578-4403** to provide any additional information needed to enroll in the copay program. PrudentRx will proactively contact you to initiate this process.
- PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for the full amount of the 30% coinsurance on specialty medications that are eligible for the PrudentRx program.
- If you or a covered family member is not currently taking but will start a new specialty medication covered under the PrudentRx Copay Program, you may reach out to PrudentRx to enroll; otherwise, they will proactively contact you so that you can take full advantage of the PrudentRx program.
- The PrudentRx Program Drug List may be updated periodically. The current drug list is available at **prudentrx.com/prudentes**.

How does this program affect my plan costs and out-of-pocket maximum?

If an eligible specialty medication does not qualify as an "essential health benefit" under the Affordable Care Act, member cost-share payments for this medication, whether made by you or a manufacturer copayment assistance program, do not count toward the plan's prescription drug out-of-pocket maximum. A list of specialty medications that are not considered to be essential health benefits is available by contacting PrudentRx. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

How do I contact PrudentRx?

PrudentRx can be reached at **1-800-578-4403** to answer any questions regarding the PrudentRx Copay Program.



Make your 2024 decisions

There are two ways for you to enroll or make changes between October 16 and October 27:

1. **By phone:** Call the Siemens Energy Benefits Service Center (SEBSC) at **1-844-950-0359**, weekdays from 10 a.m. to 6 p.m. Eastern Time. Representatives can answer questions about benefits eligibility, pricing and coverage. When you call, you must provide your SEBSC phone PIN. You will be given the option of receiving your Confirmation of Enrollment (COE) via email or U.S. mail.
2. **Online:** Log on to **yourEnergyBenefits.com** and enter your User ID and Password. If you don't remember them, see the "Forgot UserID or Password?" chart on page 5.

   - **Make your elections.** Review the information on the **Enrollment** page, consider your options and choices for 2024, and make your elections.
   - **Select Complete Enrollment** to submit your elections. When you see the **Completed Successfully** screen, you know that your elections have been submitted.
   - **Print your confirmation when prompted** (only available through the online system during Annual Enrollment) and review it carefully. After enrollment closes, you can review your elections at any time by selecting **Future Coverage** under the **Health and Insurance** tab.
   - **Look for a confirmation email** if you provided a personal email address and elected to receive electronic communications. If you do not have an email address on file, a Confirmation of Enrollment (COE) will be sent to you via U.S. mail. You can make changes to your benefit plan options for 2024 until the end of your enrollment period, October 27, 2023.

Dropping coverage

You can drop coverage for yourself and/or your dependents at any time by calling the SEBSC, and you can re-enroll provided you have had continuous coverage other than through Medicare. You will be required to confirm that you had coverage elsewhere during the period you were not enrolled in the Company's retiree health care plans.

Forgot your password for yourEnergyBenefits.com?

- Go to **yourEnergyBenefits.com**.
  - —At the login screen, select **Forgot UserID or Password?**
- For security purposes, you'll be asked to provide:
  - —The last four digits of your Social Security Number
  - —Your date of birth
- You can then select to either receive a:
  - —One-time access code via text messaging or via phone call; or
  - —Temporary password via U.S. mail

Forgot your SEBSC phone PIN?

- Contact the SEBSC at **1-844-950-0359**.
- For security purposes, you'll be asked to provide:
  - —The last four digits of your Social Security Number
  - —Your date of birth
- Once your identity is verified, the SEBSC representative will send a one-time access code to your mobile phone, if one is on file. Otherwise, a new phone PIN will be sent to your address via U.S. mail.

Take your benefits on the go with the Alight Mobile app

Access your benefits anytime, anywhere, using the free Alight Mobile app. Download it on the App Store or Google Play.

What happens if you do not enroll

If you are currently enrolled in a Siemens Energy medical, dental and/or vision plan, your current elections will automatically carry over to 2024.

Post-age 65 Medicare-eligible retirees and covered dependents

When you and/or any of your covered dependents turn age 65 and become eligible for Medicare, you will no longer be eligible for post-retirement health care coverage (medical, dental, prescription drug and vision) under the Siemens Energy, Inc., Group Plans. However, you or your covered dependent will be able to take advantage of a service offered by Alight Retiree Health Exchange™, which can help you select and enroll you or your covered dependent in an individual health plan. The individual health plan market offers Medicare-eligible participants a variety of medical, prescription drug, dental and vision plan options, which allow retirees to choose an individual plan that meets their coverage needs.

Alight Retiree Health Exchange is an independent insurance service provider that offers guided access for Medicare-eligible retirees and dependents to individual market-based health plans from many of America's leading insurance providers. This voluntary service provides personal guidance, enrollment assistance and advocacy along the way—all at no cost to retirees. It's important to note that post-age 65 retirees and their post-age 65 covered dependents may enroll in individual health plans offered from alternate sources other than Alight Retiree Health Exchange, such as directly through insurance carriers.

As you or your covered dependent approach age 65, you'll receive more information about your options from Alight Retiree Health Exchange.

Protecting your privacy

Your information is personal—and Siemens Energy wants to help you safeguard your information. Your mobile number is a safer way to communicate. You may opt in to text messaging to receive select notifications through **yourEnergyBenefits.com**. Be sure to review, add or update your mobile number to help safeguard against fraudulent activity and identity theft.

Step 1: Go to **yourEnergyBenefits.com**.

Step 2: From **Your Profile** select **Personal Information** and add or update your mobile number.

Step 3: From **Your Profile** select **Manage Communications** to elect opt-in text messaging under **Delivery Preference**.

Additional information and notices

Summary of Material Modifications

This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2024. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Energy, Inc. Group Insurance and Flexible Benefits Program–Part 2 Retiree Program dated September 28, 2020, 2022 and 2023 SMM cover pages.

Keep this newsletter with the SPD you have already received. If you have any questions about this SMM or want a complete copy of the SPD, please contact the SEBSC at **1-844-950-0359**.

Compare medical plans with Summaries of Benefits and Coverage (SBCs)

The SBCs for the medical plans are available at **yourEnergyBenefits.com**. They summarize important information in a standard format, so you can compare across all plan options. To access the SBCs on the site, select the **Health and Insurance** tab from the home page, and under **Coverage Details**, select **Plan Information**.

You may also obtain a paper version of the SBC for any of the medical plan options, free of charge, by contacting the SEBSC at **1-844-950-0359**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in Health Programs and Activities

Learn how Siemens Energy is committed to protecting retirees and their families from discrimination under our health care programs by reviewing the enclosed notice.

HIPAA Privacy Notice reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens Energy to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens Energy is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on **yourEnergyBenefits.com** or call the SEBSC at **1-844-950-0359** to request a paper copy.

Dropping dependent coverage during Annual Enrollment

If you believe you will need to drop or change dependent coverage during or close to Annual Enrollment due to a qualified life event (such as marriage, birth of a child, divorce or a dependent no longer meeting the age requirements), make sure you follow the change-in-status process by notifying the SEBSC at **1-844-950-0359** within 30 days after the event.

If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent will not be eligible for COBRA coverage, but may be able to obtain coverage through a state Health Insurance Marketplace.

Paying for your benefits

Please contact the SEBSC at **1-844-950-0359**, weekdays from 10 a.m. to 6 p.m. Eastern Time if you want to change how you pay your monthly premiums.

Complete details of the various benefits offered under the Siemens Energy benefit program can be found in the legal plan documents and insurance contracts that govern the plans in the program (i.e., the Summary Plan Description and applicable Summaries of Material Modifications and insurance contracts that govern the plan and program). If there is a difference between this information and the documents and contracts, the documents and contracts will govern. Siemens Energy, Inc., as the plan sponsor of the Siemens Energy benefit plans, reserves the right to amend or terminate the plans or any part of the plans it sponsors at any time and for any reason.

January, 2023

Siemens Energy evaluates the impact of COVID-19 as information is made available and new directives are being issued by federal and local authorities. This provides important benefits reminders to help support you during this time.

Coverage for At-Home Over-the-Counter (OTC) COVID-19 Diagnostic Tests

Effective January 15, 2022 and continuing for the duration of the public health emergency period (PHE), the cost of at-home OTC COVID-19 tests used for diagnostic purposes will be covered with no member cost share for those enrolled in a Siemens Energy medical and prescription drug plan.

Coverage details:

- U.S. Food and Drug Administration (FDA) authorized or approved OTC COVID-19 diagnostic at-home tests will be covered without a doctor's prescription or clinical assessment by a healthcare provider, limited to 8 tests per member per month.
  Note: *If purchasing a test kit that includes two tests, that will count as two of the eight covered tests.*
- The tests are to be purchased for diagnostic purposes (for example, the individual is symptomatic or believed to have been exposed to COVID-19). COVID-19 tests purchased for employment purposes are not covered.
- If you are enrolled in Cigna International, contact them directly to understand if they have a network or preferred retailer for at-home OTC COVID-19 tests or if you will need to pay first and submit a claim for reimbursement.

Coverage for COVID-19 Oral Antiviral Therapeutic Drugs

Late December 2021, Pfizer and Merck received an Emergency Use Authorization (EUA) from the FDA for its oral antiviral therapy for COVID-19.

- Members with prescription drug coverage through CVS/caremark, will pay no out-of-pocket costs for the medications.
- Members enrolled under Cigna International's prescription drug plan may be responsible for dispensing fees at the pharmacy. Check with Cigna for details.

Summary of Material Modifications (SMM)

The Health and Group Benefits Updates section of this document serves as a Summary of Material Modifications (SMM) for benefit changes effective 2023. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Energy, Inc. Group Insurance and Flexible Benefits Program dated January 1, 2021 and subsequent SMMs dated 2022. It also supplements or modifies the information presented in the SPD for the Siemens Energy Group Insurance and Flexible Benefits Program – Retiree Coverages Parts 2, 2A, 2C dated September 28, 2020 and subsequent SMMs dated 2022.

Keep this information with the SPD you have already received. If you have any questions about this SMM or want a complete copy of the SPD, please contact the Siemens Energy Benefits Service Center (SEBSC) at **844-950-0359**.

SIEMENS energy

What's Inside

2023 Annual Enrollment begins October 10 and ends October 21

Siemens Energy knows that your well-being is important to you and your loved ones. That's why Siemens Energy provides you, and your eligible dependents, with benefits that support your overall well-being.

Be sure to access the health care you need throughout the year, including preventive care, which is generally covered at 100% when visiting an in-network provider. It's also important that you see your provider annually, or more often, if needed. Remember that early detection can help you and your doctor focus on health issues before they become more serious.

Take time to review this newsletter, which provides information on your 2023 benefits.

Contributions

Medical and dental plans

For 2023, medical and dental plan premiums will change.

Medical plan changes and reminders

Retiree Health Savings Medical Plan

The Health Savings Account (HSA) individual contribution maximum amount will increase from $3,650 to $3,850, and the family contribution maximum will increase from $7,300 to $7,750 in 2023. If you are age 55 or older, you can continue to contribute an additional $1,000 to your HSA in 2023. All HSA contributions must be made directly through Optum Bank.

The advantages of contributing to your HSA

The money in your HSA is available to help you pay for eligible expenses. But did you know that there are several tax advantages to contributing to your HSA?

- **Tax-free distribution:** Money used on eligible health care expenses is not taxed.
- **Tax-free earnings:** Interest and investment earnings on your account are not taxed.

Retiree Health Reimbursement Medical Plan

Your Health Reimbursement Account (HRA) is a great way to help you pay for your health care expenses. Siemens Energy will continue to provide an automatic contribution to your account of $400 for you and $800 if you cover yourself and a spouse or domestic partner.

Your HRA is there for you to use to pay for eligible medical expenses. The maximum HRA balance that can roll over from year to year is $4,000.

Keep in mind that throughout the year, your HRA balance can be greater than the maximum carryover. Just be sure to use any amounts over $4,000 by the end of each year.

Any future out-of-pocket medical expenses will automatically be paid to your provider. If you turn off the automatic payment option, you choose how and when to access your account. For example, you can use your HRA to pay for a medical claim expense, or you can pay out of pocket. If you've turned off the automatic payment option, you will need to submit your claims for eligible expenses incurred in 2022 by March 31, 2023.

Vision plan reminder

In order for you to have vision coverage, you must be enrolled in a medical plan through Siemens Energy.

CVS/caremark prescription drug coverage

CVS/caremark will continue to be the prescription drug administrator.

Protecting your privacy

Your information is personal—and Siemens Energy wants to help you safeguard your information. Your mobile number is a safer way to communicate. You may opt in to text messaging to receive select notifications through **yourEnergyBenefits.com**. Be sure to review, add or update your mobile number to help safeguard against fraudulent activity and identity theft.

Step 1: Go to **yourEnergyBenefits.com**.

Step 2: From **Your Profile** select **Personal Information** and add or update your mobile number.

Step 3: From **Your Profile** select **Manage Communications** to elect opt-in text messaging under **Delivery Preference**.

Make your 2023 decisions

There are two ways for you to enroll or make changes between October 10 and October 21:

1. **By phone:** Call the Siemens Energy Benefits Service Center (SEBSC) at **1-844-950-0359**, weekdays from 10 a.m. to 6 p.m. Eastern Time. Representatives can answer questions about benefits eligibility, pricing and coverage. When you call, you must provide your SEBSC phone PIN. You will be given the option of receiving your Confirmation of Enrollment (COE) via email or U.S. mail.
2. **Online:** Log on to **yourEnergyBenefits.com** and enter your User ID and Password. If you don't remember them, see the "Forgot UserID or Password?" chart on page 5.

   - **Make your elections.** Review the information on the **Enrollment** page, consider your options and choices for 2023, and make your elections.
   - **Select Complete Enrollment** to submit your elections. When you see the **Completed Successfully** screen, you know that your elections have been submitted.
   - **Print your confirmation when prompted** (only available through the online system during Annual Enrollment) and review it carefully. After enrollment closes, you can review your elections at any time by selecting **Future Coverage** under the **Health and Insurance** tab.
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Dropping coverage

You can drop coverage for yourself and/or your dependents at any time by calling the SEBSC, and you can re-enroll provided you have had continuous coverage other than through Medicare. You will be required to confirm that you had coverage elsewhere during the period you were not enrolled in the Company's retiree health care plans.

Forgot your password for yourEnergyBenefits.com?

- Go to **yourEnergyBenefits.com**.
  - —At the login screen, select **Forgot UserID or Password?**
- For security purposes, you'll be asked to provide:
  - —The last four digits of your Social Security Number
  - —Your date of birth
- You can then select to either receive a:
  - —One-time access code via text messaging or via phone call; or
  - —Temporary password via U.S. mail

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What happens if you do not enroll

If you are enrolled in a Siemens Energy 2022 medical, dental and/or vision plan, your current elections will carry over to 2023.

Post-age 65 Medicare-eligible retirees and covered dependents

When you and/or any of your covered dependents turn age 65 and become eligible for Medicare, you will no longer be eligible for post-retirement health care coverage (medical, dental, prescription drug and vision) under the Siemens Energy, Inc., Group Plans. However, you or your covered dependents will be able to take advantage of a service offered by Alight Retiree Health Solutions™, which can help you select and enroll you or your covered dependents in an individual health plan. The individual health plan market offers Medicare-eligible participants a variety of medical, prescription drug, dental and vision plan options, which allow retirees to choose an individual plan that meets their coverage needs.

Alight Retiree Health Solutions is an independent insurance service provider that offers guided access for Medicare-eligible retirees and dependents to individual market-based health plans from many of America's leading insurance providers. This voluntary service provides personal guidance, enrollment assistance and advocacy along the way—all at no cost to retirees. It's important to note that post-age 65 retirees and their post-age 65 covered dependents may enroll in individual health plans offered from alternate sources other than Alight Retiree Health Solutions, such as directly through insurance carriers.

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Nondiscrimination in Health Programs and Activities

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HIPAA Privacy Notice reminder

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SIEMENS energy

What's Inside

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Any future out-of-pocket medical expenses will automatically be paid to your provider. If you turn off the automatic payment option, you choose how and when to access your account. For example, you can use your HRA to pay for a medical claim expense, or you can pay out of pocket. If you've turned off the automatic payment option, you will need to submit your claims for eligible expenses incurred in 2021 by March 31, 2022.

Vision plan reminder

In order for you to have vision coverage, you must be enrolled in a medical plan through Siemens Energy.

CVS/caremark prescription drug coverage

CVS/caremark will continue to be the prescription drug administrator.

Consumer Price Index

For retirees covered under the Pre-1991 Cost-Sharing Arrangement, Siemens Energy will contribute toward the increase in the cost of your 2021 medical coverage over the cost of last year's coverage up to the medical care component of the CPI-W for the 12-month period that ended April 2021. Any of the 2022 cost increase that exceeds the medical care component of the CPI-W will be reflected in your share of the cost for retiree medical coverage. The medical care component increase in the CPI-W from April 2020 to April 2021 was 2%. To find more detailed information:

- Visit **https://www.bls.gov/cpi/tables/supplemental-files/home.htm**.
- Go to **April 2021** and select **CPI-W**.
- View line 39 (column AD) in the MS Excel file.

Protecting your privacy

Your information is personal—and the Company wants to help you safeguard your information. Your mobile number is a safer way to communicate. You may opt in to text messaging to receive select notifications through **yourEnergyBenefits.com**. Be sure to review, add or update your mobile number to help safeguard against fraudulent activity and identity theft.

Step 1: Go to **yourEnergyBenefits.com**.

Step 2: From **Your Profile** select **Personal Information** and add or update your mobile number.

Step 3: From **Your Profile** select **Manage Communications** to elect opt-in text messaging under **Delivery Preference**.

Make your 2022 decisions

There are two ways for you to enroll or make changes between October 11 and October 22:

1. **By phone:** Call the Siemens Energy Benefits Service Center (SEBSC) at **1-844-950-0359**, weekdays from 10 a.m. to 6 p.m. Eastern Time. Representatives can answer questions about benefits eligibility, pricing and coverage. When you call, you must provide your SEBSC phone PIN. You will be given the option of receiving your Confirmation of Enrollment (COE) via email or U.S. mail.
2. **Online:** Log on to **yourEnergyBenefits.com** and enter your User ID and Password. If you don't remember them, see the "Forgot UserID or Password?" chart on page 5.

   - **Make your elections.** Review the information on the **Enrollment** page, consider your options and choices for 2022, and make your elections.
   - **Select Complete Enrollment** to submit your elections. When you see the **Completed Successfully** screen, you know that your elections have been submitted.
   - **Print your confirmation when prompted** (only available through the online system during Annual Enrollment) and review it carefully. After enrollment closes, you can review your elections at any time by selecting **Future Coverage** under the **Health and Insurance** tab.
   - **Look for a confirmation email** if you have provided a personal email address and elected to receive electronic communications. If you do not have an email address on file, a Confirmation of Enrollment (COE) will be sent to you via U.S. mail. You can make changes to your benefit plan options for 2022 until the end of your enrollment period, October 22, 2021.

Dropping coverage

You can drop coverage for yourself and/or your dependents at any time by calling the SEBSC, and you can re-enroll provided you have had continuous coverage other than through Medicare. You will be required to confirm that you had coverage elsewhere during the period you were not enrolled in the Company's retiree health care plans.

Forgot your password for yourEnergyBenefits.com?

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- For security purposes, you'll be asked to provide:
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What happens if you do not enroll

If you are enrolled in a Siemens Energy 2021 medical, dental and/or vision plan, your current elections will carry over to 2022.

Post-age 65 Medicare-eligible retirees and covered dependents

When you and/or any of your covered dependents turn age 65 and become eligible for Medicare, you will no longer be eligible for post-retirement health care coverage (medical, dental, prescription drug and vision) under the Siemens Energy, Inc., Group Plans. However, you or your covered dependent will be able to take advantage of a service offered by Aon Retiree Health Exchange™, which can help you select and enroll you or your covered dependent in an individual health plan. The individual health plan market offers Medicare-eligible participants a variety of medical, prescription drug, dental and vision plan options, which allow retirees to choose an individual plan that meets their coverage needs.

Aon Retiree Health Exchange is an independent insurance service provider that offers guided access for Medicare-eligible retirees and dependents to individual market-based health plans from many of America's leading insurance providers. This voluntary service provides personal guidance, enrollment assistance and advocacy along the way—all at no cost to retirees. It's important to note that post-age 65 retirees and their post-age 65 covered dependents may enroll in individual health plans offered from alternate sources other than Aon Retiree Health Exchange, such as directly through insurance carriers.

As you or your covered dependent approach age 65, you'll receive more information about your options from Aon Retiree Health Exchange.

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This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2022. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Energy, Inc. Group Insurance and Flexible Benefits Program dated January 1, 2021.

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The SBCs for the medical plans are available at **yourEnergyBenefits.com**. They summarize important information in a standard format, so you can compare across all plan options. To access the SBCs on the site, select the **Health and Insurance** tab from the home page, and under **Coverage Details**, select **Plan Information**.

You may also obtain a paper version of the SBC for any of the medical plan options, free of charge, by contacting the SEBSC at **1-844-950-0359**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in Health Programs and Activities

Learn how Siemens Energy is committed to protecting retirees and their families from discrimination under our health care programs by reviewing the enclosed notice.

HIPAA Privacy Notice reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens Energy is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on **yourEnergyBenefits.com** or call the SEBSC at **1-844-950-0359** to request a paper copy.

Dropping dependent coverage during Annual Enrollment

If you believe you will need to drop or change dependent coverage during or close to Annual Enrollment due to a qualified life event (such as marriage, birth of a child, divorce or a dependent no longer meeting the age requirements), make sure you follow the change-in-status process by notifying the SEBSC at **1-844-950-0359** within 30 days after the event.

If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent will not be eligible for COBRA coverage, but may be able to obtain coverage through a state Health Insurance Marketplace.

Paying for your benefits

Please contact the SEBSC at **1-844-950-0359**, weekdays from 10 a.m. to 6 p.m. Eastern Time if you want to change how you pay your monthly premiums.

Complete details of the various benefits offered under the Siemens Energy benefit program can be found in the legal plan documents and insurance contracts that govern the plans in the program (i.e., the Summary Plan Description and applicable Summaries of Material Modifications and insurance contracts that govern the plan and program). If there is a difference between this information and the documents and contracts, the documents and contracts will govern. Siemens Energy, Inc., as the plan sponsor of the Siemens Energy benefit plans, reserves the right to amend or terminate the plans or any part of the plans it sponsors at any time and for any reason.

CPI

SIEMENS energy

What's Inside

2022 Annual Enrollment begins October 11 and ends October 22, 2021

Siemens Energy knows that your well-being is important to you and your loved ones. That's why the Company provides you, and your eligible dependents, with benefits that support your overall well-being.

Be sure to access the health care you need throughout the year, including preventive care, which is generally covered at 100% when visiting an in-network provider. It's also important that you see your provider annually, or more often, if needed. Remember that early detection can help you and your doctor focus on health issues before they become more serious.

Take time to review this newsletter, which provides information on your 2022 benefits.

Contributions

Medical and dental plans

For 2022, medical and dental plan premiums will change.

Medical plan changes and reminders

Retiree Health Savings Medical Plan

The Health Savings Account (HSA) individual contribution maximum amount will increase from $3,600 to $3,650, and the family contribution maximum will increase from $7,200 to $7,300 in 2022. If you are age 55 or older, you can continue to contribute an additional $1,000 to your HSA in 2022. All HSA contributions must be made directly through Optum Bank.

The advantages of contributing to your HSA

The money in your HSA is available to help you pay for eligible expenses. But did you know that there are several tax advantages to contributing to your HSA?

- **Tax-free distribution:** Money used on eligible health care expenses is not taxed.
- **Tax-free earnings:** Interest and investment earnings on your account are not taxed.

Retiree Health Reimbursement Medical Plan

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Search by key words or use the .PDF bookmarks or the Table of Contents or hyperlinked text to navigate this document

Siemens Energy, Inc. Group Insurance and Flexible Benefits Program – Part 2 Retiree Program

Retiree Medical Coverage Options:

- **Retiree Health Savings Medical Plan**
- **Retiree Health Reimbursement Medical Plan**
- **Retiree 90/10 Medicare Carve-Out Medical Plan**

Retiree Dental Coverage Option

Retiree Vision Coverage Options:

- **Basic, Enhanced, and Premier**

Retiree Life Insurance

Available to Certain Retirees and Their Eligible Dependents

Effective: September 28, 2020

TABLE OF CONTENTS

SECTION 1 – WELCOME

This Summary Plan Description ("SPD") for certain retiree component plans (the "Retiree Program") under the Siemens Energy, Inc. Group Insurance and Flexible Benefits Program (the "Plan") explains:

- Who is eligible to enroll in Retiree Medical (including Prescription Drug) Coverage, Dental Coverage and/or Vision Coverage) and who is eligible to receive Retiree Life Insurance coverage.
- How Benefits are paid.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- Your rights and responsibilities under the Retiree Program.

How to Use This SPD

- Read the entire SPD and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future Summary of Material Modifications on the **yourenergybenefits.com** website or may request printed copies by contacting the Siemens Energy Benefits Service Center (SEBSC) at **1-844-950-0359**.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control. However, the applicable insurance company contracts will control in the event of a conflict with the insurance-related terms of this SPD.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

IMPORTANT!
A healthcare service, procedure, treatment, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (For definitions of Medically Necessary and Covered Health Service, see Section 22, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Retiree Program.

If you (and/or your Dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice regarding Medicare and prescription drug coverage in Section 14 for more details.

UnitedHealthcare is the Claims Administrator for the self-insured Retiree Medical Coverage options offered in this Retiree Program, and CVS Caremark administers the prescription drug coverage. The Retiree Program offers three medical options, all of which provide Benefits for the same Covered Health Services. This SPD explains the differences in how each of the three options work and describes the Benefits made available to you and your covered family members. The Retiree Health Savings Medical Plan option includes a Health Savings Account ("HSA") feature and is not available to anyone who is enrolled in Medicare. The Retiree Health Reimbursement Medical Plan option includes a Health Reimbursement Account ("HRA") feature and is an alternative to the Retiree Health Savings Medical Plan option if you are under age 65. The Retiree 90/10 Medicare Carve-Out Medical Plan option coordinates benefits with Medicare Part A and Part B. For those who qualify, the Retiree 90/10 Medicare Carve-Out Medical Plan is the only option available to you if you are enrolled in Medicare.

Retiree Medical Quick Reference Box

- UnitedHealthcare Group Policy Number: **921844**
- UnitedHealthcare member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Services Administrator: **1-833-593-4147** or www.myuhc.com
- Optum Bank (HSA claims administrator): **1-866-234-8913** or **https://www.optumbank.com/**
- Mail medical claims to: UnitedHealthcare, Claims, P.O. Box 740800, Atlanta, GA 30374-0800

Prescription Drug Quick Reference Box

- CVS/caremark member services: **1-888-996-0024** or https://www.caremark.com
- Mail prescription drug claims to: P.O. Box 52196, Phoenix, AZ 85072-2196

Delta Dental of New York is the Claims Administrator for the self-insured Retiree Dental Coverage offered in this Retiree Program. If you are eligible for Retiree Medical Coverage, you may enroll in Retiree Dental Coverage, even if you do not elect to enroll in Retiree Medical Coverage.

Retiree Dental Quick Reference Box

- Delta Dental member services: **1-888-894-7039** or **https://www1.deltadentalins.com/group-sites/siemensenergy.html**
- Mail dental claims to: Delta Dental – Claims, P.O. Box 2105, Mechanicsburg, PA 17055-6999

EyeMed is the insurer and Claims Administrator for the three Retiree Vision Coverage options offered in the Retiree Program. If you are enrolled in Retiree Medical Coverage, you may also elect Retiree Vision Coverage. Your eligible Dependents enrolled in Retiree Medical Coverage will also be eligible to enroll in the Retiree Vision Coverage.

Retiree Vision Quick Reference Box

- To find an EyeMed ***Insight*** Network participating provider, contact member services: **1-866-800-5457** or https://member.eyemedvisioncare.com/siemens/en
- Mail Out-of-Network claims to: First American Administrators, Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

Retiree Life Insurance Coverage is available to limited groups of retirees. Life Insurance coverage is insured by The Hartford. Retiree Life Insurance Coverage is not an elective benefit. A limited group of retirees continue to be eligible for retiree life insurance coverage through the Retiree Program.

Retiree Life Insurance Quick Reference Box

- The Hartford member services: **1-888-301-5615** (life claims)

Please read this SPD thoroughly to learn how the Retiree Program works. If you have questions, contact the SEBSC at **1-844-950-0359** or call the number on the back of the member ID card for your Plan option.

SECTION 2 – ELIGIBILITY, ENROLLMENT, AND COST

What this section includes:
- Who is eligible for coverage under the Retiree Program
- The factors that impact your cost for Retiree Medical Coverage
- Instructions and timeframes for enrolling yourself and your eligible Dependents
- When coverage begins
- When you can make changes under the Retiree Program

Eligibility

Your eligibility to receive benefits under the Retiree Program generally depends on whether you are eligible to enroll in the Retiree Medical Coverage, even if you do not elect medical coverage. You are eligible to enroll in the Retiree Medical Coverage, as it may be amended or terminated in the future, if you terminate employment:

- From Siemens Energy and from a covered employment status (job or position in which you were scheduled to work a minimum of 20 hours per week) after reaching age 55; *and*
- You have at least 10 years of eligible service in a covered employment status (job or position in which you were scheduled to work a minimum of 20 hours per week) with Siemens Energy; *and*
- You are under age 65. The limited exceptions to this age restriction and eligibility for coverage after age 65 are described below.

If you are eligible for Retiree Medical Coverage, you may also be eligible to elect Dental Coverage and/or Vision Coverage under the Retiree Program.

Effective with employment terminations on or after August 1, 2009, Siemens Corporation expanded access to the Retiree Program to certain long-service non-union employees and to employees who were members of the Houston IBEW Local 716 or the Federation of Independent Salaried Unions and its Affiliates in the Pittsburgh area (FISU) who terminate employment with Siemens Energy (and previously with Siemens Corporation) but do not meet the minimum age 55 eligibility requirement for Retiree Coverages. You and your eligible Dependents are eligible to enroll in the elective Plan options provided under the Retiree Program, as it may be amended or terminated in the future, on an "**Access-only**" basis if you terminate employment:

- From Siemens Energy and from a covered employment status (job or position in which you were scheduled to work a minimum of 20 hours per week) after reaching age 50; *and*
- The sum of your age in full years (rounded down) plus full years of eligible service (rounded down) in a covered employment status (job or position in which you were scheduled to work a minimum of 20 hours per week) with an SOC that participates in the Retiree Program equals at least 75; *and*
- You are under age 65 (unless you are enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan option).

"Access-only" means that you will be responsible for paying 100% of the cost of coverage under the Retiree Medical Coverage for you and any enrolled eligible

Dependents. "Access-only" coverage ends when any enrolled eligible individual reaches age 65.

Important

- Your years of service used to determine your eligibility and cost to enroll in coverage under the Retiree Program will include periods during which you are employed at Siemens Energy in a position that is eligible for the Retiree Program. For Transferring Employees, as defined in the Siemens Energy, Inc. Pension Plan, your years of service as an employee of Siemens Corporation prior to September 28, 2020 count for purposes of determining your eligibility for and cost to enroll in the Retiree Program. For Siemens Energy employees hired between September 29, 2020 and December 31, 2021 from a Siemens Energy affiliate or a Siemens Corporation affiliate, your years of services with the Siemens Energy affiliate or Siemens Corporation affiliate will also count for purposes of determining your eligibility to enroll in the Retiree Program.
- Service with an acquired business prior to ownership by Siemens Energy is usually excluded in determining eligibility and cost-sharing for Retiree coverage (see *Employee as a Result of an Acquisition, Merger or Joint-Venture* below).
- Employees covered by a collective bargaining agreement are not eligible for the Retiree Program unless the collective bargaining agreement in effect when they terminated employment specifically provided or provides for such Retiree coverages.
- Retiree coverages are not offered to post-age-65 non-union retirees and their post-age-65 Dependents or to post-age 65 Retirees who were members of the Houston IBEW Local 716 or the Federation of Independent Salaried Unions and its Affiliates in the Pittsburgh area (FISU) and their post-age-65 covered Dependents. However, certain small, defined groups of retirees who retired before January 1, 2002, and their Dependents who were already enrolled in or eligible for coverage under Siemens Corporation-sponsored post-age-65 health benefits plans on December 31, 2012, are "grandfathered" and continue to receive Retiree coverage, as described below.
- Effective September 28, 2020, Siemens Corporation spun off the assets and liabilities from the Siemens Group Insurance and Flexible Benefits Program to the Siemens Energy Group Insurance and Flexible Benefits Plan for (1) former employees of Siemens Energy or one of its affiliates (as defined in the Siemens Energy, Inc. Pension Plan); and (2) Transferring Employees, as defined in the Siemens Energy, Inc. Pension Plan, who in either case were eligible under the Siemens Group Insurance and Flexible Benefits Program - Part 2 Retiree Program on September 27, 2020.
- The SEBSC is responsible for maintaining eligibility service data. If you have any questions, you can call the SEBSC at **1-844-950-0359**. Representatives are available to assist you from 10 a.m. to 6 p.m., Eastern Time, Monday through Friday.

Your eligible Dependents may also participate in the Retiree Program. The following are eligible Dependents:

- Your Spouse or Domestic Partner who is under age 65 (unless he or she is enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan Option).
- Your or your Spouse's or Domestic Partner's child who is under age 26, including a natural child, stepchild, a legally adopted child (from the date of placement in the home or from birth, provided that a written agreement to adopt the child has been entered into prior to the child's birth), a child placed with you for adoption or a child for whom you or your Spouse are the legal guardian. A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order, as described in Section 21, *Other Important Information*.
  - As long as you are a Retiree Program participant, coverage may be continued indefinitely for your unmarried child who is incapable of self-care and dependent on you for a significant portion of living expenses and other financial support because of a physical or mental handicap (as determined by the Claims Administrator and subject to periodic review). However, the handicap must have occurred before the child's eligibility ceased or would have ceased had they been a covered Dependent under the Retiree Program. A final determination by the Claims Administrator must be made as to the child's handicapped status ***before*** the child's eligibility ceases.
- If you and your Spouse or Domestic Partner are both eligible for the Retiree Program, your child may be covered as the Dependent of only one parent. A child is considered "placed with you for adoption" when you assume and retain a legal obligation for support of that child in anticipation of adoption. The child is no longer considered "placed with you for adoption" when this legal obligation ends.

Important

- A Dependent child may not enroll in Retiree Medical, Dental, or Vision coverage during your lifetime unless you or your Spouse or Domestic Partner are also enrolled. However, if you are not enrolled in the Retiree Program, you die before reaching age 65, and you would have been eligible for the Retiree Program if you had terminated employment on the day before your death, your surviving Spouse or Domestic Partner under age 65 and any eligible child may enroll in the Retiree Program. If you lose eligibility for the Retiree Program when you reach age 65, your Spouse or Domestic Partner who is under 65 years of age and any eligible enrolled child may continue coverage until your Spouse or Domestic Partner reaches age 65.

Cost of Coverage

Unless you are an "access-only" participant, you and the Siemens Energy entity from which you retire share in the cost of the Retiree Medical Coverage. Your monthly cost for Retiree Medical Coverage depends on the Dependents you choose to enroll and the cost-sharing provisions that apply to retirees in your group. If you are eligible to participate in the Retiree Program on an "**access-only**" basis, you pay the **full cost** of Retiree Medical Coverage for yourself and your enrolled Dependents.

You will pay the full cost if you elect Retiree Dental Coverage. If you are enrolled in Basic Retiree Vision Coverage, Siemens Energy pays the full cost for you and your covered Dependents. However, you must be enrolled in Retiree Medical Coverage in

order to receive Basic Retiree Vision Coverage. You may choose to pay for a higher level of coverage under the Enhanced or Premier Vision Coverage options. If you are eligible, Siemens Energy pays the full cost of your Retiree Life Insurance Coverage. You can obtain your current cost by calling the SEBSC at **1-844-950-0359**.

How to Enroll

Once you elect to retire, call the SEBSC at **1-844-950-0359** for details on the enrollment procedures for the Retiree Program. It is best to contact the SEBSC 60 to 90 days before your anticipated retirement date to ensure timely processing of your enrollment.

You may elect to defer the effective date of coverage for you and your eligible Dependents until a later date, but remember that coverage for the Retiree Program is no longer available to most retirees or Dependents who reach age 65. If you defer coverage under the Retiree Program when **first** eligible, you do not have to provide certification of prior coverage later when you **first** elect to enroll in coverage under any Plan option within the Retiree Program.

Your eligible Dependents do not have to start coverage on the same date you do. However, until you lose eligibility for coverage by reaching age 65 or death, you must have been enrolled for your eligible Dependents to continue to be enrolled.

Each year during Annual Enrollment, you have the opportunity to review and change your Retiree Medical, Dental and Vision Coverage elections. Any changes you make during Annual Enrollment will become effective the following January 1.

Important

- If you wish to change your Retiree Medical, Dental and/or Vision Coverage election or dependent coverage following the birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the SEBSC by calling **1-844-950-0359** or using the **yourenergybenefits.com** website within 30 days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

Your coverage will begin on the first of the month following your termination of employment or your enrollment or on the first day of the Plan year, as may apply. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them within 30 days of your eligibility date.

Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify the SEBSC within 30 days of the birth, adoption, or placement for adoption.

If You Are Hospitalized When Your Retiree Medical Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility on the day your coverage begins, the Retiree Medical Coverage will pay Benefits for Covered Health Services related to that Inpatient Stay for the time period you are a participant in the Retiree Medical Coverage, as long as you receive Covered Health Services in accordance with the terms of the Retiree Medical Coverage.

In-Network Benefits are available only if you receive Covered Health Services from In-

Network providers.

Changing Your Coverage

You can drop coverage for yourself and/or your Dependents at any time by calling the SEBSC. If you are paying for your coverage through deductions from your Siemens Energy Pension Plan benefit and you notify the SEBSC by the 5th day of the month, your coverage will be terminated at the end of that month. If you contact the SEBSC after the 5th day of the month, your coverage will be terminated at the end of the following month.

If you are being billed directly for your coverage under the Retiree Program and you call the SEBSC to drop coverage, your coverage will be terminated on the last day of the month in which you made your last premium payment.

If you drop coverage under the Retiree Program and wish to re-enroll in the Retiree Program again at a later date, you may do so if you have a qualified life event. You will also be required to confirm that you had coverage elsewhere (other than through Medicare) during the period you were not enrolled in the Retiree Program.

If you have a qualified life event and need to change your coverage during the year, you must notify the SEBSC within 30 days of the qualified event. Examples of qualified life events include:

- You get divorced or legally separated, have your marriage annulled, or your Domestic Partnership ends;
- Your Spouse or Domestic Partner dies;
- Your child loses eligibility for coverage in the Retiree Program; or
- Your child dies.

If you have deferred coverage, you may enroll in any coverage you are still eligible for by calling the SEBSC at any time.

Change of Address

The Siemens Energy Benefits Service Center cannot accept address changes by letter or address change cards. You can change your address on the **yourenergybenefits.com** website or by calling the Siemens Energy Benefits Service Center at **1-844-950-0359** between 10 a.m. and 6 p.m. EST, Monday through Friday. You will be required to provide your Username and Password. Once you identify yourself, say “representative” and you will be connected to a representative who can record your change of address.

If you need to change your home address and do not remember your Username or Password:

- From a computer, follow the "I forgot" prompts from the log-in page on the **yourenergybenefits.com** website to set up a new Username and/or Password. When you log back on, you will be able to change your address.
- If you have a cell phone and remember your phone PIN, call the SEBSC. Once you provide the last four digits of your Social Security Number, your date of birth, and your phone PIN, the SEBSC representative can text you a one-time code to secure your call. When you call back using the one-time code, the representative will be able to change your address.
- If you need a new phone PIN, call the SEBSC. Provide your full name, date of birth, the retiree's dates of hire and termination or retirement, and the full address on record (the "old" address). The SEBSC representative will record your "new" address as a "temporary" address and send a letter with a temporary PIN. Once you receive the letter, follow the instructions to re-set the PIN. This will post your "new" address as "permanent" or you can make other changes.

The SEBSC will forward your new address to your Medical, Dental and/or Vision Claims Administrators or the insurance companies and make the change on your Siemens Energy Pension Plan and Siemens Energy Savings Plan records, if applicable.

Cost-Sharing Arrangements

Access-Only Coverage

You will pay 100% of the full cost of coverage under the Retiree Medical Coverage for yourself and any Dependents if, when you retire, you meet the Eligibility Requirements to participate in the Retiree Program as described above *and*

- You were hired or rehired by Siemens Corporation on or after January 1, 2004, or you were employed by an Siemens Corporation Operating Company that elected to participate in the Retiree Program on or after January 1, 2004; *or*
- You have at least 10 years (rounded down), but less than 15 years (rounded down) of eligible service, and you were:
  - Hired or rehired by Siemens Corporation on or after October 1, 1991, but no later than December 31, 2003; or
  - Hired or rehired by Siemens Energy & Automation ("SE&A") on or after January 1, 1991, but no later than December 31, 2003.

Siemens Energy Fixed Dollar Subsidy

Siemens Energy will subsidize (pay a portion of) the cost of coverage under the Retiree Medical Coverage for you and your eligible Dependents based on the Siemens Energy Fixed Dollar Calculation described below if, when you retire, you meet the Eligibility Requirements to participate in the Retiree Program as described above, *and*

- You have at least 15 full years of eligible service *and* you were:
  - *Under age 40* on September 30, 1991, *and* were employed by a Siemens Corporation Operating Company that participated in the Retiree Program, *or*

- *Under age 40* on January 1, 1991, *and* were employed by a division of SE&A that participated in the SE&A Retiree Medical Program; *or*

■ You have at least 15 full years of eligible service, *and* you were:

- Hired or rehired by Siemens Corporation on or after October 1, 1991, but no later than December 31, 2003; *or*
- Hired or rehired by SE&A on or after January 1, 1991, but no later than December 31, 2003.

Exceptions

■ If you are a former employee of Siemens Power Generation, Inc. (now known as Siemens Energy, Inc.), the Siemens Energy Fixed Dollar Calculation will apply to you if you terminate:

- after reaching age 58 with at least 30 full years of eligible service, *or*
- after reaching age 60 with at least 10 full years of eligible service.

If you are a former employee of Siemens Power Generation, Inc. (now known as Siemens Energy, Inc.) and you do not meet these requirements, you will pay the full cost for Retiree Medical Coverage provided you are eligible for coverage on an "access-only" basis.

■ Other employee groups with an eligibility or cost-sharing exception are described below under the heading, Different Eligibility or Cost-Sharing Arrangements.

Siemens Energy Fixed Dollar Calculation

The **Siemens Energy Fixed Dollar Calculation** determines the maximum amount Siemens Energy will contribute towards your Retiree Medical Coverage in two steps.

First, Siemens Energy determines the ***maximum monthly Fixed Dollar amount*** that corresponds to your status as a retiree or Dependent and your eligibility for Medicare. The maximum monthly Fixed Dollar amounts are:

■ $194.42 for a retiree under age 65 who is not eligible for Medicare;

■ $41.62 for a post-age-65 union or "grandfathered" retiree who can continue coverage after age-65 if the retiree is eligible for Medicare; or $41.62 for an eligible non-union or union retiree under age 65 who is eligible for Medicare due to a disability;

■ $202.21 for a Spouse, Domestic Partner, or other covered Dependent under age 65 who is not eligible for Medicare; and

■ $43.28 for a post-age-65 Spouse, Domestic Partner, or other covered Dependent of a union or "grandfathered" retiree who can continue coverage after age 65 if the Spouse, Domestic Partner, or other Dependent is eligible for Medicare, or $43.28 for a Spouse, Domestic Partner, or other covered Dependent of an eligible non-union or union retiree who is under age 65 and eligible for Medicare due to a disability.

Second, Siemens Energy multiplies the applicable maximum monthly Fixed Dollar amount by a ***percentage multiplier*** that is based on your age and eligible service on the date you retire from active employment, as shown on Table 1 on the next page. ("Eligible service" is service with Siemens Energy.) This calculation determines the **Fixed Dollar subsidy** that Siemens Energy will contribute towards your Retiree Medical Coverage cost. Your age-and-service percentage multiplier does not increase as you age, and your Fixed Dollar subsidy is re-calculated only if and when your eligibility for Medicare changes.

Your net cost is equal to the difference between the total cost of the Retiree Medical Coverage that you have elected and the **Fixed Dollar subsidy** as determined by the Siemens Energy Fixed Dollar Calculation.

The total cost of Retiree Medical Coverage generally increases each year, so your cost generally increases each year. Call the SEBSC at **1-844-950-0359** if you have any questions or require additional information on the calculation for your Retiree Medical Coverage cost.

Fixed Dollar Subsidy – Example

Suppose you were hired on January 15, 2001, by a Siemens Corporation Operating Company that participated in Retiree Coverages and became a Siemens Energy employee on September 28, 2020. If you terminate employment with Siemens Energy at age 60 with 20 years of eligible service, your Fixed Dollar subsidy is $118.21 per month (= $194.42 maximum monthly Fixed Dollar amount X 60.8% age-and-service percentage multiplier). If the current cost for your Retiree Medical Coverage is $800 a month, your contribution will be $681.79 (= $800 – $118.21 Fixed Dollar subsidy). A calculation using the Spouse, Domestic Partner or dependent child's maximum monthly Fixed Dollar amount will determine your monthly net cost for your Spouse's, Domestic Partner's, or dependent child's Retiree Medical Coverage.

Years of Eligible Service	Age at Termination							
	55 %	56 %	57 %	58 %	59 %	60 %	61 %	62 or older
10	27.0	29.7	32.4	35.1	37.8	40.5	42.8	45.0
11	28.4	31.2	34.1	36.9	39.7	42.6	44.9	47.3
12	29.7	32.7	35.7	38.7	41.6	44.6	47.1	49.5
13	31.1	34.2	37.3	40.4	43.5	46.6	49.2	51.8
14	32.4	35.7	38.9	42.2	45.4	48.6	51.3	54.0
15	33.8	37.2	40.5	43.9	47.3	50.7	53.5	56.3
16	35.1	38.7	42.2	45.7	49.2	52.7	55.6	58.5
17	36.5	40.1	43.8	47.4	51.1	54.7	57.8	60.9
18	37.8	41.6	45.4	49.2	53.0	56.7	59.9	63.0
19	39.2	43.1	47.0	50.9	54.9	58.8	62.0	65.3
20	40.5	44.6	48.6	52.7	56.7	60.8	64.2	67.5
21	41.9	46.5	50.3	54.5	58.6	62.8	66.3	69.8
22	43.2	47.6	51.9	56.2	60.5	64.8	68.4	72.0
23	44.6	49.2	53.5	57.9	62.4	66.9	70.6	74.3
24	45.9	50.5	55.1	59.7	64.3	68.9	72.7	76.5
25	47.3	52.0	56.7	61.5	66.2	70.9	74.9	78.8
26	48.6	53.5	58.4	63.2	68.1	72.9	77.0	81.0
27	50.0	55.0	60.0	65.0	70.0	75.0	79.1	83.3
28	51.3	56.5	61.6	66.7	71.9	77.0	81.3	85.5
29	52.7	58.0	63.2	68.5	73.8	79.0	83.4	87.8
30 or more	54.0	59.4	64.8	70.2	75.6	81.0	85.5	90.0

Table 1 – Age and Service Percentage Multiplier for Siemens Energy Contribution

Pre-1991 Cost-Sharing Arrangements

Siemens Energy will subsidize (pay a portion of) the cost of Retiree Medical Coverage for you and your eligible Dependents based on the **Pre-1991 Cost-Sharing Arrangement** that corresponds to your age and service on the reference dates described below, if when you retire, you meet the Eligibility Requirements to participate in the Retiree Program as described above, *and either:*

- On September 30, 1991, you were employed by one of a limited number of Siemens Corporation Operating Companies that participated in the Retiree Program on that date; *or*
- On January 1, 1991, you were employed by a division of SE&A that participated in the SE&A Retiree Medical Program on that date.

Important! As of January 1, 2009, Siemens Corporation reduced the annual increase in the cost of Retiree Medical Coverage for retirees covered under the Pre-1991 Cost-Sharing Arrangement by increasing the Siemens Energy (formerly Siemens Corporation) contribution each year. Siemens Energy contributes up to the amount of the increase in the medical care services component of the *Consumer Price Index* (CPI-W) for the 12-month period ending in April of the prior year. Any increase in cost for Retiree Medical Coverage that is above the medical care services component of CPI-W applicable to the prior year will be reflected in your share of the cost for Retiree Medical Coverage. The increase in the medical care services component of CPI-W from April 2018 to April 2019 was 2.4%.

What is the *Consumer Price Index* (CPI-W)?
The CPI-W (for Urban Wage Earners and Clerical Workers) is a number established by the U.S. Department of Labor to identify changes in prices customers pay for a variety of goods and services. Find more detailed information at https://www.bls.gov/cpi/tables/supplemental-files/home.htm. Go to April 2019 and select CPI-W. View line 39 (column AD) in the MS Excel file and you will see the 2.4% increase.

- If you were age 55 or older with at least 10 full years of service or if you were age 65 or older with five or more full years of service as of September 30, 1991 (January 1, 1991, for SE&A):

  Siemens Corporation paid 90% of the cost of your Retiree Medical Coverage until December 31, 2008, and thereafter as adjusted for CPI-W as explained above.

- If you were age 50 or older, but not eligible to retire as of September 30, 1991 (January 1, 1991, for SE&A):

  Siemens Corporation paid the greater of 80% of the cost of your Retiree Medical Coverage or a percentage based on your age and service at termination (see Table 1 above) until December 31, 2008, and thereafter as adjusted for CPI-W as explained above. You pay the remaining amount.

- If you were age 40 to 49 as of September 30, 1991 (January 1, 1991, for SE&A):

  Siemens Corporation paid a percentage of the cost of your Retiree Medical Coverage based on your age and full years of eligible service at termination as indicated on Table 1 above until December 31, 2008, and thereafter as adjusted for CPI-W as explained above. You pay the difference.

  For example, suppose you were employed by an Siemens Corporation Operating

Company that participated in the Retiree Program and you were age 45 on September 30, 1991 (January 1, 1991, for SE&A), and you retired at age 60 with 25 years of eligible service. In this case, Siemens Corporation paid 70.9% of the total cost for your Retiree Medical Coverage until December 31, 2008, and you paid the remaining 29.1%.

For 2020, any increase in the cost of Retiree Medical Coverage above 2.4% (the increase in the medical care services component of the CPI-W for the 12-month period that ended April 2019) was reflected in the amount you pay for Retiree Medical Coverage. If the cost for Retiree Medical Coverage increased 5% in 2020, you will see the additional 2.6% increase that is above the CPI-W in your Retiree Medical Coverage premium. Call the Siemens Energy Benefits Service Center at **1-844-950-03595** if you have any questions or if you require additional information on the calculation for your Retiree Medical Coverage.

Transfers Between Affiliated Companies

If you transfer to another affiliate within Siemens Energy, *and* you have not attained the age of 55 *and* completed at least 10 full years of eligible service, you become eligible for Retiree Coverages ***only if*** the affiliate you transferred to, and later retire from, participates in the Retiree Program ***and*** you meet the eligibility requirements for Retiree Coverages at the time you retire. At the time you retire, you become covered under Retiree Coverages and all of its features applicable to the affiliate to which you have transferred. Service with an affiliate participating in the Retiree Program prior to your transfer will be considered in determining your eligibility and Siemens Energy's contribution, if any, towards your medical coverage. Service with an affiliate that was not participating in the Retiree Program prior to your transfer *will not* be considered in determining your eligibility and Siemens Energy's contribution, if any, towards your medical coverage.

If you transfer from an affiliate that participates in the Retiree Program to another affiliate after you have already attained the age of 55 ***and*** completed at least 10 full years of eligible service, you will be eligible for Retiree Coverages based on the following rules:

- If you transfer to an affiliate that does not offer Retiree Coverages, you will be eligible for coverage at retirement and Siemens Energy's contribution, if any, towards your Retiree Medical Coverage will be determined based on your age and service as of the date of transfer.
- If you transfer back to an affiliate that offers Retiree Coverages, service from all affiliates participating in this Retiree Program will be combined to determine Siemens Energy's contribution, if any, towards your medical coverage.
- **NOTE:** Service at affiliates that do not participate in the Retiree Program does not count for eligibility or cost-sharing. Only service with an affiliate that participates in the Retiree Program will be considered in determining eligibility and cost-sharing.
- If the affiliate to which you are transferred participates in Siemens Energy's Retiree Coverages with different eligibility or cost-sharing contribution provisions, your eligibility and Siemens Energy's contribution provisions will be based on the provisions in effect at the prior affiliate.
- If you transfer to an affiliate with the same eligibility and cost-sharing contribution provisions as the affiliate you transferred from, your service will continue to

accumulate in the same manner.

- If you transfer from an affiliate that did not participate in the Retiree Program to an affiliate that participates in the Retiree Program, you are eligible to participate based on the provision that applies to employees hired as of the date of your transfer. Years of service while employed at an affiliate that did not participate in the Retiree Program are not counted in determining eligibility and Siemens Energy cost-sharing contribution, if any, towards your Retiree Medical Coverage.

Call the Siemens Energy Benefits Service Center at **1-844-950-0359** to find out if your affiliate participates in the Retiree Program.

Service Rules for 1991 Transition Group of Employees

You are eligible for the Siemens Corporation Pre-1991 cost-sharing arrangement ***only if*** you were part of the original 1991 transition group (i.e., you were an employee of a Siemens Corporation Operating Company that participated in the Retiree Coverages as of September 30, 1991, or you were an employee of SE&A on January 1, 1991) ***and*** you had reached age 40 or older prior to September 30, 1991 (or prior to January 1, 1991, for SE&A Retiree Program participants). You cannot become eligible for the Pre-1991 Siemens Corporation cost-sharing arrangement by transferring to another Siemens Corporation affiliate *or* as a result of an acquisition.

Localized Delegates

Eligible inbound delegates and transfers to the U.S. from a non-U.S. Siemens Energy affiliate (as defined in the Siemens Energy, Inc. Pension Plan), who have localized and are initially employed at a Siemens Energy affiliate participating in the Retiree Program, will be **eligible for coverage** based on their original hire date (as adjusted for any breaks in service) with the non-U.S. Siemens Energy affiliate, if they terminate employment after September 30, 2001.

Delegates who localize or employees who transfer to the U.S. from a non-U.S. Siemens Energy affiliate on or after January 1, 2004, **will not be eligible for any Siemens Energy contribution** towards the cost of Retiree Medical Coverage, regardless of the number of years that they have worked for a Siemens Energy affiliate.

For localized delegates and transfers from non-U.S. Siemens Energy affiliates who localized after September 30, 1991, and before January 1, 2004, service for **Siemens Energy Fixed Dollar contribution purposes** will be based solely on employment at a Siemens Energy affiliate participating in the Retiree Program (and will not include service prior to the date of localization).

Eligibility for Coverage If You Are Medicare-Eligible or Over Age 65

You (or your Spouse, Domestic Partner, or child) are eligible for the Retiree 90/10 Medicare Carve-Out Medical Plan option due to disability ***if:***

- You are under age 65, you are eligible for the Retiree Program, and you become eligible for Medicare. If you are enrolled in coverage under a Non-Medicare-Eligible Retiree Medical Coverage option, you will be enrolled in the Retiree 90/10 Medicare Carve- Out Plan option effective with the first of the month following your Medicare eligibility date. Family members who are not Medicare-eligible may continue their enrollment under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options until they reach age 65 or otherwise lose eligibility for coverage

under those Retiree Program options.

- You are the disabled dependent child of a retiree who is or was eligible for Retiree Medical Coverage. Your eligibility for coverage will not extend the eligibility of other family members.

Most Retirees and their Dependents who are eligible for Medicare are not eligible for medical coverage under the Retiree Program. Once you (or your Dependent) reach age 65, you (or your Dependent) are eligible for coverage under the Retiree 90/10 Medicare Carve-Out Medical Plan and other Retiree coverages ***only if*** you were a member of one of the following groups that continue to be eligible for Retiree Coverages at or after age 65***:***

- You were a member of a "grandfathered" group of union and non-union employees acquired or employed by Siemens Power Transmission & Distribution (SPT&D, Benefit Group 045, Branch 201).
- You were a member of Siemens Power Generation IBEW Local 124, Kansas City, Missouri (Benefit Group 347).

Different Eligibility or Cost-Sharing Arrangements

Siemens Energy, Inc. (formerly known as Siemens Power Generation, Inc.)

- Effective January 1, 2001, the cost for all Siemens Westinghouse Power Corporation retirees is determined based on the Siemens Energy Fixed Dollar Calculation. Eligible service includes pre-acquisition service.
- Former Siemens Power Generation, Inc. employees pay 100% of the premium for Retiree Medical Coverage unless they were hired prior to January 1, 2004, and terminate after reaching age 58 with at least 30 years of service *or* after reaching age 60 with at least 10 years of service. If eligible employees meet the requirement of age 58 with at least 30 years of service or age 60 with at least 10 years of service, the Siemens Energy Fixed Dollar Calculation applies.
- Effective September 30, 2006, employees of Siemens Demag Delaval Turbomachinery Inc. (Demag), employees of TurboCare, Inc.**,** and employees of TurboCare LLC (formerly known as TurboCare Gas Turbine Services LLC) are eligible to participate in the Retiree Program under the same eligibility as employees of Siemens Energy, Inc. However, Demag, TurboCare, Inc. and Turbocare LLC employees pay 100% of the cost for Retiree Medical Coverage regardless of age or eligible service at termination.
- Effective September 30, 2006, employees of Siemens Power Generation, Inc. (except for Turbine Airfoil Coating and Repair LLC and Demag, TurboCare, Inc., and TurboCare LLC) became eligible for Retiree Coverages under the age 55 and 10 years of eligible service requirements. Cost-sharing requirements did not change.

Dresser-Rand Non-Union Employees – Includes Transfers to Siemens Government Technologies, Inc. (Benefit Group 741 and Benefit Group 748)

If you are a grandfathered Ingersoll-Rand employee eligible for Post-Retirement Coverage from Ingersoll-Rand, you will need to notify the SEBSC of your intent to retire so that the SEBSC can notify Ingersoll-Rand. Neither you nor any Dependent will be eligible for coverage under any Retiree Program option.

- If you are a grandfathered Dresser-Rand non-union employee hired before April 1, 2008, and eligible for Post-Retirement Coverage:
  - You and Siemens Energy will both pay a share of the cost of your coverage based on provisions in effect before Siemens Corporation acquired Dresser-Rand. Under the Dresser- Rand plan, the maximum company contribution was limited to $6,650 per year.
  - Your eligibility for coverage under the Retiree Program (and eligibility for your eligible covered Spouse or Domestic Partner) will end at age 65.
- Retiree Coverages to age 65 only are available on an "access-only" basis to all other current and future employees who at retirement are at least 55 years of age and have at least 10 full years of eligibility service. Prior service will be recognized for eligibility if you were employed by a company that was acquired by Siemens Energy.

Dresser-Rand Olean Union Employee (Benefit Group 742)

- All employees represented by the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, Local 4601, Olean, NY, who were actively on the payroll and met the criteria as of April 1, 2008, are eligible for the prevailing Retiree Medical Coverages available to non-bargaining unit employees:
  - You and Siemens Energy will both pay a share of the cost of your coverage based on provisions in effect before Siemens Corporation acquired Dresser-Rand. Under the Dresser- Rand plan, the maximum company contribution was limited to $6,650 per year.
  - Your eligibility for Retiree Medical Coverage (and eligibility for your eligible covered Spouse or Domestic Partner) will end at age 65. Coverage for child who is a Dependent will end when you reach age 65 (or when your covered Spouse or Domestic Partner reaches age 65, if later) or when the child reaches age 26 (if sooner).
  - If you (or your covered Dependent) become eligible for Medicare before reaching age 65, you (or your Medicare-eligible Spouse or Domestic Partner) will be enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan Option until age 65.
  - You will not be eligible for Retiree Dental, Vision, or Life coverage (except for one grandfathered retiree who is eligible for $5,000 of Retiree Life).
- Olean union employees hired after April 1, 2008, are not eligible for coverage under the Retiree Program.

Dresser-Rand Painted Post Union Employees (Benefit Group 743)

- Employees represented by the Painted Post IUE/CWA Local 313 who have grandfathered eligibility for Retiree Coverages are eligible for Retiree Medical Coverage to age 65.
- Based on provisions in effect before Siemens Corporation acquired Dresser-Rand, coverage to age 62 for the retiree only will be available at the same cost as for a Dresser-Rand salaried retiree. You and Siemens Energy will both share in the cost of your coverage. The maximum amount of company contribution under the Dresser-Rand plan was limited to $6,650 per year.
- From age 62 to age 65, coverage for the retiree only will be provided at no cost.

- Retiree Medical Coverage to age 65 will be available to your Dependent on an "access-only" basis, which means you will pay 100% of the full cost.
- You will not be eligible for Retiree Dental, Vision, or Life coverage (except for one grandfathered retiree who is aligned with the Wellsville union group and eligible for $4,750 of Retiree Life).
- Other Painted Post union hourly employees are not eligible for coverage under the Retiree Program.

Siemens Energy Employee as a Result of a Siemens Energy Acquisition or Merger

If you were employed by a company that was acquired by Siemens Energy, eligible service generally begins on the date of the acquisition. In some cases, as determined at the time of the acquisition, service prior to your date of employment with Siemens Energy is included in determining eligible service. In other cases, at the time of the acquisition, Siemens Energy chose to adopt another date from which eligibility service is counted.

Retiree health and welfare service dates are maintained by the SEBSC. Active employees can view their eligibility service dates on the **yourenergybenefits.com** website by selecting *Your Critical Data* from the Home page. If you have any questions, you can also call the SEBSC toll free at **1-844-950-0359.** Representatives are available to assist you from 10 a.m. to 6 p.m. Eastern Time, Monday through Friday (after you enter your password, say the word "representative").

SECTION 3 – HIGHLIGHTS OF THE RETIREE HEALTH SAVINGS MEDICAL PLAN OPTION

What this section includes:

- Annual Deductible
- Coinsurance
- Out-of-Pocket Maximum
- Payment Terms and Features
- Retiree Health Savings Account ("HSA")

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services and prescription drugs before you are eligible to begin receiving Benefits (with certain exceptions). There are separate In-Network and Out-of-Network Annual Deductibles for the Retiree Health Savings Medical Plan option. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible for the Retiree Health Savings Medical Plan option. Once you have met the In-Network Annual Deductible, you will pay Coinsurance equal to 15% of the Eligible Expense for any further In-Network Covered Health Services. Once you have met the Out-of-Network Annual Deductible, you will pay Coinsurance equal to 35% of the Eligible Expense for any further Out-of-Network Covered Health Services.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services and prescription drugs. There are separate In-Network and Out-of-Network Maximums for this option. If your eligible out-of-pocket expenses in a calendar year exceed the In- or Out-of-Network annual maximum, the Plan pays 100% of the corresponding Eligible Expenses for Covered Health Services and prescription drugs through the end of the calendar year.

Payment Terms and Features

Table 2 on the next page provides an overview of the Retiree Health Savings Medical Plan option Annual Deductible and Out-of-Pocket Maximum for Individual and Family (two or more Covered Persons) coverage.

Retiree Health Savings Medical Plan Option	In-Network	Out-of-Network
Annual Deductible Medical and Prescription Drug Combined ■ Individual ■ Family (two or more Covered Persons) The Annual Deductible applies to all Covered Health Services except Preventive Care Services. * You are subject to the entire Family deductible (even if one family member has met the individual deductible).	$2,000 $4,000 *	$3,000 $6,000 *
Annual Out-of-Pocket Maximum Medical and Prescription Drug Combined ■ Individual ■ Family (two or more Covered Persons) ** If you elect Family coverage, the ***In-Network*** Out-of-Pocket Maximum cost for any one person is $7,350 in 2020 and 2021.	$5,500 $11,000**	$7,000 $14,000
Annual or Lifetime Maximum Benefit	There is no dollar limit to the amount the Medical Plan will pay for essential health benefits during the calendar year or the entire period you are enrolled in the Medical Plan.	

Table 2 – Retiree Health Savings Medical Plan Option

Table 3 below identifies what does and does not apply toward your In-Network and Out-of-Network Out-of-Pocket Maximums:

Retiree Health Savings Medical Plan Out-of-Pocket Maximum	In-Network	Out-of-Network
Annual Deductible	Yes	Yes
Prescription Drugs	Yes	N/A
Coinsurance Payments, except for those Covered Health Services identified in the Section 8, *Schedule of Benefits* table that do not apply to the Out-of-Pocket Maximum	Yes	Yes
Charges for non-Covered Health Services	No	No

The amounts of any reductions in Benefits you incur by not obtaining Prior Authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

Table 3 – Retiree Health Savings Medical Plan Option Out-of-Pocket Maximum

About Your Retiree Health Savings Account ("HSA")

About your Retiree HSA:
- Who is eligible and how to enroll
- Contributions
- Additional medical expense coverage available with your Health Savings Account
- Using the HSA for Non-Qualified Expenses
- Rolling over funds in your HSA

The Retiree Health Savings Medical Plan option is a high-deductible medical plan that allows you to contribute to a Health Savings Account ("HSA").

A description of the HSA is provided in this section of the SPD and is intended to be accurate and reasonably complete. You may make contributions to an HSA that is established and maintained by Optum Bank, an HSA trustee, or you make may contributions to another HSA trustee/custodian of your choice. Optum Bank is independent of United Healthcare and Siemens Energy. Optum Bank is solely responsible for setting administrative policy and procedures for the HSA and reserves the right to make changes as circumstances or regulations may require or permit.

An HSA is a tax-savings vehicle that allows you to save for health care costs. Depending on your needs, you can use the account to pay for eligible health care and prescription expenses now, or let the account grow with earnings that, for the most part, are tax-free to use for health care costs during your later retirement years.

Who Is Eligible and How To Enroll

To be eligible to contribute to an HSA, you:

- Must be enrolled in the Retiree Health Savings Medical Plan option;
- Cannot participate in any other health plan that is not a high deductible health plan, such as your Spouse's or Domestic Partner's non-high deductible health plan;
- Cannot be enrolled in Medicare;
- Do not receive health benefits under TRICARE;
- Have not received Veterans Administration (VA) benefits within the past three months (this does not apply to preventive care or to veterans with a service-connected disability who receive medical care through the VA); and
- Cannot be claimed as a dependent on another person's tax return.

Contributions

Your HSA is funded by your personal contributions. These funds can be used to help

pay for your eligible medical, prescription drug, dental, and vision expenses. You can also use these funds for any other purpose, but you may be subject to income tax and penalties. Any balance remaining in your HSA at the end of the year will carry over to next year.

Contributions to your HSA can be made by you or by any other individual. Siemens Energy does not contribute to your HSA. All funds placed into your HSA are owned and controlled by you, subject to any administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the HSA (and generally are not enrolled in any other health plan) until the earlier of (i) the due date for that year's tax return; or (ii) the date on which the contributions reach the annual contribution maximum.

Note that if your coverage under a HSA-compatible high-deductible health plan terminates, no further contributions may be made to the HSA.

Your annual contribution maximum is the individual or family limit set by the IRS – in 2020, up to $3,550 ($3,600 for 2021) for individual coverage or up to $7,100 ($7,200 for 2021) for family coverage. From age 55 until age 65 or you become eligible for Medicare, you can make additional catch-up contributions of up $1,000 (in 2020 and 2021) beyond the IRS contribution limit. Your eligible Spouse who is at least 55 years of age may also make catch-up contributions for the same amount, but these contributions must be deposited in a separate HSA maintained in your Spouse's name. The maximum limits set by the IRS may be found on the IRS website at https://www.irs.gov/.

If you enroll in a high-deductible health plan midyear (not on January 1st) and are still enrolled on December 1st of that year, you will still be allowed to contribute the maximum amount set by the IRS. However, you must remain enrolled in a high-deductible health plan until the end of the next calendar year or you may be subject to tax implications and an additional tax of 6% on any excess contributions.

To enroll in an HSA through Optum Bank, log on to https://enrollhsa.optumbank.com/enrollment#/**.** From the landing page, click **Continue** and complete the application. Include Siemens Energy's Group Number (**921844** for UHC or **921844A** for Anthem) to have the monthly fees paid by Siemens Energy. Once you are an Optum Bank HSA account holder, you can set up deposits, view monthly statements, make payments, and otherwise manage your account online. For further information, check the Optum Bank Customer Support website (https://www.optumbank.com/customer-service-support) or call **1-866-234-8913**.

To transfer funds to or from your Optum Bank HSA, you may need the following information.

Bank routing number (ABA number): **124384877**

Optum Bank Address: 2525 Lake Park Blvd.
Salt Lake City, UT 84120

Reimbursable Expenses

The funds in your HSA can be used to help you pay for eligible health care and prescription expenses for you and your eligible dependents' out-of-pocket costs under the Retiree Health Savings Medical Plan option, including Annual Deductibles and Coinsurance.

There are important rules you need to know about an HSA. For more information about

HSAs, contact your tax advisor or visit the U.S. Treasury website at http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

IRS Publication 502 is accessible at https://www.irs.gov/ or by calling 800-TAX-FORM (829-3676).

Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll over. If your participation in the Retiree Health Savings Medical Plan option terminates for any reason, the funds in your HSA will continue to be owned and controlled by you.

SECTION 4 – HIGHLIGHTS OF THE RETIREE HEALTH REIMBURSEMENT MEDICAL PLAN OPTION

What this section includes:
- Annual Deductible
- Coinsurance
- Out-of-Pocket Maximum
- Payment Terms
- Health Reimbursement Account ("HRA")

Annual Deductible

The Annual Deductible for the Retiree Health Reimbursement Medical Plan option is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate In-Network and Out-of-Network Annual Deductibles for the Retiree Health Reimbursement Medical Plan option. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible for the Retiree Health Reimbursement Medical Plan option. Once you have met the In-Network Annual Deductible, you will pay Coinsurance equal to 15% of the Eligible Expense for any further In-Network services. Once you have met the Out-of-Network Annual Deductible, you will pay Coinsurance equal to 35% of the Eligible Expense for any further Out-of-Network services.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate In-Network and Out-of-Network Out-of-Pocket Maximums for the Retiree Health Reimbursement Medical Plan option. If your eligible out-of-pocket expenses in a calendar year exceed the annual In- or Out-of-Network Maximum, the Plan pays 100% of corresponding Eligible Expenses for Covered Health Services incurred through the end of the calendar year. There is a separate Out-of-Pocket Maximum that applies to the CVS/caremark Retiree Prescription Drug Program.

Payment Terms and Features

Table 4 – Retiree Health Reimbursement Medical Plan Option Table 4 – Retiree Health Reimbursement Medical Plan Option on the next page provides an overview of the Retiree Health Reimbursement Medical Plan option Annual Deductible and Out-of-Pocket Maximum for Individual (one covered person) and Family (two or more Covered Persons) coverage.

Retiree Health Reimbursement Medical Plan Option	In-Network	Out-of-Network
Annual Deductible ■ Individual ■ Individual plus one ■ Family (three or more Covered Persons The Annual Deductible applies to all Covered Health Services except Preventive Care Services.	 $900 $1,800 $2,250	 $1,350 $2,700 $3,375
Coinsurance	15%	35%
Annual Out-of-Pocket Maximum ■ Individual ■ Individual plus one ■ Family (three or more Covered Persons) The Out-of-Pocket Maximum includes all Covered Health Services. *If you elect individual plus one or family coverage, the In-Network Out-of-Pocket Maximum for any one person is $3,700). **If you elect family individual plus one or family coverage, the Out-of-Network Out-of-Pocket Maximum for any one person is $4,700.	 $3,700 $7,400* $10,000*	 $4,700 $9,400** $14,000**
Annual and Lifetime Maximum Benefit	There is no dollar limit to the amount the Medical Plan will pay for essential health benefits during the calendar year or the entire period you are enrolled in this Medical Plan.	

Table 4 – Retiree Health Reimbursement Medical Plan Option

Table 5 below identifies what does and does not apply toward your In-Network and Out-of-Network Out-of-Pocket Maximums:

Retiree Health Reimbursement Medical Plan Option Out-of-Pocket Maximum	In-Network	Out-of-Network
Payments toward the Annual Deductible	Yes	Yes
Prescription Drug expenses	No	N/A

Coinsurance Payments, except for those Covered Health Services identified in the Section 9, *Schedule of Benefits* table that do not apply to the Out-of-Pocket Maximum	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining Prior Authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

Table 5 – Retiree Health Reimbursement Medical Plan Option Out-of-Pocket Maximum

About Your Health Reimbursement Account ("HRA")

As of January 1 of each calendar year in which you are enrolled in the Retiree Health Reimbursement Medical Plan option, Siemens Energy will make an automatic HRA contribution of $400 for you plus an additional $400 for a covered Spouse or Domestic Partner. The full amount of Siemens Energy's annual contribution to your HRA will be immediately available to pay your or your covered Dependent's Eligible Expenses and is prorated if your enrollment begins any time after January 1. You cannot make any contributions to your HRA.

Your HRA is set up to make automatic payments of Coinsurance, including Coinsurance applied to the Annual Deductible, directly to your In-Network provider, until funds are exhausted. Your In-Network or Out-of-Network Coinsurance may be reimbursed directly to you if you file a claim and funds are available.

If you want to discontinue the HRA Automatic Payment feature, go to www.myuhc.com and click on the **Register Now** button. Enter the information from your medical plan ID card. Select a User ID, Password, and security question; then agree to the website "Terms and Conditions." Choose **Claims & Accounts** from the home page. From the left toolbar, select **Automatic Payment Options** and then **Disenroll**. Choose **Confirm** to complete your request.

Siemens Energy's contributions to your HRA are intended solely for reimbursement of qualified medical expenses. You can use your HRA to pay for any out-of-pocket Eligible Expense. You cannot use your HRA to pay for prescription drugs, even if they are covered under the CVS/caremark Retiree Prescription Drug Plan, or to pay for any amount over the Eligible Expense that you may be required to pay as "Balance Billing" if you use an Out-of-Network provider. You also cannot use your HRA to pay for dental or vision expenses or to pay any portion of the monthly cost of your medical coverage.

Claims must be filed with the claims administrator no later than 90 days from the end of the calendar year in which the expense was incurred.

At the end of each calendar year, any balance in your HRA, up to a maximum of $4,000, will be rolled into your HRA for the next year if you continue your participation in the Retiree Health Reimbursement Medical Plan option. However, the transfer will not post to your new plan year account until after March 31. Your HRA is not portable. If you do not re-enroll or continue participation in the Retiree Health Reimbursement Medical Plan option, if you reach age 65, if you terminate your enrollment in the Retiree Health Reimbursement Medical Plan option, or if Siemens Energy ceases to offer a Retiree Program option with an HRA feature, any balance in your HRA will be forfeited.

SECTION 5 – HIGHLIGHTS OF THE RETIREE 90/10 MEDICARE CARVE-OUT MEDICAL PLAN OPTION

What this section includes:

- Coordination with Medicare Part A and Part B
- Annual Deductible
- Coinsurance
- Out-of-Pocket Maximum
- Payment Terms
- How Benefits Are Calculated and Paid – Two Examples

Note: Most groups of non-union retirees aged 65 or older, members of the Houston IBEW Local 716 and FISU unions aged 65 or older, and such retirees' Dependents aged 65 or older are not eligible for the Retiree Program. The Retiree 90/10 Medicare Carve-Out Medical Plan option, however, covers certain defined groups of union and non-union retirees and their covered Dependents who are eligible for Medicare. The Retiree 90/10 Medicare Carve-Out Medical Plan option also covers retirees or Dependents under age 65 who would otherwise be eligible for coverage under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options but are eligible for Medicare due to a disability.

Important!
The Retiree 90/10 Medicare Carve-Out Medical Plan option coordinates with Medicare benefits. **The plan pays as if you are enrolled in Medicare Part A and Part B regardless of whether you are actually enrolled in coverage under either Part.**
The benefit payable under this plan is determined using the Medicare-Approved Amount. Then, the amount payable (or that could be paid) by Medicare is deducted by the Benefit payable by this plan. If the Medicare benefit is equal to or exceeds the plan Benefit, no additional payments will be made. If the Medicare benefit is less than the Benefit allowed under this plan, the difference between the Medicare benefit and the plan Benefit will be paid. The Benefit paid by this plan equals the amount of the Benefit allowed under this plan minus the Medicare benefit amount. In addition to paying the Annual Deductible and Coinsurance, as may apply, you are responsible for any charge that is not covered by this plan or by Medicare.

If you or your Dependent becomes eligible for Medicare or reaches age 65, you must call the SEBSC at **1-844-950-0359** at least 30 days before the Medicare-eligibility date to elect coverage under the Retiree 90/10 Medicare Carve-Out Medical Plan option. If you or your covered Dependent remain eligible for coverage under the Retiree 90/10 Medical Carve-Out Medical Plan option, you or your covered Dependent will be treated as if you or your covered Dependent are enrolled in Medicare Part A and Part B. In addition, if you do not contact the SEBSC at the time you or your covered Dependent becomes eligible for Medicare, and if the Retiree Program continues to pay Benefits as if you or your covered Dependent were not eligible for Medicare, you will be responsible for reimbursing the Plan for the amount of any Benefits that were incorrectly paid to or on behalf of you or your covered Dependent as a result of your failure to notify the SEBSC of your or your covered Dependent's eligibility for Medicare.

Annual Deductible

You must meet the Medicare annual deductible before you begin to accumulate expenses that apply to the Annual Deductible for this option. The Annual Deductible for the Retiree 90/10 Medicare Carve-Out Medical Plan option is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits from this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Coinsurance

Your Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible for the Retiree 90/10 Medicare Carve-Out Medical Plan option. You receive the same level of Benefits whether you see Providers In-Network or Out-of-Network. Once you have met the Annual Deductible, you will pay Coinsurance equal to 10% of the Eligible Expense and Medicare and this plan together will pay 90% of the Eligible Expense for any further services until you have met the annual Out-of-Pocket Maximum.

- The maximum amount that this plan will pay for a Covered Health Service is based on the Eligible Expense, which will be based on the Medicare-Approved Amount.
- You will incur the lowest cost if you always use Medicare Participating Providers. A Medicare Participating Provider has agreed to accept the Medicare-Approved Amount as full payment for any Covered Service. For more information, see *Determining the Allowable Expense When This Plan Is Secondary to Medicare* in Section 18 below.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual Out-of-Pocket Maximum, the plan pays 100% of corresponding Eligible Expenses for Covered Health Services incurred through the end of the calendar year. There is a separate Out-of-Pocket Maximum that applies to the CVS/caremark Retiree Prescription Drug Plan.

Payment Terms and Features

Table 6 below provides an overview of the Retiree 90/10 Medicare Carve-Out Medical Plan option, Annual Deductible and Out-of-Pocket Maximum for Individual (one covered person) and Family (two or more Covered Persons) coverage.

Retiree 90/10 Medicare Carve-Out Medical Plan Option	
Annual Deductible ■ Individual ■ Family (two or more Covered Persons) The Annual Deductible applies to all Covered Health Services except Preventive Care Services.	$300 $600
Office Visits	You pay 10% after Deductible is met.
Coinsurance	You pay 10% after Deductible is met.

Annual Out-of-Pocket Maximum ■ Individual ■ Family (two or more Covered Persons) The Out-of-Pocket Maximum includes all Covered Health Services.	 $1,500 $3,000
Annual and Lifetime Maximum Benefit	There is no dollar limit to the amount the Medical Plan will pay for essential health benefits during the calendar year or the entire period you are enrolled in this Medical Plan.

Table 6 – Retiree 90/10 Medicare Carve-Out Medical Plan Option

Table 7 below identifies what does and does not apply toward your Out-of-Pocket Maximum:

Retiree 90/10 Medicare Carve-Out Medical Plan Option Out-of-Pocket Maximum	Applies to Annual Out-of-Pocket Maximum?
Payments toward the Annual Deductible for this plan	Yes
Payments toward the Annual Deductible for Medicare	No
Prescription Drug expenses	No
Coinsurance Payments, except for those Covered Health Services identified in the Section 10, *Schedule of Benefits* table that do not apply to the Out-of-Pocket Maximum	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not obtaining Prior Authorization as required	No
Charges that exceed Eligible Expenses	No

Table 7 – Retiree 90/10 Medicare Carve-Out Medical Plan Option Out-of-Pocket Maximum

How Benefits Are Paid – Two Examples

Below are two examples that show how benefits are calculated and paid under the Retiree 90/10 Medicare Carve-Out Medical Plan option if you have already met the calendar year Annual Deductibles for Medicare Part B and the plan.

- If your provider accepts Medicare, you pay Coinsurance equal to 10% of the Medicare-Approved Amount; you do not owe the provider any difference between the Total Charge and the Medicare-Approved Amount (the "Medicare Disallowed Amount").
- If your provider does ***not*** accept Medicare, you may be responsible for paying the Medicare Disallowed Amount (or "Balance Billing") in addition to your Coinsurance – even after you have met the annual Out-of-Pocket Maximum for this plan. This "disallowed" or balance-billed charge is only $4.65 in Example 2. However, Balance Billing can be substantial and is not applied to your annual Out-of-Pocket Maximum.

		Example 1	Example 2
A	**Total Charge** as billed	$291.50	$185.00
	Medicare-Approved Amount	**$129.60**	**$180.35**
	Medicare Disallowed Amount ■ not Covered by Medicare or the Plan ■ you do not owe (if provider accepts Medicare) or ***You owe*** (if provider does not accept Medicare)	$161.90	$4.65
B = A X 90%	UHC calculates 90% of Medicare-Approved Amount	$116.64	$162.32
C = A X 80%	Medicare pays 80% of Medicare-Approved Amount	$103.68	$144.29
D = B **–** C	Retiree 90/10 Medicare Carve-Out Medical Plan pays the difference	$12.96	$18.03
E = A **–** B	You pay 10% **Coinsurance**	$12.96	$18.04
	Total **Eligible Expense** = **C + D + E**	**$129.60**	**$180.35**
	If your provider does not accept Medicare, you may still owe	**$161.90**	**$4.65**

SECTION 6 – HOW THE RETIREE MEDICAL COVERAGE WORKS

What this section includes:
- Accessing Benefits – In-Network and Out-of-Network providers and facilities
- Eligible Expenses
- Rights and Notices
- How claims will be handled if you are eligible for Medicare

Accessing Benefits

As a participant in the Retiree Health Savings Medical Plan option, the Retiree Health Reimbursement Medical Plan option, or the Retiree 90/10 Medicare Carve-Out Medical Plan option (the "Retiree Medical Coverage"), you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the In-Network level of Benefits under your Retiree Medical Coverage when you receive Covered Health Services from Physicians and other health care professionals that are Medicare Participating Providers.

You can choose to receive In-Network Benefits or Out-of-Network Benefits under any of the three Retiree Medical Coverage options in which you are enrolled. There is no difference in the level of Benefits payable In-Network or Out-of-Network if you are enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan option. However, you will generally minimize your Out-of-Pocket expenses by using In-Network (for the Retiree Health Savings Medical Plan option and the Retiree Health Reimbursement Medical Plan option) or Medicare Participating Providers (for the Retiree 90/10 Medicare Carve-Out Medical Plan option).

In-Network Benefits apply to Covered Health Services that are provided by an In-Network Physician or other In-Network provider.

Emergency Health Services are always paid as In-Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by an In-Network facility and provided under the direction of either an In-Network or Out-of-Network Physician or other provider. In-Network Benefits include Physician services provided in an In-Network facility by an In-Network or an Out-of-Network Emergency Room Physician, radiologist, anesthesiologist or pathologist.

Out-of-Network Benefits under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options apply to Covered Health Services that are provided by an Out-of-Network Physician or other Out-of-Network provider, or Covered Health Services that are provided at an Out-of-Network facility. Out-of-Network Benefits will apply to Covered Health Services received outside the U.S.

Depending on your geographic area and the service you receive, you may have access through UnitedHealthcare's ***Shared Savings Program*** to Out-of-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 in Section 22, *Glossary* for details about how this program applies.

Under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options, when you receive Covered Health Services from an In-Network provider, you

will generally be billed at a lower rate than if you receive the same care from an Out-of-Network provider. Also, if you choose to seek care outside the UnitedHealthcare Network, Benefits are generally paid at a lower level. Therefore, in most instances, your out-of-pocket expenses will be less if you use an In-Network provider.

Under the Retiree 90/10 Medicare Carve-Out Medical Plan option, if you do not use a Medicare Participating Provider, the amount paid by the plan and Medicare together may be less than 90% of the total billed amount. In addition to paying any Coinsurance that may apply, you are required to pay the amount that exceeds the Eligible Expense or the Medicare-Approved Amount ("Balance Billing"). The amount in excess of the Eligible Expense or Medicare-Approved Amount could be significant, and this amount does not apply to the Out-of-Pocket Maximum. Before you receive care, you may want to ask providers that are not Medicare Participating Providers about their billed charges or verify that your providers accept Medicare.

Health Services from Out-of-Network Providers Paid as In-Network Benefits

If specific Covered Health Services are not available from an In-Network provider, you may be eligible to receive In-Network Benefits under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options when Covered Health Services are received from an Out-of-Network provider (a "Gap Exception"). You may request a Gap Exception if there is no In-Network provider within a 30-mile radius of your home. If you require specialty care and there is no appropriate In-Network provider, your In-Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from an In-Network provider, UnitedHealthcare will work with you and your In-Network Physician to coordinate care through an Out-of-Network provider.

Looking for an In-Network Provider?
In addition to other helpful information, UnitedHealthcare's consumer website contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for In-Network Physicians available in your Retiree Medical Coverage.

In-Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. You can obtain a directory of In-Network providers free of charge by calling the number on your ID card or online at www.myuhc.com. Keep in mind, a provider's Network status may change. Before obtaining services, you should always verify the Network status of a provider. You can verify the provider's status by calling UnitedHealthcare or by logging on to www.myuhc.com.

Network providers are independent practitioners and are not employees of Siemens Energy or UnitedHealthcare. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

It is possible that you might not be able to obtain services from a particular In-Network provider. The network of providers is subject to change. Or you might find that a particular In-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 In-Network provider to get In-Network Benefits.

Do not assume that an In-Network provider's agreement includes all Covered Health Services. Some In-Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Provider

If you have a medical condition that needs special services, UnitedHealthcare may direct you to an In-Network physician or In-Network facility or a Designated Provider that is outside your local geographic area. If you are required to travel to obtain organ transplantation services from a Designated Provider located more than 50 miles from your home, you may be reimbursed certain travel expenses at the Claims Administrator's discretion.

If you are directed to a Designated Provider, In-Network Benefits under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan option will be paid only if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your In-Network Physician must notify UnitedHealthcare of special service needs that might warrant referral. If you do not notify UnitedHealthcare in advance, and if you receive services from an Out-of-Network facility or other Out-of-Network provider, In-Network Benefits will not be paid under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan option. Out-of-Network Benefits may be available if the special-needs services you receive are Covered Health Services for which Benefits are provided under your Retiree Medical Coverage.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select an In-Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 30 days of the date you are notified, UnitedHealthcare will select a single In-Network Physician for you. In the event that you do not use the selected In-Network Physician, Covered Health Services will be paid under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan option as Out-of-Network Benefits.

Transition of Care

If you (or a family member) are enrolling in the Retiree Health Savings or Retiree Health Reimbursement Medical Plan option for the first time, your provider is not part of the UnitedHealthcare Choice Plus Network, and you are receiving an ongoing course of treatment, you may be able to continue receiving services from that provider in certain situations and for a limited period of time. Examples of conditions that may be eligible for transition of care include:

- Qualified maternity care
- Participating in an ongoing course of treatment, such as radiation or chemotherapy
- In-progress inpatient hospital or facility care
- Behavioral or mental health conditions
- Follow-up surgical or rehabilitative care

If you are eligible for transition of care benefits, you must coordinate through United Healthcare. You can apply for transition of care during Annual Enrollment or no later than 30 days after your coverage under the Retiree Medical Coverage becomes

effective. For more information about transition of care, including eligibility rules, forms and details about how to apply, call UnitedHealthcare at **1-833-593-4147**.

Eligible Expenses

Siemens Energy has delegated to UnitedHealthcare the discretion and authority to decide whether a service, procedure, treatment, or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under your Retiree Medical Coverage.

Eligible Expenses are the amount the Claims Administrator determines will be paid for Benefits. For In-Network Benefits for Covered Health Services provided by an In-Network provider under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Out-of-Network Benefits for Covered Health Services provided by an Out-of-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare) under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options, you will be responsible to the Out-of-Network Physician or provider the Balance Billing. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines.

For In-Network Benefits under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options, Eligible Expenses are based on the following:

- When Covered Health Services are received from an In-Network provider or a Designated Provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from an Out-of-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 or Deductible. The Retiree Medical Coverage will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits under the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options, when Covered Health Services are received from an Out-of-Network provider, Eligible Expenses are determined based on:

- Rates agreed to by the Out-of-Network provider and one of UnitedHealthcare's vendors, affiliates, or subcontractors.
- If rates have not been agreed to, then one of the following applies:
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - When a rate cannot be determined by either of these two methods and a Gap Exception does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator for the Retiree Medical Coverage options generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's Network (or a Medicare Participating Provider if you are enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan option) and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator for your Retiree Medical Coverage at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need Prior Authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Retiree Medical Coverage provides Benefits under the Plan for a mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

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

The amount you must pay for such Covered Health Services (including any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Prior Authorization or notify the Claims Administrator. For information on notification or Prior Authorization, contact your issuer.

Workers' Compensation Not Affected

Benefits provided under this Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Retiree Medical Coverage are intended to supplement coverage provided by Medicare for any enrolled participant who is eligible for Medicare. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Retiree Medical Coverage), you should enroll in and maintain coverage under both Medicare Part A and Part B. If the Retiree Medical Coverage is the secondary payer as described in Section 18, *Coordination of Benefits*, this Plan will pay Benefits under the Retiree Medical Coverage as if you were covered under both Medicare Part A and Part B, even if you are not enrolled in coverage under either Part. As a result, you will be responsible for the costs that Medicare would have paid, and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Retiree Medical Coverage), you should follow all rules of the Medicare Advantage plan that require you to seek services from that plan's participating providers. When the Retiree Medical Coverage is the secondary payer, the Retiree Medical Coverage will pay any Benefits available to you under the Retiree Medical Coverage as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

SECTION 7 – PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program
- Covered Health Services which require Prior Authorization

Care Management

When you seek Prior Authorization as required (unless you are eligible for Medicare; see below), UnitedHealthcare will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

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

Personal Health Support Nurses focus their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and Cost-Effective services available.

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

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

- **Admission counseling –** Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management –** If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission management –** This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk management –** Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical

specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

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

Prior Authorization – If You Are Not Eligible for Medicare

Prior Authorization is required for certain Covered Health Services unless you are eligible for Medicare. In general, your In-Network primary Physician and other In-Network providers are responsible for obtaining Prior Authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining Prior Authorization. For more information on the Covered Health Services that require Prior Authorization, please refer to Section 11, *Additional Coverage Details*.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from an In-Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician, and other providers are In-Network providers and that they have obtained the required Prior Authorization. In-Network facilities and In-Network providers cannot bill you for services for which they fail to prior authorize as required. You can contact UnitedHealthcare by calling the number on the back of your ID card.

When you choose to receive certain Covered Health Services from Out-of-Network providers, you are responsible for obtaining Prior Authorization before you receive these services. Note that your obligation to obtain Prior Authorization is also applicable when an Out-of-Network provider intends to admit you to an In-Network facility or refers you to In-Network providers.

To obtain Prior Authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

In-Network providers are generally responsible for obtaining Prior Authorization from the United Healthcare before they provide certain services to you. However, there are some In-Network Benefits – for instance, an organ transplant or participation in a Clinical Trial – for which you are responsible for obtaining Prior Authorization from UnitedHealthcare.

When you choose to receive certain Covered Health Services from Out-of-Network providers, you are responsible for obtaining Prior Authorization from UnitedHealthcare before you receive these services or as soon as is reasonably possible in the case of a

non-scheduled outpatient diagnostic or therapeutic procedure or treatment, outpatient surgery or admission (including an Emergency admission) to a Hospital or other inpatient facility. **In many cases, if you fail to obtain Prior Authorization for a Covered Health Service as required, Benefits will be reduced. After you have met the Annual Deductible for your Retiree Medical Coverage, you will pay in full the next $300 of Covered Expenses, and Benefits will be limited to 50% of the balance of Covered Expenses.**

If You Are Eligible for Medicare

If you are enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan option, Medicare pays before your Retiree Medical Coverage pays Benefits, and the Prior Authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 18, *Coordination of Benefits*. The Retiree 90/10 Medicare Carve-Out Medical Plan option does not require you to obtain authorization before receiving Covered Health Services, but Medicare may.

Important! You must notify the SEBSC by calling **1-844-950-0359** if you or a covered Dependent becomes eligible for Medicare due to a disability or if you or a covered Dependent reaches age 65.

- If you are enrolled in the Retiree Health Savings or Health Reimbursement Medical Plan option and you or your covered Dependent continues to be eligible to participate in the Retiree Medical Coverage, as described in Section 2, *Eligbility*, you or your covered Dependent will automatically be enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan option, which coordinates with Medicare.
- Unless you are a member of a retiree group that is eligible for coverage after age 65, as described in Section 2, *Eligibility*, eligibility to participate in the Retiree Program will end for you or your covered Dependent who reaches age 65.
- Family members who are not Medicare-eligible may continue their enrollment in the Retiree Health Savings Medical or Retiree Health Reimbursement Medical Plan option until they reach age 65, provided they continue to be eligible to participate in the Retiree Program.

Once you or a covered Dependent becomes eligible for Medicare, you or your covered Dependent will be treated as if you or your Dependent had enrolled in Medicare Part A and Part B, even if you or your covered Dependent does not in fact enroll in coverage under either Part. In addition, if you do not contact the SEBSC at the time you or your covered Dependent becomes eligible for Medicare, and if your Retiree Medical Coverage continues to pay Benefits as if you or your covered Dependent were not eligible for Medicare, you will be responsible for reimbursing the Retiree Program for the amount of any Benefits that have been incorrectly paid to or on behalf of you or your covered Dependent as a result of your failure to notify the SEBSC of your or your covered Dependent's eligibility for Medicare.

SECTION 8 – SCHEDULE OF BENEFITS FOR THE RETIREE HEALTH SAVINGS MEDICAL PLAN OPTION

Table 8 below provides an overview of coverage levels under the Retiree Health Savings Medical Plan option. For detailed descriptions of your Benefits, refer to Section 11, *Additional Coverage Details*.

Table 8 Covered Health Services * Retiree Health Savings Medical Plan Option	**Percentage of Eligible Expenses Payable by the Plan:**	
	In-Network	**Out-of-Network**
Acupuncture Services See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Allergy Care	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Ambulance Services – Emergency Only	85% after you meet the In-Network Annual Deductible	
Clinical Trials Benefits are available when Covered Health Services are provided by either In-Network or Out-of-Network providers; however, the Out-of-Network provider must agree to accept the In-Network level of reimbursement by signing a Network provider agreement specifically for the patient enrolling in the trial. (Out-of-Network Benefits are not available if the Out-of-Network provider does not agree to accept the In-Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries In-Network and Out-of-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Dental Services – Accident Only	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 8 Covered Health Services * Retiree Health Savings Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	Out-of-Network
Diabetes Services ■ Diabetes Self-Management and Training / Diabetic Eye Examinations / Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
■ Diabetes Equipment	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME)	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Emergency Health Services – Outpatient	85% after you meet the In-Network Annual Deductible	
Habilitative Services	Depending upon where the Covered Health Service is provided, Benefits for habilitative services will be the same as those stated under *Rehabilitation Services – Outpatient* and *Spinal Treatment* in this section.	
Gender Dysphoria See Section 11, *Additional Coverage Details*, for limits	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your separate prescription drug coverage.	
Hearing Aids See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Home Health Care See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Hospice Care See Section 11, *Additional Coverage Details* for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Hospital – Inpatient Stay See Section 11, *Additional Coverage Details* for Prior Authorization requirements	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 8 Covered Health Services * Retiree Health Savings Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Injections / Infusion Therapy Services Administered in a Physician's Office	85% per injection after you meet the Annual Deductible	65% per injection after you meet the Annual Deductible
Maternity Services 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. Remember to enroll your newborn during the 30-day period that begins on the child's date of birth.	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Mental Health Services ■ Inpatient ■ Outpatient	85% after you meet the Annual Deductible 85% after you meet the Annual Deductible	65% after you meet the Annual Deductible 65% after you meet the Annual Deductible
Neurobiological Disorders – Autism Spectrum Disorder Services ■ Inpatient ■ Outpatient	85% after you meet the Annual Deductible 85% after you meet the Annual Deductible	65% after you meet the Annual Deductible 65% after you meet the Annual Deductible
Nutritional Counseling See Section 11, *Additional Coverage Details* for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Obesity Surgery See Section 11, *Additional Coverage Details* for limits	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Ostomy Supplies	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 8 Covered Health Services * Retiree Health Savings Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Outpatient Surgery, Diagnostic and Therapeutic Services		
■ Outpatient Surgery	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic Services		
• Preventive Lab and radiology / X-ray	100%	65% after you meet the Annual Deductible
• Preventive mammography testing	100%	65% after you meet the Annual Deductible
• Sickness and Injury related diagnostic services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic/Therapeutic Services – CT Scans, PET Scans, MRI and Nuclear Medicine	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Preventive Care Services (and Lactation Support)		
■ Physician Office Services	100%	65% after you meet the Annual Deductible
■ Outpatient Diagnostic Services	100%	65% after you meet the Annual Deductible
■ Breast Pumps	100%	65% after you meet the Annual Deductible
Private Duty Nursing – Outpatient See Section 11, *Additional Coverage Details* for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 8 Covered Health Services * Retiree Health Savings Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	Out-of-Network
Prosthetic Devices	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Reconstructive Procedures		
■ Physician's Office Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Hospital – Inpatient Stay	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Prosthetic Devices	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Surgery	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic/Therapeutic Services – CT Scans, PET Scans, MRI and Nuclear Medicine	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Rehabilitation Services – Outpatient See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services See Section 11, *Additional Coverage Details* for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy See Section 11, *Additional Coverage Details* for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 8 Covered Health Services * Retiree Health Savings Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Substance-Related and Addictive Disorder Services		
■ Inpatient	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Transplantation Services Out-of-Network Benefits include services provided at an In-Network facility that is not a Designated Provider and services provided at an Out-of-Network facility.	100% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Travel and Lodging See Section 11, *Additional Coverage Details* for limits	For patient and companion(s) of patient undergoing transplant procedures	
Urgent Care Center Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Vision Care (Orthoptic Therapy and Hardware Only)	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

* You must obtain Prior Authorization from UnitedHealthcare or Personal Health Support, as described in Section 7, *Personal Health Support and Prior Authorization* to receive full Benefits before receiving certain Covered Health Services from an Out-of-Network provider. In general, if you visit an In-Network provider, that provider is responsible for obtaining Prior Authorization from UnitedHealthcare or Personal Health Support before you receive certain Covered Health Services. See Section 11, *Additional Coverage Details* for further information.

Table 8 – Schedule of Benefits for Retiree Health Savings Medical Plan

SECTION 9 – SCHEDULE OF BENEFITS FOR THE RETIREE HEALTH REIMBURSEMENT MEDICAL PLAN OPTION

Table 9 below provides an overview of coverage levels under the Retiree Health Reimbursement Medical Plan option. For detailed descriptions of your Benefits, refer to Section 11, *Additional Coverage Details*.

Table 9 **Covered Health Services *** **Retiree Health Reimbursement Medical Plan Option**	**Percentage of Eligible Expenses Payable by the Plan:**	
	In-Network	**Out-of-Network**
Acupuncture Services See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Allergy Care	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Ambulance Services – Emergency Only	85% after you meet the Annual Deductible	85% after you meet the Annual Deductible
Clinical Trials Benefits are available when the Covered Health Services are provided by either In-Network or Out-of-Network providers. However, the Out-of-Network provider must agree to accept the In-Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Out-of-Network Benefits are not available if the Out-of-Network provider does not agree to accept the In-Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries In-Network and Out-of-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Dental Services – Accident Only	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 9 Covered Health Services * Retiree Health Reimbursement Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	Out-of-Network
Diabetes Services ■ Diabetes Self-Management and Training / Diabetic Eye Examinations / Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
■ Diabetes Equipment	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME)	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Emergency Health Services – Outpatient	85% after you meet the In-Network Annual Deductible	
Habilitative Services	Depending upon where the Covered Health Service is provided, Benefits for habilitative services will be the same as those stated under *Rehabilitation Services – Outpatient* and *Spinal Treatment* in this section.	
Gender Dysphoria See Section 11, *Additional Coverage Details*, for limits	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your separate prescription drug coverage.	
Hearing Aids See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Home Health Care See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Hospice Care See Section 11, *Additional Coverage Details* for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Hospital – Inpatient Stay See Section 11, *Additional Coverage Details* for Prior Authorization requirements	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 9 Covered Health Services * Retiree Health Reimbursement Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	Out-of-Network
Injections / Infusion Therapy Services Administered in a Physician's Office	85% per injection after you meet the Annual Deductible	65% per injection after you meet the Annual Deductible
Maternity Services 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. Remember to enroll your newborn during the 30-day period that begins on the child's date of birth.	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Mental Health Services ■ Inpatient ■ Outpatient	85% after you meet the Annual Deductible 85% after your meet the Annual Deductible	65% after you meet the Annual Deductible 65% after you meet the Annual Deductible
Neurobiological Disorders – Autism Spectrum Disorder Services ■ Inpatient ■ Outpatient	85% after you meet the Annual Deductible 85% after your meet the Annual Deductible	65% after you meet the Annual Deductible 65% after you meet the Annual Deductible
Nutritional Counseling See Section 11, *Additional Coverage Details* for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Obesity Surgery See Section 11, *Additional Coverage Details* for limits	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Table 9 Covered Health Services * Retiree Health Reimbursement Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Office Visits		
■ Primary Care Provider	85% after your meet the Annual Deductible	65% after you meet the Annual Deductible
■ Specialist	85% after your meet the Annual Deductible	65% after you meet the Annual Deductible
Ostomy Supplies	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Outpatient Surgery, Diagnostic and Therapeutic Services		
■ Outpatient Surgery	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic Services		
• Preventive Lab and radiology / X-ray	100%	65%
• Preventive mammography testing	100%	65%
• Sickness and Injury related diagnostic services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic/Therapeutic Services – CT Scans, PET Scans, MRI and Nuclear Medicine	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 9 Covered Health Services * Retiree Health Reimbursement Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Preventive Care Services (and Lactation Support)		
■ Physician Office Services	100%	65%
■ Outpatient Diagnostic Services	100%	65%
■ Breast Pumps	100%	65%
Private Duty Nursing – Outpatient See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Prosthetic Devices	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Reconstructive Procedures		
■ Physician's Office Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Hospital – Inpatient Stay	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Prosthetic Devices	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Surgery	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Diagnostic / Therapeutic Services – CT Scans, PET Scans, MRI and Nuclear Medicine	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Rehabilitation Services – Outpatient See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 9 Covered Health Services * Retiree Health Reimbursement Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	Out-of-Network
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy See Section 11, *Additional Coverage Details*, for limits	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Substance-Related and Addictive Disorder Services ■ Inpatient ■ Outpatient	85% after you meet the Annual Deductible 85% after you meet the Annual Deductible	65% after you meet the Annual Deductible 65% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible
Transplantation Services Out-of-Network Benefits include services provided at an In-Network facility that is not a Designated Provider and services provided at an Out-of-Network facility.	100%	65% after you meet the Annual Deductible
Travel and Lodging See Section 11, *Additional Coverage Details* for limits	For patient and companion(s) of patient undergoing transplant procedures	
Urgent Care Center Services	85% after you meet the Annual Deductible	65% after you meet the Annual Deductible

Table 9 Covered Health Services * Retiree Health Reimbursement Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Vision Care ■ Orthoptic therapy ■ Vision hardware	85% after your meet the Annual Deductible 85% after you meet the Annual Deductible	65% after you meet the Annual Deductible 65% after you meet the Annual Deductible

* You must obtain Prior Authorization from United Healthcare or Personal Health Support, as described in Section 7, *Personal Health Support and Prior Authorization* to receive full Benefits before receiving certain Covered Health Services from an Out-of-Network provider. In general, if you visit an In-Network provider, that provider is responsible for obtaining Prior Authorization from UnitedHealthcare or Personal Health Support before you receive certain Covered Health Services. See Section 11, *Additional Coverage Details* for further information.

Table 9 – Schedule of Benefits for Retiree Health Reimbursement Medical Plan Option

SECTION 10 – SCHEDULE OF BENEFITS FOR RETIREE 90/10 MEDICARE CARVE-OUT MEDICAL PLAN OPTION

Table 10 below provides an overview of coverage levels under the Retiree 90/10 Medicare Carve-Out Medical Plan option. For detailed descriptions of your Benefits, refer to Section 11, *Additional Coverage Details*.

Table 10 Covered Health Services Retiree 90/10 Medicare Carve-Out Medical Plan Option	**Percentage of Eligible Expenses Payable by the Plan:**
Acupuncture Services See Section 11, *Additional Coverage Details*, for limits	90% after you meet the Annual Deductible
Allergy Care	90% after you meet the Annual Deductible
Ambulance Services – Emergency Only	90% after you meet the Annual Deductible
Clinical Trials Benefits are available for Covered Health Services that are provided by a provider that agrees to accept the Medicare level of reimbursement by signing a provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the provider does not agree to accept the Medicare level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.
Congenital Heart Disease (CHD) Surgeries In-Network and Out-of-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	90% after you meet the Annual Deductible
Dental Services – Accident Only	90% after you meet the Annual Deductible

Table 10 Covered Health Services Retiree 90/10 Medicare Carve-Out Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:
Diabetes Services ■ Diabetes Self-Management and Training / Diabetic Eye Examinations / Foot Care ■ Diabetes Equipment	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training / diabetic eye examinations / diabetic foot care will be paid the same as those stated under each Covered Health Service category in this section. Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.
Durable Medical Equipment (DME)	90% after you meet the Annual Deductible
Emergency Health Services – Outpatient	90% after you meet the Annual Deductible
Habilitative Services	Depending upon where the Covered Health Service is provided, Benefits for habilitative services will be the same as those stated under *Rehabilitation Services – Outpatient* and *Spinal Treatment* in this section.
Gender Dysphoria See Section 11, *Additional Coverage Details*, for limits	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your separate prescription drug coverage.
Hearing Aids See Section 11, *Additional Coverage Details*, for limits	90% after you meet the Annual Deductible
Home Health Care See Section 11, *Additional Coverage Details*, for limits	90% after you meet the Annual Deductible

Table 10 Covered Health Services Retiree 90/10 Medicare Carve-Out Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:
Hospice Care See Section 11, *Additional Coverage Details* for limits	90% after you meet the Annual Deductible
Hospital – Inpatient Stay See Section 11, *Additional Coverage Details* for Prior Authorization requirements	90% after you meet the Annual Deductible
Injections / Infusion Therapy Services Administered in a Physician's Office	90% per injection after you meet the Annual Deductible
Maternity Services 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. Remember to enroll your newborn during the 30-day period that begins on the child's date of birth.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Mental Health Services ■ Inpatient ■ Outpatient	90% after you meet the Annual Deductible
Neurobiological Disorders – Autism Spectrum Disorder Services ■ Inpatient ■ Outpatient	90% after you meet the Annual Deductible
Nutritional Counseling See Section 11, *Additional Coverage Details* for limits	90% after you meet the Annual Deductible
Obesity Surgery See Section 11, *Additional Coverage Details* for limits	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Office Visits ■ Primary Care Provider ■ Specialist	90% after you meet the Annual Deductible
Ostomy Supplies	90% after you meet the Annual Deductible

Table 10 Covered Health Services Retiree 90/10 Medicare Carve-Out Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:
Outpatient Surgery, Diagnostic and Therapeutic Services	
■ Outpatient Surgery	90% after you meet the Annual Deductible
■ Outpatient Diagnostic Services	
• Preventive Lab and radiology / X-ray	100%
• Preventive mammography testing	100%
• Sickness and Injury related diagnostic services	90% after you meet the Annual Deductible
■ Outpatient Diagnostic/Therapeutic Services – CT Scans, PET Scans, MRI and Nuclear Medicine	90% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	90% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible
Preventive Care Services (and Lactation Support) ■ Physician Office Services ■ Outpatient Diagnostic Services ■ Breast Pumps	100%
Private Duty Nursing – Outpatient See Section 11, *Additional Coverage Details*, for limits	90% after you meet the Annual Deductible
Prosthetic Devices	90% after you meet the Annual Deductible
Reconstructive Procedures ■ Physician's Office Services ■ Hospital – Inpatient Stay ■ Physician Fees for Surgical and Medical Services ■ Prosthetic Devices ■ Outpatient Surgery ■ Outpatient Diagnostic Services ■ Outpatient Diagnostic / Therapeutic Services – CT Scans, PET Scans, MRI and Nuclear Medicine ■ Outpatient Therapeutic Treatments	90% after you meet the Annual Deductible

Table 10 Covered Health Services Retiree 90/10 Medicare Carve-Out Medical Plan Option	Percentage of Eligible Expenses Payable by the Plan:
Rehabilitation Services – Outpatient See Section 11, *Additional Coverage Details*, for limits	90% after you meet the Annual Deductible
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services See Section 11, *Additional Coverage Details*, for limits	90% after you meet the Annual Deductible
Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy See Section 11, *Additional Coverage Details*, for limits	90% after you meet the Annual Deductible
Substance-Related and Addictive Disorder Services ■ Inpatient ■ Outpatient	90% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	90% after you meet the Annual Deductible
Transplantation Services	90% after you meet the Annual Deductible
Travel and Lodging See Section 11, *Additional Coverage Details* for limits	For patient and companion(s) of patient undergoing transplant procedures
Urgent Care Center Services	90% after you meet the Annual Deductible
Vision Care ■ Orthoptic therapy ■ Vision hardware	90% after you meet the Annual Deductible

Table 10 – Schedule of Benefits for Retiree 90/10 Medicare Carve-Out Medical Plan Option

SECTION 11 – ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which your Retiree Medical Coverage pays Benefits
- Covered Health Services that require you to obtain Prior Authorization from Personal Health Support before you receive them

This section supplements the tables in Section 3 (Retiree Health Savings Medical Plan Option), Section 4 (Retiree Health Reimbursement Medical Plan Option), and Section 5 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Highlights*, and Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), and Section 10 (Retiree Medicare-Eligible 90/10/ Medical Plan Option), *Schedule of Benefits*.

While the tables provide you with Benefit limitations along with information on the Annual Deductible and Coinsurance that apply separately to each of the Retiree Medical Coverage options, this section includes descriptions of the Benefits for each Covered Health Service under the Retiree Medical Coverage. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support to request Prior Authorization (unless you are enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan option).

If you are enrolled in the Retiree Health Savings Medical Plan Option or the Retiree Health Reimbursement Medical Plan Option and you fail to obtain Prior Authorization as required, Benefits will be reduced. After satisfaction of the Annual Deductible for this Plan, you will pay in full the next $300 of Covered Expenses, and Plan benefits will be limited to 50% of the balance of Covered Expenses.

For easy reference, the Covered Health Services in this section appear in the same order as they do in the tables. Services that are not covered are described in Section 12, *Exclusions* and Limitations.

Acupuncture Services

This Plan pays Benefits for acupuncture services when the service is performed by a provider in the provider's office, when the provider is either practicing within the scope of his/her license (if state license is available) or is certified by a national accrediting body.

Any combination of In-Network and Out-of-Network Benefits is limited to 18 visits per calendar year.

Ambulance Services – Emergency and Non-Emergency

The Plan pays Benefits for Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Air ambulance transportation is only covered as medically appropriate. Coverage includes non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) between health care facilities when the ambulance transportation is any of the following, as UHC determines to be appropriate: (1) from a non-network hospital to a network hospital; (2) to a hospital that provides a

required higher level of care that was not available at the original hospital; (3) to a more cost-effective acute care facility; or (4) from an acute facility to a sub-acute setting.

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 UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life-threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's 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.
- 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, 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.
  - 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.
    - ♦ 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 dru*g 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. UnitedHealthcare may, at any time, request documentation about the trial; or
- The subject or purpose of the Clinical 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 your Retiree Medical Coverage.

Prior Authorization Requirement
You must obtain Prior Authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain Prior Authorization as required, Benefits will be subject to a $300 reduction in addition to a 50% reduction in benefits after deductible.

Congenital Heart Disease (CHD) Surgeries

Your Retiree Medical Coverage pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact CHD Resource Services at 1-888-936-7246 or Care Coordination℠ at the toll-free number on your ID card or Personal Health Support at the toll-free number on your ID card for information about these guidelines.

Prior Authorization Requirement
For Out-of-Network Benefits, please remember you must obtain Prior Authorization from the Claims Administrator as soon as CHD is suspected or diagnosed.

Dental Services – Accident Only

Dental services are covered by your Retiree Medical Coverage when all of the following are true:

- Treatment is necessary because of accidental damage;
- Dental services are received from a Doctor of Dental Surgery ("DDS") or a Doctor of Medical Dentistry ("DMD"); and
- The dental damage is severe enough that initial contact with a Physician or Dentist occurred within 72 hours of the accident.

Your Retiree Medical Coverage also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures;
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system); and
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Benefits are available only for treatment of a sound, natural tooth.

The Physician or Dentist must certify that the injured tooth was:

- A virgin or unrestored tooth; or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan; and
- Completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident." Benefits are not available for repairs to teeth that are injured as a result of such activities.

Diabetes Services

Diabetes Self-Management and Training / Diabetic Eye Examinations / Foot Care

Your Retiree Medical Coverage covers outpatient self-management training for the treatment of diabetes, education, and medical nutrition therapy services ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Equipment

Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*. Diabetic supplies – including insulin syringes, blood glucose monitors, lancets and lancet devices, and blood glucose, urine and ketone test strips – are covered under the Retiree Prescription Drug Program.

Prior Authorization Requirement
Unless you are covered under the Retiree 90/10 Medicare Carve-Out Medical Plan Option, for Out-of-Network Benefits, you must obtain Prior Authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

Durable Medical Equipment (DME)

Your Retiree Medical Coverage pays for Durable Medical Equipment (DME) that meets each of the following:

- Ordered or provided by a Physician for outpatient use;
- Used for medical purposes;
- Not consumable or disposable;
- Not of use to a person in the absence of a disease or disability; and
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.

Prior Authorization Requirement
Unless you are covered under the Retiree 90/10 Medicare Carve-Out Medical Plan Option, for Out-of-Network Benefits, you must obtain Prior Authorization from the Claims Administrator if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. To receive In-Network Benefits, you must purchase or rent the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing In-Network Physician.

Examples of DME include but are not limited to:

- Equipment to assist mobility, such as a standard wheelchair;
- A standard Hospital-type bed;
- Oxygen concentrator units and the rental of equipment to administer oxygen;
- Delivery pumps for tube feedings;

- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by this Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital – Inpatient Stay*, *Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section;
- Braces that stabilize an injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. Braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage;

Benefits are provided for a single unit of Durable Medical Equipment (for example, one insulin pump) and repair for that unit. Benefits are provided for the repair or replacement of a unit of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three-year timeframe. Repairs for necessary DME – including the replacement of essential accessories, such as hoses, tubes, and mouth pieces – are only covered when required to make the item or device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item or device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

Emergency Health Services – Outpatient

Your Retiree Medical Coverage pays for services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

In-Network Benefits will be paid for an Emergency admission to an Out-of-Network Hospital as long as Personal Health Support is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to an Out-of-Network Hospital. If you continue your stay in an Out-of-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to an In-Network Hospital, Out-of-Network Benefits will apply.

Emergency claims in a foreign country will be paid at the In-Network level.

Non-Emergency claims in a foreign country will be paid at the Out-of-Network level.

Prior Authorization Requirement
Unless you are covered under the Retiree 90/10 Medicare Carve-Out Plan Option, for Out-of-Network Benefits, you must obtain Prior Authorization from Personal Health Support within 48 hours of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency.

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit).
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described under your separate prescription drug coverage.
- 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:
    - Augmentation mammoplasty
    - 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)
    - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple)
  - 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).
  - The two letters need to be signed within 12 months of the request for surgery.
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement
For In- or Out-of-Network Benefits, you must notify UnitedHealthcare as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with Activities of Daily Living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or, Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, and vocational training are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

Your Retiree Medical Coverage may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Retiree Health Coverage to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Retiree Health Coverage may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Hearing Aids

Your Retiree Medical Coverage pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by an Otolaryngologist and/or Audiologist. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone-anchored hearing aids. Bone-anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/ surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to one per aid per ear in a 48-month period.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- Ordered by a Physician; and
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when Skilled Care is required.

UnitedHealthcare will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

For participants in the Retiree Health Savings or Retiree Health Reimbursement Medical Plan options, any combination of In-Network Benefits and Out-of-Network Benefits for Home Health Care is limited to 90 visits per calendar year, and Benefits for Home Health Care are not combined with Benefits for Private Duty Nursing. For participants in the Retiree 90/10 Medicare Carve-Out Medical Plan option, all Benefits for Home Health Care and Private Duty Nursing is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services.

Prior Authorization Requirement
For Out-of-Network Benefits for nutritional foods, Private Duty Nursing, and Skilled Nursing, you must obtain Prior Authorization from the Claims Administrator five business days before receiving services or as soon as is reasonably possible.

Hospice Care

Your Retiree Medical Coverage pays Benefits for Hospice Care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Out-of-Network Benefits for Hospice Care, you must obtain Prior Authorization from the Claims Administrator five business days before receiving services.

Hospital – Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during the Inpatient Stay; and
- Room and board in a Semi-private Room (a room with two or more beds).

Prior Authorization Requirement:
For Out-of-Network Benefits for an Inpatient Hospital Stay, you must obtain Prior Authorization from the Claims Administrator as follows:

- ***for elective admissions:*** five business days before admission or as soon as reasonably possible;
- ***for Emergency admissions*** (also termed non-elective admissions): within two business days of admission, or as soon as is reasonably possible.

Hyperhidrosis

Your Retiree Medical Coverage pays Benefits for medical and surgical treatment of excessive sweating (hyperhidrosis).

Injections / Infusion Therapy Services Administered in a Physician's Office

Your Retiree Medical Coverage pays Benefits for injections received in a Physician's office when no other health service is received – for example, allergy immunotherapy – and for infusion therapy service administered in a Physician's office. Drugs that are routinely self-injected are covered under the Retiree Prescription Drug Program.

Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

Benefits will be paid for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; and
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain Prior Authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment,
- Partial Hospitalization/Day Treatment,
- Outpatient Treatment, and
- Intensive Outpatient Treatment.

Prior Authorization Requirement
For Out-of-Network Benefits for Mental Health Services:
- For a scheduled admission, you must obtain authorization prior to the admission.
- For a non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

Services include the following:

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

The Claims Administrator also provides administrative services for care and treatment of Mental Health and Substance-Related and Addictive Disorders.

You are encouraged to contact the Claims Administrator for referrals to providers and coordination of care. To obtain Prior Authorization, contact UnitedHealthcare at **1-833-593-4147**.

Neurobiological Disorders – Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

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

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

are subject to the Annual Deductible for your Retiree Medical Coverage, Coinsurance, and Out-of-Pocket Maximum.

Benefits include the following levels of care:

- Inpatient treatment,
- Partial Hospitalization/Day Treatment,
- Intensive Outpatient Treatment, and
- Outpatient treatment.

Prior Authorization Requirement
For Out-of-Network Benefits for Neurobiological Disorders – Autism Spectrum Disorder Services, you must obtain authorization prior to a scheduled admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Services include the following:

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

The Claims Administrator provides administrative services for each level of care.

Contact the Claims Administrator for referrals to providers and coordination of care. To review In-Network providers, obtain Prior Authorization or to talk to an ABA specialist, contact UnitedHealthcare at **1-833-593-4147**.

Nutritional Counseling

For Covered Persons with medical conditions that require a special diet, your Retiree Medical Coverage will pay for up to three individual sessions per calendar year for Covered Health Services provided by a registered dietician. Some examples of such medical conditions include:

- Diabetes mellitus
- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)
- Morbid obesity

When nutritional counseling services are billed as a preventive care service, these

services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

Your Retiree Medical Coverage covers surgical treatment of morbid obesity for Bariatric surgery only.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 22, *Glossary* and are not Experimental or Investigational or Unproven Services.

Obesity surgery is covered on an inpatient basis provided all of the following are true:

- Person is 18 years or older.
- BMI of 40 or greater, for at least two years.
- BMI of 35-39 for at least two years with evidence of co-morbid conditions attributable to obesity: sleep apnea, Type-2 Diabetes, asthma, hypertension, CHD, osteoarthritis, gall bladder disease, several types of cancers, amongst other conditions.
- Evidence of nutritional counseling by a physician for at least six months within two years of surgery date.

Lap Band surgery is covered provided the following conditions are met:

- Person is 18 years old or older.
- BMI of 40 or greater for two years.
- BMI of 35 to 39 for at least two years with evidence of co-morbid conditions attributable to obesity: sleep apnea, Type-2 Diabetes, asthma, hypertension, CHD, osteoarthritis, gall bladder disease, several types of cancers, amongst other conditions.
- Evidence of nutritional counseling by a physician for at least six months within two years of surgery date.

Sleeve gastrectomy procedures are covered subject to the conditions listed above.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain Prior Authorization from the Claims Administrator as soon as the possibility of obesity surgery arises.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

Your Retiree Medical Coverage pays for Covered Health Services for surgery and

related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Prior Authorization Requirement
For Out-of-Network Benefits for sleep apnea surgeries, cochlear implant and orthognatic surgeries, you must notify the Claims Administrator five business days before scheduled services are received or within one business day or as soon as is reasonably possible for non-scheduled services.

Outpatient Diagnostic Services

Your Retiree Medical Coverage pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab and radiology/X-ray.
- Mammography testing. 3-D mammography is covered 100% under preventive care and for screening purposes when received In-Network.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.

Outpatient Diagnostic/Therapeutic Services – CT Scans, PET Scans, MRI, or Nuclear Medicine

Your Retiree Medical Coverage pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment.

Outpatient Therapeutic Treatments

Your Retiree Medical Coverage pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Prior Authorization Requirement
For Out-of-Network Benefits for the following outpatient therapeutic services, you must obtain Prior Authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require Prior Authorization include dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy, and MR-guided focused ultrasound.

Physician Fees for Surgical and Medical Services

Your Retiree Medical Coverage pays for Physician Fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Physician's Office Services – Sickness and Injury

Benefits are paid by your Retiree Medical Coverage for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic, or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing following genetic counseling when ordered by the Physician. You must obtain Prior Authorization from UnitedHealthcare for Genetic Testing by Out-of-Network providers.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain Prior Authorization for Genetic Testing, specifically including testing for the Breast Cancer susceptibility gene (BRCA).

Preventive Care Services (and Lactation Support)

Preventive care services are provided on an outpatient basis at a Physician's office, an Alternate Facility, or a Hospital. Preventive care services encompass medical services 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, including Gardasil, 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. 3-D mammography is covered 100% under preventive care when

received In-Network.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of purchasing or renting one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under the heading *Covered Health Services* in Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), or Section 10 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Schedule of Benefits*.

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

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

Private Duty Nursing

Your Retiree Medical Coverage pays for Covered Health Services for Private Duty Nursing care given on an outpatient basis when provided by a licensed nurse (RN, LPN, or LVN).

For participants in the Retiree Health Savings and Retiree Health Reimbursement Medical Plan options, any combination of In-Network Benefits and Out-of-Network Benefits for Private Duty Nursing is limited to 90 visits per calendar year, and Benefits for Private Duty Nursing are not combined with Benefits for Home Health Care. For participants in the Retiree 90/10 Medicare Carve-Out Medical Plan option, all Benefits for Home Health Care and Private Duty Nursing is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services.

Prosthetic Devices

Benefits are paid by your Retiree Medical Coverage for prosthetic devices that replace a limb or body part including:

- Artificial limbs;
- Artificial eyes; and
- Post-mastectomy bras and breast prostheses as required by the Women's Health and Cancer Rights Act of 1998.

Benefits are also provided for one wig per lifetime for medically induced loss of hair – for instance, as the result of chemotherapy.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits are provided for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of a unit of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the

three-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain Prior Authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device.

Note: Prosthetic devices are different from DME – see *Durable Medical Equipment* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By "improving or restoring physiologic function," it is meant that the target organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Procedures are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as reconstructive procedures. Reshaping a nose with a prominent "bump" is an example of a Cosmetic Procedure because appearance may be improved but there is no effect on function such as breathing. This Plan does not provide Benefits for Cosmetic Procedures.

Some services are considered reconstructive in some circumstances and cosmetic in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better; whereas in other situations, the purpose is to improve appearance and function (such as vision). For example, the primary purpose of upper eyelid surgery may be to improve vision (this is reconstructive) while on other occasions, the primary purpose of upper eyelid surgery may be to improve appearance (this is cosmetic).

Prior Authorization Requirement
You must obtain Prior Authorization from the Claims Administrator five business days before undergoing a Reconstructive Procedure. When you obtain Prior Authorization, the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded

Please note that Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by this Plan if the initial breast implant followed mastectomy. In certain cases when not cosmetic in nature, replacement of an existing breast implant is covered under the Gender Dysphoria benefits. Other services mandated by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about

Benefits for mastectomy-related services.

Rehabilitation Services – Outpatient Therapy

Your Retiree Medical Coverage provides short-term outpatient rehabilitation services for:

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication, and auditory processing only following the placement of a cochlear implant or when the disorder results from Injury, Sickness, stroke, cancer, developmental delay, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.

Please note that the Plan excludes any type of therapy, service, or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Benefits are limited to:

- 60 visits per calendar year for physical therapy and occupational therapy (combined limit);
- 60 visits per calendar year for speech therapy;
- Unlimited visits per calendar year for pulmonary rehabilitation therapy; and
- Unlimited visits per calendar year for cardiac rehabilitation therapy.

These visit limits apply to In-Network Benefits and Out-of-Network Benefits combined.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Your Retiree Medical Coverage will pay Benefits for restorative speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. In addition, benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if Manipulative Treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Prior Authorization Requirement
For Out-of-Network Benefits for physical therapy, occupational therapy, and/or speech therapy, you must obtain Prior Authorization from the Claims Administrator five business days before services or call the number on the back of your ID card as soon as is reasonably possible.

Skilled Nursing Facility / Inpatient Rehabilitation Facility Services

Your Retiree Medical Coverage pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Services and supplies received during the Inpatient Stay; and
- Room and board in a Semi-private Room (a room with two or more beds).

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to 60 visits per calendar year.

Please note that, in general, the intent of Skilled Nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or Illness that requires an intensity of care or a combination of Skilled Nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when Skilled Nursing and/or rehabilitation services are needed on a daily basis. Benefits are ***not*** available when these services are considered Intermittent Care (such as physical therapy three times a week).

Prior Authorization Requirement
For Out-of-Network Benefits, please remember you must obtain Prior Authorization from the Claims Administrator as follows:
- **for elective admissions:** five business days before admission;
- **for non-elective admissions:** within one business day or the same day of admission; and
- **for Emergency admissions:** within two business days or the same day of admission, or as soon as is reasonably possible.

Benefits are ***not*** available for custodial, maintenance or Domiciliary Care (including administration of enteral feeds) which, even if such care is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, maintenance, or Domiciliary Care may be provided by persons without special skill or training. Such care may include, but is not limited to, help in getting in

and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy

Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Your Retiree Medical Coverage provides Benefits for Spinal Treatment that is provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Please note that the Retiree Medical Coverage excludes any type of therapy, service, or supply including, but not limited to, spinal manipulations by a chiropractor or other Physician for the treatment of a condition when the therapy, service, or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Any combination of In-Network and Out-of-Network Benefits for Spinal Treatment is limited to 25 visits per calendar year.

Prior Authorization Requirement
For Out-of-Network Benefits, you must obtain Prior Authorization from the Claims Administrator five business days before receiving Spinal Treatment or as soon as reasonably possible.

Substance-Related and Addictive Disorder Services

Substance-Related and Addictive Disorder Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

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

Services include the following:

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

The applicable Claims Administrator provides administrative services for all levels of care.

You are encouraged to contact the applicable Claims Administrator for referrals to

providers and coordination of care.

Prior Authorization Requirement
For Out-of-Network Benefits for Substance-Related and Addictive Disorder Services, you must obtain authorization prior to a scheduled admission or as soon as is reasonably possible for a non-scheduled admission (including an Emergency admission).

Temporomandibular Joint (TMJ) Services

Your Retiree Medical Coverage pays for Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, and open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration* (FDA)-approved TMJ implants only when all other treatment has failed.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

The Plan covers dental charges necessary because of injury to natural teeth resulting from an accident, and surgical and non-surgical treatment for temporomandibular joint dysfunction (TMJ) including splints and appliances.

Prior Authorization Requirement
For Out-of-Network Benefits, please remember you must obtain Prior Authorization from the Claims Administrator five business days before temporomandibular joint services are performed during an Inpatient Hospital Stay in a Hospital.

Transplantation Services

Organ and tissue transplants are Covered Health Services when ordered by a Physician and subject to certain conditions. **Notification is required for all transplant services.** The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven.

Transplant candidates should be listed with United Network for Organ Sharing (UNOS), the private, non-profit organization that manages the U.S. organ transplant system under contract with the federal government, http://www.unos.org. There are 11 UNOS regions in the U.S., and facilities need to comply with UNOS policies. Hospitals register patients with UNOS as candidates for organ transplant. When an organ becomes available, it goes to the UNOS-registered candidate with the greatest medical need for that organ. UNOS notifies the hospital when their patient has a match.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable when the organ recipient is covered under this Plan.

For the highest level of Benefits, services must be received at a Designated Provider.

The Annual Deductible for the Retiree Health Reimbursement Medical Plan option and the Annual Deductible for the Retiree 90/10 Medicare Carve-Out Medical Plan option will not apply to In-Network Benefits when a transplant listed below is received at a Designated Provider. The services described under *Travel and Lodging* below are Covered Health Services ***only*** in connection with a transplant received at a Designated Provider.

Examples of transplants for which Benefits are available include but are not limited to:

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high-dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Provider. If a separate charge is made for a bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search;
- Heart transplants;
- Heart/lung transplants;
- Lung transplants;
- Kidney transplants;
- Kidney/pancreas transplants;
- Liver transplants;
- Liver/small bowel transplants;
- Pancreas transplants; and
- Small bowel transplants.

Your Retiree Medical Coverage does not require that cornea transplants be performed at a Designated Provider in order for you to receive In-Network Benefits. Benefits for cornea transplants that are provided by an In-Network Physician at an In-Network Hospital are paid as if the transplant was received at a Designated Provider.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under your Retiree Medical Coverage, there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Travel and Lodging Assistance Program for Transplantation Services

Your Retiree Medical Coverage may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider that is located ***50 or more miles*** from your home address. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at **1-800-842-0843**.

Travel and Lodging Expenses

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 qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The 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 patient resides **more than 50 miles** from the Designated Provider.
- 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 and/or the companion's travel is not Medically Necessary.
- The bariatric, cancer, congenital heart disease and transplant, spine, and joint care programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50 per day, for the caregiver if the patient is in the Hospital.
- A per diem rate, up to $50 per day, for the patient if the patient is not in the Hospital.
- A per diem rate, up to $100 per day, for the patient and one caregiver if the patient is not in the Hospital. When a child is the patient, two persons may accompany the child.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Examples of items that are not covered:

- Meals.
- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- 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.

Prior Authorization Requirement
For Out-of-Network Benefits, please remember you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Urgent Care Center Services

Your Retiree Medical Coverage pays for Covered Health Services received at an Urgent Care Center. When Urgent Care services are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.

Vision Care (Orthoptic Therapy and Hardware Only)

Benefits for Vision Hardware under the three Retiree Medical Coverage options include one pair of eyeglass lenses and frames or contact lenses for treatment of keratoconus or post-cataract surgery. Unlimited lenses for glasses are covered with a diagnosis of Aphakia.

SECTION 12 – EXCLUSIONS AND LIMITATIONS: WHAT THE RETIREE MEDICAL COVERAGE WILL NOT COVER

What this section includes:

- Services, supplies, and treatments that are not Covered Health Services, except as may be specifically provided for in Section 11, *Additional Coverage Details*

Your Retiree Medical Coverage does not pay Benefits for the following services, treatments, or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), or Section 10 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Schedule of Benefits*, those limits are stated in the corresponding Covered Health Service category in Section 11, *Additional Coverage Details*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 11, *Additional Coverage Details*. Please review all limits carefully, as your Retiree Medical Coverage will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says, "this includes" or "including but not limited to," it is not the intent to limit the description to that specific list. When the SPD does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Movement therapy.
6. Applied kinesiology
7. Rolfing.
8. Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
9. 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 Spinal Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 11, *Additional Coverage Details*.

Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners.
   - Air purifiers and filter.
   - Batteries and battery chargers.
   - Dehumidifiers.
   - Humidifiers.
6. Devices and computers to assist in communication and speech.
7. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

Dental

1. Dental care (which includes dental X-rays, supplies and appliances, and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 11, *Additional Coverage Details.*
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums. Examples include:
   - Extraction, restoration, and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 11, *Additional Coverage Details*.
3. Dental implants.
4. Dental braces (orthodontics).
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.
6. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services and all services related to Experimental or Investigational or Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, procedure, treatment, therapy, device, or pharmacological regimen is the only available treatment for a particular condition will not result in payment of Benefits if the service or procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 11, *Additional Coverage Details*.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:
   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).
2. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.
4. Treatment of subluxation of the foot.
5. Shoe orthotics.

Gender Dysphoria

Cosmetic Procedures, including the following:

1. Abdominoplasty.

2. Blepharoplasty.
3. Body contouring, such as lipoplasty.
4. Brow lift.
5. Calf implants.
6. Cheek, chin, and nose implants.
7. Gluteal augmentation
8. Injection of fillers or neurotoxins.
9. Face lift, forehead lift, or neck tightening.
10. Facial bone remodeling for facial feminizations.
11. Hair removal.
12. Hair transplantation.
13. Lip augmentation.
14. Lip reduction.
15. Liposuction.
16. Mastopexy.
17. Pectoral implants for chest masculinization.
18. Rhinoplasty.
19. Skin resurfacing.
20. Transsexual surgery or any treatment for sexual inadequateness that does not qualify for Gender Dysphoria treatment.
21. Voice modification surgery.
22. Voice lessons and voice therapy.

Non-covered procedures include:

1. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
2. Sperm preservation in advance of hormone treatment or gender surgery.
3. Cryopreservation of eggs or fertilized embryos.

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

Hearing Aids

1. Bone-anchored hearing aids except when either of the following applies:
   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
2. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled

under the Plan.

3. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings
   - Ace bandages
   - Gauze and dressings
   - Syringes
   - Diabetic test strips
3. Orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment* in Section 11, *Additional Coverage Details*.

   Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics or any orthotic braces available over-the-counter.
4. Tubings and masks, except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in Section 11, *Additional Coverage Details*.

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

In addition to all other exclusions listed in this Section 12, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services* and/or *Substance-Related and Addictive Disorder Services* in Section 11*, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *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 impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.
4. Educational/behavioral services that are primarily focused on building skills and capabilities in communication, social interaction, and learning.
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. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
8. Transitional Living services (also known as a half-way house).

Nutrition

1. Megavitamin and nutrition based therapy.
2. Food of any kind. Foods that are not covered include:
   - Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) or are Medically Necessary to sustain life. Infant formula available over-the-counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 22, *Glossary*. Examples include:
   - Pharmacological regimens, nutritional procedures, or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Cosmetic surgery or therapy that does not qualify for Gender Dysphoria treatment.
2. Replacement of an existing 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. See *Reconstructive Procedures* in Section 11, *Additional Coverage Details*.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion, or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs, except for one per lifetime for medically induced loss of hair.
6. Services received from a personal trainer.
7. Liposuction.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.

3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider.
4. Services that are self-directed to a freestanding or Hospital-based diagnostic facility.
5. Expenses for a second opinion by a doctor who is financially associated with the doctor who recommends the first course of treatment.
6. Expenses related to:
   - assistant surgeons (coverage may be available in very limited circumstances).
   - stand-by doctor (coverage may be available in very limited circumstances related to complicated or high-risk procedures, provided that the doctor is actually in the operating room during the performance of a procedure and is prepared to proceed with the surgical procedure).
7. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.
   - This exclusion does not apply to mammography.

Reproduction

1. Any treatment of infertility including infertility treatment-related services:
   - Ovulation predictor kits.
   - Infertility drugs, in vitro fertilization, artificial insemination, gamete infrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIF), variations of these procedures.
   - Storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees), and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - All costs associated with surrogate motherhood; non-medical costs associated with a gestational carrier.
2. Surrogate parenting, donor oocytes (eggs), donor sperm, and host uterus.
3. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
4. The reversal of male or female voluntary sterilization procedures.

Services Provided Under Another Plan

1. Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid

for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Transplants

1. Health services for organ, multiple organ, and tissue transplants, except as described in *Transplantation Services* in Section 11, *Additional Coverage Details,* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in Section 11, *Additional Coverage Details*, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses.

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services for organ transplantation services received from a Designated Provider may be reimbursed at UnitedHealthcare's discretion.

Vision

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 22, *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this SPD under Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), or Section 10 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Schedule of Benefits*.

- Not otherwise excluded in the SPD under Section 12, *Exclusions and Limitations*.

2. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
3. Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when:
   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage, adoption, or custody.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 11, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Court-ordered treatment or hospitalization, unless treatment is being sought by a participating Physician or is otherwise covered under Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), or Section 10 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Schedule of Benefits*.
   - Required to obtain or maintain a license of any type.
4. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in a non-war zone.
5. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
6. Non-birth related medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible for coverage under your Retiree Medical Coverage.
7. Health services received after the date your Retiree Medical Coverage ends, including health services for medical conditions arising before the date Retiree Medical Coverage ends.
8. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of Retiree Medical Coverage.
9. In the event that an Out-of-Network provider waives the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Annual Deductible is waived.
10. Charges in excess of Eligible Expenses or in excess of any specified limitation.
11. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.
12. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor, or cancer. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as a treatment of obstructive sleep apnea.

13. Non-surgical treatment of obesity, including morbid obesity.
14. Surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 40 or with BMI of 35 to 39 for at least two years with evidence of co-morbid conditions) as described under *Obesity Surgery* in Section 11, *Additional Coverage Details*).
15. Growth hormone therapy (except as specifically covered under the *CVS/caremark* Specialty Pharmacy Program).
16. Custodial Care or maintenance care.
17. Domiciliary Care.
18. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
19. Private Duty Nursing received on an inpatient basis.
20. 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 described under *Hospice Care* in Section 11, *Additional Coverage Details*.
21. Rest cures.
22. Psychosurgery.
23. Treatment of benign gynecomastia (abnormal breast enlargement in males).
24. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
25. Appliances for snoring, except for CPAP machines, which are covered up to $1,000.
26. Any charges for missed appointments, room or facility reservations, completion of claim forms, or record processing.
27. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply, or equipment.
28. Any charge for services, supplies, or equipment advertised by the provider as free.
29. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency.
30. Any charges prohibited by federal anti-kickback or self-referral statutes.
31. Chelation therapy, except to treat heavy metal poisoning.
32. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
33. Outpatient rehabilitation services, spinal treatment, manipulative treatment or supplies, including, but not limited to, spinal manipulations by a chiropractor or other Doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
34. Spinal treatment, including chiropractic and osteopathic manipulative treatment to treat an illness, such as asthma or allergies.
35. Speech therapy to treat stuttering, stammering, or other articulation disorders except when the speech disorder results from Injury, Sickness, stroke, cancer,

developmental delay, Congenital Anomaly, or Autism Spectrum Disorder as described in *Section 11, Additional Coverage Details*.

36. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 11, Additional Coverage Details.*

37. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 11, *Additional Coverage Details*.

38. Homeopathic treatment.

39. Light boxes.

40. 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.

41. Blood administration for the purpose of general improvement in physical condition.

42. Lamaze training.

43. Fetal sex determination (amniocentesis, CVS, ultrasound, or any other procedures requested solely to determine the sex of the fetus).

44. Cardiac and pulmonary rehabilitation programs (such as counseling and monitored exercise to maintain or improve general health), unless approved by the Claims Administrator for your Retiree Medical Coverage option.

45. Smoking cessation programs and treatment of nicotine addiction except for preventive counseling as provided by the Claims Administrator for your Retiree Medical Coverage option or drugs or supplies provided under the Prescription Drug Program as required by the Affordable Care Act.

46. Marriage counseling.

47. E-mail and internet consultations and telemedicine.

48. Expenses resulting from inappropriate billing procedures, such as:
    - procedure unbundling,
    - separate billing for procedures considered incidental to a primary procedure, or
    - incorrect application of CPT-4 code rules.

SECTION 13 – HOW TO CLAIM RETIREE MEDICAL COVERAGE BENEFITS

In-Network Benefits

In general, if you receive Covered Health Services from an In-Network provider, UnitedHealthcare will pay the Physician or facility directly. If an In-Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to an In-Network provider at the time of service, or when you receive a bill from the provider.

Out-of-Network Benefits

If you receive a bill for Covered Health Services from an Out-of-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com or by calling the toll-free number on your ID card. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age, and relationship to the Retiree or principal Covered Person.
- The number as shown on your ID card.
- The name, address, and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due to you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Retiree Medical Coverage allows. It is your responsibility to pay the Out-of-Network provider the charges you incurred, including any difference between what you were billed and what the Retiree Medical Coverage paid ("Balance Billing").

Payment of Benefits

You may not assign your Retiree Medical Coverage Benefits or any cause of action related to your Retiree Medical Coverage Benefits to an Out-of-Network provider without UnitedHealthcare's consent. When an assignment is not obtained, UnitedHealthcare will send the reimbursement directly to you. For administrative convenience, United Healthcare reserves the right, in its discretion, to make Benefit payments to an Out-of-Network provider directly for services rendered to you. Such direct payment will not be deemed to constitute consent by UnitedHealthcare to an assignment or a waiver of the consent requirement. In the case of any such assignment of Benefits or payment to an Out-of-Network provider, the Plan has the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan. Additionally, if an in-network provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by United Healthcare, United Healthcare may reduce payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

When you assign your Benefits under the Plan to an out-of-Network provider with United Healthcare's consent, and the Out-of-Network provider submits a claim for payment, you and the Out-of-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider.

When UnitedHealthcare in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the provider as well.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them.

You can also view and print all of your EOBs online at www.myuhc.com. See Section 22, *Glossary*, for the definition of Explanation of Benefits.

Important – Timely Filing of Out-of-Network Claims
All claim forms for Out-of-Network services must be submitted within 12 months after the date of service. Otherwise, the Retiree Medical Coverage will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim Is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below in Section 24, *Claim and Appeal Procedures for Retiree Coverages*.

SECTION 14 – RETIREE PRESCRIPTION DRUG PROGRAM

The prescription drug program for the Retiree Health Savings, the Retiree Health Reimbursement, and the Retiree 90/10 Medicare Carve-Out Medical Plan options (the "Retiree Prescription Drug Program") is administered by CVS/caremark. The same Pharmacy Services are covered under each of the Retiree Medical Coverage options, but there are differences in how the Annual Deductible and annual Out-of-Pocket Maximum apply. For the Retiree Health Savings Medical Plan option, the cost of covered prescription drugs is combined with In-Network medical expenses and applied to the In-Network Annual Deductible and In-Network Out-of-Pocket Maximum. For the Retiree Health Reimbursement and the Retiree 90/10 Medicare Carve-out Medical Plan options, there is no Annual Deductible for prescription drugs but there is a separate Out-of-Pocket Maximum. The Retiree Prescription Drug Program is made up of three parts: a Retail Pharmacy Program, a Mail Pharmacy Program, and a Specialty Drug Program.

For each prescription medication you take on a long-term basis (three months or more), you can use a participating retail pharmacy for your initial prescription (up to 30-day supply) and one refill (for a total of two 30-day fills). You will then be notified to switch to an 84- to 90-day supply of your prescription, which can be filled either through a CVS/caremark Mail Pharmacy or through your local CVS pharmacy. If you choose to continue purchasing less than an 84- to 90-day supply of the medication at retail, your claim will not be covered by the Retiree Prescription Drug Program and you will pay the entire cost. *This paragraph does not apply to members and their covered Dependents who participate in the Specialty Drug Program or are enrolled in the Retiree 90/10 Medicare Carve-out Medicare Plan option.*

You can avoid paying the extra retail cost by using the CVS/caremark mail-order service and having the prescriptions delivered directly to your home or by filling your prescriptions at your local CVS pharmacy.

Formulary and Preferred Drug List (PDL)

The Retiree Prescription Drug Program has adopted the CVS/caremark Formulary, including its Preferred Drug List (PDL), as the Retiree Prescription Drug Program's covered formulary. Drugs determined as "non-formulary" based on CVS/caremark's current formulary are not covered by the Retiree Prescription Drug Program.

Underlying principles of the CVS/caremark Formulary Development and Management Process include:

- CVS/caremark is committed to providing a clinically objective formulary;
- Decisions on formulary inclusions and exclusions are made by a committee of clinical pharmacists and Physicians;
- The prescribing Physician always makes the ultimate determination as to the most appropriate course of therapy.

CVS/caremark regularly reviews and makes changes to the formulary and PDL. The PDL review process focuses on many factors, including the following:

- Adding products that have demonstrated enhanced clinical efficacy and/or provide more convenient dosage forms;

- Removing products that may require less convenient therapy dosing, may have more side effects or may cost more when compared to available options on the PDL.

If you have a question about whether a particular expense is covered, contact CVS/caremark at **1-866-478-5802**.

Medication Information

CVS/caremark's website, www.caremark.com, has extensive information on the medications that are covered. This information includes what the drug is used for, side effects, and costs. It can even help you determine the cost of your medication before you make a purchase. We hope you will consider the CVS/caremark website an important resource when you want to learn more about medications.

PLEASE NOTE: When using www.caremark.com to price a medication, the price does not account for any Annual Deductible or Out-of-Pocket Maximum accumulators. For additional information on pricing, please contact member services.

For answers to your questions about the CVS/caremark Retail Pharmacy Program or the CVS Maintenance Choice® or Mail-Order Service, visit www.caremark.com or call **1-866-478-5802**. Customer Service Representatives and Pharmacists are available 24 hours a day, seven days a week, except on holidays.

Annual Deductible

Retiree Health Savings Medical Plan Option:

The cost of covered prescription drugs is applied to the In-Network Annual Deductible for the Retiree Health Savings Medical Plan option. You pay 100% of the cost of Eligible Expenses, including covered prescription drugs, until you reach the In-Network Annual Deductible (Individual or Family, depending on your enrollment) for the Retiree Health Savings Medical Plan option. If you elect Family coverage, you are subject to the entire Family deductible even if one family member has met the individual deductible. Once you have satisfied the applicable In-Network Annual Deductible, you pay Coinsurance for Eligible Expenses, including covered prescription drugs, until you reach the In-Network Out-of-Pocket Maximum (Individual or Family, depending on your enrollment) for the Retiree Health Savings Medical Plan option.

Retiree Health Savings Medical Plan Option Annual In-Network Deductible – combined medical and prescription drug expenses:

	In-Network
	$2,000 individual
	$4,000 family

Retiree Health Reimbursement Medical Plan Option:

Under the Retiree Health Reimbursement Medical Plan option, there is no Annual Deductible for prescription drugs. You pay Coinsurance for your covered prescription drugs until you reach the applicable annual Out-of-Pocket Maximum (Individual or Family) for the Retiree Prescription Drug Program.

Retiree 90/10 Medicare Carve-Out Medical Plan Option:

Under the Retiree 90/10 Medicare Carve-Out Medical Plan option, there is no Annual Deductible for prescription drugs. You pay Coinsurance for your covered prescription drugs until you reach the applicable annual Out-of-Pocket Maximum (Individual or Family) for the Retiree Prescription Drug Program.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum dollar amount you and/or your family members will pay before the Plan pays 100% of your covered prescription expenses for the rest of the calendar year.

Retiree Health Savings Medical Plan Option Out-of-Pocket Maximum:

The cost of covered medical and prescription drugs is applied to the In-Network Out-of-Pocket Maximum. Once you have met the In-Network Annual Deductible, you pay Coinsurance for Eligible Expenses, including covered prescription drugs, until you reach the In-Network Out-of-Pocket Maximum for the Retiree Health Savings Medical Plan option. If you elect Family coverage, you are subject to the entire Family In-Network Out-of-Pocket Maximum even if one family member has met the individual maximum amount. However, the combined (medical plus prescription drug) In-Network Out-of-Pocket Maximum cost for any one person will not exceed $7,350 in 2020 and 2021.

Retiree Health Savings Medical Plan Option In-Network Out-of-Pocket Maximum – combined medical and prescription drug expenses:

In-Network

$5,500 individual

$11,000 family ($7,350 for each individual in the family)

Retiree Health Reimbursement Medical Plan Option Prescription Drug Out-of-Pocket Maximum:

For the Retiree Health Reimbursement Medical Plan option, there is a separate annual Out-of-Pocket Maximum of $2,300 per covered individual or $3,500 per family that applies to the Retail Pharmacy Program, Mail Pharmacy Program, and Specialty Drug Pharmacy Program under the Retiree Prescription Drug Program.

Retiree 90/10 Medicare Carve-Out Medical Plan Option Prescription Drug Out-of-Pocket Maximum:

For the Retiree 90/10 Medicare Carve-Out Medical Plan option, there is a separate annual Out-of-Pocket Maximum of $5,100 per covered individual or $10,200 per family that applies to the Retail Pharmacy Program, Mail Pharmacy Program, and Specialty Drug Pharmacy Program under the Retiree Prescription Drug Program.

The Retail Pharmacy Program

For a prescription drug that you or your covered dependent need immediately or will require for 30 days or less, you should make use of the **CVS/caremark** Retail Pharmacy

Program. Prescription drug prices are discounted before the coinsurance is applied to the cost of your prescriptions. More than 68,000 retail pharmacies participate in the CVS/caremark national network. Major chains include CVS, Osco, RiteAid, Walgreen's and Walmart. To locate a nearby participating pharmacy, to request a directory of participating pharmacies, or if you have any questions regarding a prescription medication or claim, visit the CVS/caremark member website at www.caremark.com or call CVS/caremark customer service at **1-888-996-0024.**

Using a Retail Pharmacy

Present your ID card at the time of purchase and the pharmacist will use an automated system to verify your coverage and prescription. There are no claim forms to fill out unless you purchase the drug at a non-participating pharmacy.

If you have a prescription filled at a non-participating pharmacy, you will pay the full price of the prescription at the time of purchase and you must complete a claim form in order for the expense to be applied to your In-Network Annual Deductible and In-Network Out-of-Pocket Maximum (if you are a participant in the Retiree Health Savings Medical Plan option) or to your Prescription Drug Out-of-Pocket Maximum (if you are enrolled in the Retiree Health Reimbursement or Retiree 90/10 Medicare Carve-Out Medical Plan options) and for reimbursement (if eligible). You will be credited with the amount the Retiree Prescription Drug Program would have paid if you had used a participating pharmacy. This credit and any reimbursement will be based on the approved cost of the medication.

Important!
Some drugs have generic alternatives. Some drugs have "preferred brand-name" alternatives. When available, generic equivalent drugs will be **automatically** dispensed. If you purchase a generic drug, you pay your generic drug Copayment. If you purchase a brand name drug and there is no generic alternative, you pay your brand-name Copayment.
If you or your doctor requests a brand-name drug when a generic or "preferred brand-name" equivalent is available, you pay an amount equal to the generic or "preferred brand-name" cost, Coinsurance, or Copayment (as may apply) ***plus*** the cost difference between the requested brand-name drug and the approved cost of the generic or "preferred brand-name" drug. This cost difference is sometimes called "product selection cost." **You will pay "product selection cost" even if your doctor specifies "dispense as written" (DAW) on your prescription, unless your Doctor determines that the generic drug is not medically appropriate.** This is why "product selection cost" is also known as the "DAW penalty."

Note:
The generic, "preferred brand-name" or "non-preferred brand-name" approved cost, Coinsurance, or Copayment amount is applied to your In-Network Annual Deductible and In-Network Out-of-Pocket Maximum (if you are enrolled in the Retiree Health Savings Medical Plan option) or to your Prescription Drug Out-of-Pocket Maximum (if you are enrolled in the Retiree Health Reimbursement Medical Plan option or Retiree 90/10 Medicare Carve-Out Medical Plan option). "Product selection cost" is your responsibility and ***does not*** apply to your In- or Out-of-Network Annual Deductible or Out-of-Pocket Maximum.

Claim forms can be printed from the CVS/caremark website at www.caremark.com and must be submitted along with your receipts for processing within 12 months of the date of purchase. All properly submitted claim forms should be sent to CVS/caremark, P.O. Box 52196, Phoenix, AZ 85072-2196.

Using CVS Mail-Order Service and Maintenance Choice®

The CVS Mail-Order Service and Maintenance Choice® services allow you and your covered Dependents to order prescription drugs you use on a regular basis ("maintenance drugs") through the mail or pick them up at a CVS pharmacy near you. Through Maintenance Choice® you can purchase up to a 90-day supply of most *long-term prescription medications* or up to a 30-day supply of most Specialty medications.

A ***long-term medication*** is taken regularly for a chronic condition or long-term therapy. A few examples include prescription drugs for managing high blood pressure, asthma, diabetes, or high cholesterol.

There may be limitations on some prescriptions, such as controlled medications, that are subject to state and federal dispensing limitations. Whether you choose delivery or pick-up, you will pay the same Coinsurance or Copayment.

Coinsurance and Copayment – Retail, Mail Pharmacy and Maintenance Choice®

Please refer to Table 12 on the next page to determine your Coinsurance or Copayment for Generic drugs, Preferred Brand-Name drugs and Non-Preferred Brand-Name drugs under the Retiree Medical Coverage option that you have selected. If a minimum Copayment applies and the actual full cost of the drug is less, you will be charged the full cost of the drug. For instance, for a Generic drug purchased at Retail where 10% Coinsurance or a $5 minimum Copayment would apply, if the actual full cost is $3, you will pay $3. If the actual full cost is $30, you will pay the minimum Copayment of $5. If the actual full cost is $100, you will pay Coinsurance of $10.

When you use the CVS/caremark mail service, you do not need to fill out any claim forms or wait for reimbursement. With your first mail-order prescription, you simply complete the "Patient Profile Questionnaire" as well as a CVS/caremark Mail-Order claim form and mail it with your prescription(s) and payment(s) to CVS/caremark Mail Service Pharmacy or visit the member website at www.caremark.com. You may make one payment for each prescription for up to a 90-day supply (or up to a 30-day supply of a Specialty medication). Your prescription is delivered to your home, postage paid, by U.S. mail or UPS, along with instructions for refills.

If you are receiving long-term medication for the first time, you should ask your Physician to provide two prescriptions – one to be filled at your local participating pharmacy for the initial 30-day period to get you started and the second to be submitted to the CVS/caremark Mail Service.

Remember, you may also choose to fill your 90-day prescription (or your 30-day Specialty Pharmacy prescription) at your local CVS pharmacy with the CVS/caremark Maintenance Choice® program.

The Specialty Drug Program

The CVS Specialty Drug Program provides care for patients with chronic or serious conditions who take medications that require injection, special handling, and monitoring during distribution and usage. These medications are used to treat conditions such as Multiple Sclerosis, Rheumatoid Arthritis, and Hepatitis C and will be available only through the CVS Specialty Drug Pharmacy. With Specialty medications, the maximum quantity that can be dispensed with each fill or refill is a 30-day supply.

Table 11		Retiree Health Reimbursement Medical Plan Option or Retiree 90/10 Medicare Carve-Out Medical Plan Option
Prescription Drug Plan Feature	Retiree Health Savings Medical Plan Option	
Retail (covers one fill plus one refill, each up to 30-day supply)	• **Generic:** You pay **10%** after deductible is met; **$5** minimum Copayment • **Preferred brand:** You pay **30%** after deductible is met; **$20** minimum Copayment • **Non-preferred brand:** You pay **45%** after deductible is met; **$35** minimum Copayment	• **Generic:** You pay **10%**; **$5** minimum Copayment • **Preferred brand:** You pay **30%**; **$20** minimum Copayment • **Non-preferred brand:** You pay **45%**; **$35** minimum Copayment
Mail Order Service or CVS Retail Pharmacy (90-day supply)	• **Generic:** You pay **10%** after deductible is met; **$10** minimum Copayment • **Preferred brand:** You pay **30%** after deductible is met; **$40** minimum Copayment • **Non-preferred brand:** You pay **45%** after deductible is met; **$70** minimum Copayment	• **Generic:** You pay **10%**; **$10** minimum Copayment • **Preferred brand:** You pay **30%**; **$40** minimum Copayment • Non-preferred brand: You pay **45%**; **$70** minimum Copayment
Specialty Medications (30-day supply)	• You pay **10%** after deductible is met; no minimum Copayment • If you use a manufacturer copay or discount card to fill your specialty medications, only the cost that you pay out-of-pocket will be applied to your Deductible and Out-of-Pocket Maximum. Manufacture contributions may reduce your overall cost for the medication, but do not count towards your Deductible and Out-of-Pocket Maximum.	• You pay **10%**; no minimum Copayment • If you use a manufacturer copay or discount card to fill your specialty medications, only the cost that you pay out-of-pocket will be applied to your Prescription Drug Out-of-Pocket Maximum. Manufacture contributions may reduce your overall cost for the medication, but do not count towards your Prescription Drug Out-of-Pocket Maximum.

Table 11 – Prescription Drug Plan Features

NOTE: Specialty medications must be purchased through the CVS Specialty Drug Program in order to qualify for the Coinsurance or Copayment rates described above. If you do not use the CVS Specialty Drug Program to fill your specialty prescriptions, you will be responsible for the full cost for your Specialty medications. However, there are certain Specialty medications that are not subject to this provision and you can continue to fill them at the retail pharmacy. Call *CVS/caremarkConnect*® at **1-800-237-2767** to find out if your Specialty medication is subject to this provision. CVS/caremark also offers Specialty prescription pick-up at a CVS pharmacy.

The Specialty prescription pick-up service allows members the added convenience of having many of their Specialty medications shipped to a local CVS pharmacy location for pick up. All CVS Specialty Pharmacy products are included in this program with the exception of hemophilia products, IGIV, Remodulin and Epoprostenol (generic Flolan) and medications for Lysosomal storage disorders ("Zymes"). Certain states have additional limitations regarding this service. Interested and eligible patients can discuss Specialty pick up at CVS pharmacy with their CVS/caremark*Connect*® Specialty Pharmacy Service Representative.

Specialty Medications Require Prior Authorization

Authorization from *CVS/caremark* is required for most Specialty Pharmacy prescriptions. For more information, see *Clinical Prior Authorization Process* below.

Compound Drugs and Topical Analgesics

A compound drug is a medication made by combining or mixing ingredients (some of which may not be subject to approval by the FDA), in response to a prescription, to create a customized drug that is not otherwise commercially available. There is a separate Coinsurance amount for each covered ingredient of a compound drug. The compounded formulation must be covered and, if it is reformulated, it must meet FDA-approved guidelines for the condition for which it is prescribed and all other Retiree Prescription Drug Program provisions will apply. Ingredients, including bases and bulk compounding powders, that are not covered under the Retiree Prescription Drug Program will not be covered as part of a compound. For example, the Retiree Prescription Drug Program covers few over-the-counter products and then only under limited circumstances. Over-the-counter products that are not covered under the Retiree Prescription Drug Program but are commonly included in compounds ─ such as Benadryl, Maalox, Eucerin, and Hydrocortisone ─ will not be covered in a compound. Prior authorization will be required for any compound drug that costs $300 or more. For more information, see *Clinical Prior Authorization Process* below.

Select topical analgesics (pain patches) are manufactured commercially and are not compound drugs. These pain patches may be marketed contrary to the Federal Food, Drug and Cosmetic Act. Pain patches typically contain ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness, and stiffness. Such ingredients include, but are not limited to, lidocaine, menthol, capsaicin, and methyl salicylate. Select topical analgesics are not covered under the Retiree Prescription Drug Program.

Pharmacy Prescription Contraceptives for Females

Generic oral contraceptive drugs and formulary brand-name contraceptive drugs for which there are no generic equivalents will be covered at 100% of cost if purchased through CVS/caremark at retail or mail order. If you are prescribed a brand-name contractive drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, unless your Doctor determines that the generic drug is not medically appropriate. Over-the-counter contraceptives are **not** covered.

Clinical Prior Authorization Process

Under the Retiree Prescription Drug Program, some prescription drugs – including Specialty Pharmacy products – require Prior Authorization from *CVS/caremark*. The goal of the Prior Authorization program is to encourage safe and effective drug utilization, identify optimal drug use, and enhance members' health outcomes. Information about medications that require Prior Authorization is contained on www.caremark.com or you can call *CVS/caremark* at **888-996-0024**. *CVS/caremark* may change the list of drugs that require pre-service authorization at any time without prior notice. As new prescription drugs, generic drugs, or additional information about existing drugs become available, they will be considered for coverage under the prescription drug benefit as they are introduced. For current information on medications that may require pre-service authorization, please contact *CVS/caremark*.

If your prescriber prescribes a drug that requires Prior Authorization, a message will be generated when the claim is processed that will direct the Physician to call *CVS/caremark* to provide clinical information to help determine if use of the drug is appropriate under the clinical criteria applicable to the Retiree Prescription Drug Program. Requests for Prior Authorization will be reviewed and either granted or denied by *CVS/caremark*. Once your Physician provides the necessary information, a decision is usually made within 72 hours. Your Physician will receive a fax and you will receive a letter to notify you if your request is approved or denied. If your request is denied, the fax and letter will include the reason(s) for the denial and information on how to file an appeal. Please see Section 24 - Claim and Appeal Procedures for Retiree Coverages for more information.

Exceptions Process

Some drugs have generic alternatives. Some drugs have "preferred brand-name" alternatives. If your prescriber thinks there is a clinical reason why one of these covered prescription drug options will not work for you or why you need to continue to use a drug that has been removed by ***CVS/caremark*** from the formulary, your prescriber should call ***CVS/caremark*** toll-free at **888-996-0024** to request Prior Authorization for your current or newly prescribed drug(s).

Expenses Not Covered

The Retiree Prescription Drug Program does not cover some expenses. These include – but are not limited to – the following items even if prescribed or recommended by your prescriber:

- Medical supplies, except needles, syringes, and diabetic supplies (such as chem-strips, lancets, testing agents, and alcohol swabs).
- Any drug or supply that has not been approved by the U.S. Food and Drug

Administration ("FDA") 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.

- Expenses for off-label use of drugs (in a case where FDA approval has a limited application for that drug and the FDA-approved application does not apply to your use).
- Expenses for any drug that is included on the list of drugs that require Prior Authorization under the Retiree Prescription Drug Program and for which such Prior Authorization is not obtained, unless it is determined by *CVS/caremark* or the Independent Medical Review Authorization that such usage is Medically Necessary. The list of drugs that require Prior Authorization is available at **www.caremark.com** or you can call **888-996-0024**.
- Drugs labeled "Caution—Limited by Federal Law to Investigational Use" even though a charge is made to the individual.
- Expenses related to **Experimental or Investigational** drugs, devices or procedures except as described elsewhere in this Summary Plan Description under the heading ***Clinical Trials*** in Section 11, *Additional Coverage Information*.

  Note: Even if a drug may be categorized by the FDA as an "orphan drug," it still will not be covered until it receives the approval of the FDA.
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the covered person.
- Medication that is to be taken by or administered to a Covered Person, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Care Facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows operations on its premises of, a facility for dispensing pharmaceuticals.
- Prescriptions dispensed after one year from the original date of issue, more than six months after the date of issue for controlled substances, or prescriptions prohibited by applicable law or regulation.
- Any prescription refilled in excess of the number of refills specified by the prescriber, or any refill dispensed after one year from the prescriber's original order.
- Prescriptions exceeding a reasonable quantity as determined by *CVS/caremark* in its discretion.
- Prescriptions that do not meet *CVS/caremark* standards as determined by *CVS/caremark* requirements.
- Medications that do not meet Prior Authorization criteria (where applicable).
- Medications in excess of allowed quantity limits (where applicable).
- Drugs or supplies that are not for your personal use or that of your covered Dependent.
- Drugs the intended use of which is illegal, unethical, imprudent, abusive, or otherwise improper.
- Mail-order prescriptions that are not filled at a *CVS/caremark* Mail Service facility.
- Prescription drug claims received beyond the 12-month timely filing requirement; *CVS/caremark* must receive claims within 12 months of the prescription drug dispensed date.

- Replacement of medications lost or stolen with excessive frequency (the Retiree Prescription Drug Program will cover replacement of lost or stolen medications up to two times per year per prescription).
- Expenses that are not considered essential for the necessary care and treatment of an Injury, illness, or Pregnancy.
- Rogaine (or similar drugs with the sole purpose of promoting or stimulating hair growth), or drugs that treat hair loss, thinning hair, unwanted hair growth or hair removal, and other lifestyle agents.
- Anorexiants (except with a Prior Authorization).
- Fertility medications.
- Legend vitamins (vitamin compounds prescribed or recommended for specific medical conditions or nutritional deficiencies).
- Non-federal legend drugs.
- Prescriptions for items that are available over-the-counter unless prescribed and included under coverage as preventive medications.
- Vitamins (including nutritional supplements, even if prescribed).
- Dietary supplements and nutritional formulas (except when prescribed for the treatment of a metabolic disease or when Medically Necessary to sustain life).
- Anabolic steroids.
- Growth hormones (except as specifically covered under the Specialty Pharmacy Program).
- Therapeutic devices and appliances and durable medical equipment, except for glucose monitors and other covered supplies.

If You Are Enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan Option

If you are enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan Option, the Retiree Prescription Drug Program pays, on average, as much as the standard Medicare prescription drug coverage (Part D) and is therefore considered "creditable coverage." As a participant with creditable prescription drug coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your creditable coverage under the Retiree Prescription Drug Program will be affected. The Retiree Prescription Drug Program will become secondary for you or your covered family members who join a Medicare prescription drug plan. When the Retiree Prescription Drug Program becomes secondary, it will not pay out as much as the Medicare prescription drug plan. The Medicare prescription drug plan coverage will pay primary, which means that you or your covered family member will receive most prescription drug benefits from the Medicare prescription drug plan.

If you or any covered Dependents decide to join a Medicare drug plan, be aware that you and/or your Dependents will not be able to resume primary prescription drug coverage under this Plan until Medicare prescription drug coverage is dropped.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION 15 – OVERVIEW OF YOUR RETIREE DENTAL COVERAGE OPTION

This section describes the dental Benefits available to Retirees under age 65 who meet the eligibility requirements for the Retiree Program. The benefits of the Retiree Dental Coverage are the same as those offered to active employees under the Delta Dental PPO plan option.

Here is a summary of your Dental Coverage.

Delta Dental Retiree Plan Option	In-Network	Out-of-Network
Annual Deductible	$50 per person; $150 per family	$100 per person; $300 per family
Diagnostic & Preventive Services	100% with no Deductible	100% with no Deductible
Basic Services	80% after the Deductible	60% after the Deductible
Major Services	50% after the Deductible	50% after the Deductible
Orthodontic Services	50% with no Deductible	50% with no Deductible
Annual Benefits Maximum (excludes Orthodontia)	$2,000 – In- and Out-of-Network combined	
Orthodontia Maximum Lifetime Benefit for each person	$1,500 – In- and Out-of-Network combined	
Note: Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.		

Table 12 – Delta Dental Retiree Coverage Option

Enrollment Restriction

If you elect "No Coverage" because you have dental coverage elsewhere and you lose that coverage during the year, you can enroll for coverage for yourself and your eligible Dependents during the 30-day period that immediately follows the end of your other coverage.

The Delta Dental Retiree Coverage Option

This section of the SPD describes the Dental Coverage administered by Delta Dental of New York.

Under the Delta Dental Retiree Coverage option, you and your eligible Dependents may choose any licensed Dentist. You will receive your dental care at the lowest cost through the Delta Dental PPO Network. These Dentists have agreed to contracted fees, and you will not be charged more than your expected share of the bill. In addition, all of the Dentists in the Delta Dental PPO Network satisfy strict credentialing requirements. You can find a PPO Dentist at **deltadentalins.com/siemensenergy**.

If you cannot find a PPO Dentist, Delta Dental Premier Dentists offer the next best opportunity to save. Unlike non-Delta Dental Dentists, they have agreed to set fees, and you will not get charged more than your expected share of the bill. With a PPO or Premier Dentist, you will be assured that amounts charged by the provider are

"Reasonable and Customary," as required by the Delta Dental Retiree Coverage. Reasonable and Customary ["R&C"] or Maximum Allowed expenses are what most providers in your area charge for a covered service.

If you use a Delta Dental PPO or Premier In-Network Dentist, you will pay a lower Deductible and lower Coinsurance for most services compared to using an Out-of-Network Dentist. Out-of-Network Dentists may also charge more than the R&C amount. If you use a non-Delta provider, you are required to pay any charges over the R&C amount in addition to applicable Deductibles and Coinsurance.

Set up an Online Services account at **www.deltadentalins.com/siemensenergy** or call Delta Dental at **1-888-894-7039** to check Benefits and eligibility information. You and your family members will not need a Delta Dental ID card to visit the Dentist, but you may view and print your Delta Dental ID card from the website.

It is best to mention Delta Dental whenever you receive Dental services – the provider may participate in the PPO or be a Delta Dental Premier Dentist and, therefore, you will benefit from the discounted fees and higher level of coverage. If you are also covered under another dental plan, ask your Dental office to include information about both plans with your claim and Delta Dental will coordinate Benefits.

The Deductible

The Deductible is the amount you pay each year before the Delta Dental Coverage option pays Benefits for basic and major restorative services received from In- Network or Out-of-Network Dentists. There is no Deductible for Diagnostic and Preventive services or Orthodontic services received from In-Network or Out-of-Network Dentists.

Annual Deductible	In-Network Delta Dental PPO and Premier Dentists	Out-of-Network Non-Delta Dental Dentists
Individual Deductible	$50	$100
Family Maximum	$150	$300

Table 13 – Delta Dental Retiree Plan Option Annual Deductibles

To help limit the number of Deductibles you and your covered Dependents need to pay, the Delta Dental Coverage option includes a family maximum. The most any family has to pay in Deductibles in a calendar year is three times the individual Deductible. Once the annual family Deductible is satisfied, no further individual Deductibles need to be met for the balance of the calendar year, regardless of how large your family may be.

Note: The Deductible does not apply towards the annual maximum benefit of $2,000 per person.

Annual Maximum

The annual maximum is the most the Delta Dental Coverage option will pay in Benefits for covered services for each Covered Person in a calendar year. The annual maximum for the Delta Dental Coverage option is $2,000 for each Covered Person per year and is combined for both In-Network and Out-of-Network services you use during the year. You will always be responsible for 100% of the cost of any non-covered services that you incur.

Covered Expenses

The Delta Dental Coverage option covers a broad range of services and supplies. In all cases, Benefits are based on reasonable and customary (R&C) or maximum allowed charges.

Diagnostic and Preventive Care (Type A Services)

The goal of preventive dentistry is that each Covered Person maintains optimal oral health. For this reason, the Delta Dental Coverage option provides Benefits for diagnostic and preventive care (Type A services) at:

- 100% of reasonable and customary (maximum allowed) charges with no Deductible, if services are received from In-Network *or* Out-of-Network Dentists – subject to a combined annual maximum benefit for diagnostic and preventive (Type A), basic (Type B) and major (Type C) services of $2,000 for each covered person
- Benefits are subject to limits on frequency of service.

Service	Frequency/Limitations	Coverage
Diagnostic and Preventive Care (Type A Services)		
Oral exams	2 per calendar year	**In-Network or Out-of-Network:** 100% with no Deductible
Cleaning of teeth (oral prophylaxis) / Periodontal maintenance	4 combined per calendar year	
Full-mouth X-rays **or** Panoramic X-ray	1 every 60 calendar months	
Bitewing X-rays	1 set per calendar year	
Fluoride application	2 per calendar year for persons under age 19	
Sealants	1 treatment per tooth every three calendar years for persons under age 16	
Space maintainers	No limit	
Emergency care to relieve pain	No limit	
Pulp vitality and bacteriological studies	Based on individual necessity	

Table 14 – Diagnostic and Preventive Care (Type A Services)

Definitions of Covered Diagnostic and Preventive Care

Prophylaxis is the scaling and polishing procedure performed to remove calculus, plaque, and stains from the teeth.

Periodontal maintenance involves the removal of plaque and calculus from pockets between the teeth and gums below the gumline, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Full-mouth X-rays are X-rays that display all of the teeth and surrounding structures and areas; typically consists of 18 X-rays (14 periapical and 4 bitewing).

Panoramic X-ray is a rotational X-ray technique that displays the full mouth on one X-ray film.

Bitewing X-rays are X-rays taken of the crowns of the teeth to check for decay.

Fluoride application is placed on the outer layer of the teeth to make them more resistant to decay.

Sealants are a resin material that is placed in the pits and fissures (biting surface) of molars and premolars to prevent future decay.

Space maintainer is a dental appliance that fills the space of a lost tooth or teeth and prevents the other teeth from moving into the space.

Pulp vitality and bacteriological studies determine the health of the nerve tissue that fills the center of the tooth.

Basic Restorative Care (Type B Services)

The Delta Dental Coverage option covers basic restorative care (Type B services) at:

- 80% of reasonable and customary (maximum allowed) charges after the Deductible is met, if services are received from In-Network Dentists; or
- 60% of reasonable and customary (maximum allowed) charges after the Deductible is met, if services are received from Out-of-Network Dentists.
- Benefits are subject to a combined annual maximum benefit for diagnostic and preventive (Type A), basic restorative (Type B) and major restorative (Type C) services of $2,000 for each Covered Person.

Service	Frequency/Limitations	Coverage
Basic Restorative Care (Type B Services)		
Fillings	No limit	**In-Network:** 80% after the Deductible is met **Out-of-Network:** 60% after the Deductible is met
Root canal therapy (endodontics)	Any related X-ray, test, laboratory exam or follow-up care is considered part of the charge for root canal therapy and not a separate dental service	
Denture adjustments, relinings and rebasings	Excluding any adjustment of a denture within six months of its installation	

Service	Frequency/Limitations	Coverage
Basic Restorative Care (Type B Services)		
Periodontal scaling and root planing; other non-surgical services	1 per quadrant every 36 months for periodontal scaling and root planing	**In-Network:** 80% after the Deductible is met **Out-of-Network:**
Periodontal surgery	Including gingivectomy, gingivoplasty, gingival curettage and osseous surgery; limited to 1 surgery every 36 months per quadrant	
Simple extractions [1]	Simple extractions only	

Repair or re-cementing of crowns, inlays/onlays or bridgework	No limit	60% after the Deductible is met
Occlusal adjustments	No limit	
Consultations	2 within a calendar year	
Intraoral-periapical and extraoral X-rays	1 every 60 months	
[1] Includes routine postoperative care for simple extractions.		

Table 15 – Basic Restorative Care (Type B Services)

Definitions of Covered Basic Restorative Care

Fillings are a material that is used to fill a cavity or replace part of a tooth; usually amalgam (silver colored filling used on the posterior teeth) or composite acrylic resin (matched to the color of the tooth).

Root canal therapy removes the pulp (nerve) from the tooth and replaces it with a filling material.

Periodontal scaling and root planing involves the removal of irritants from deep pockets below the gumline (scaling) and smoothing (planning or shaving) of the root surface.

Extraction is the removal of a tooth. Simple extractions involve the removal of a tooth that is already erupted in the oral cavity. Surgical extractions involve the removal of a tooth that may be impacted in soft tissue (gum).

Occlusal adjustments made to the chewing surface of the posterior teeth (pre-molars and molars) to promote healthy periodontal tissues.

Intraoral-periapical and extraoral X-rays are taken inside (intraoral) and outside (extraoral) the mouth. Intraoral-periapical X-rays show the tooth and surrounding tissues. Extraoral X-rays are taken to identify large areas of the skull on one X-ray.

Major Restorative Care (Type C Services)

The Delta Dental Coverage option covers major restorative care (Type C services) at:

- 50% of reasonable and customary (maximum allowed) charges after the Deductible is met, if services are received from In-Network Dentists or Out-of-Network Dentists.
- Benefits are subject to a combined annual maximum benefit for diagnostic and preventive (Type A), basic restorative (Type B) and major restorative (Type C) services of $2,000 for each Covered Person.
- Type C services are subject to clinical review and Prior Authorization.

Services	Frequency/Limitations	Coverage
Major Restorative Care (Type C Services)		
Anesthetics [1]	Local anesthesia. General anesthesia and IV sedation when Medically or Dentally Necessary, with Prior Authorization	

Veneers	Limited to anterior teeth; 1 per tooth every 84 months	**In-Network:** 50% after the deductible is met **Out-of-Network:** 50% after the deductible is met
Crowns [2]	One per tooth every 84 months; plastic processed to gold, porcelain fused to gold, full cast gold, prefabricated stainless steel or prefabricated resin	
Inlays/Onlays	One per tooth every 84 months	
Dentures (full and partial) [2]	Once every 84 months	
Bridges [2]	Once every 84 months; cast gold, porcelain fused to gold, plastic processed to gold	
Surgical extractions and all other oral surgery	No limit	
Implants (including prosthetic devices) [2]	Once every 84 calendar months for prosthetic devices; *repair* of implants limited to once in a 12-month period	
Gold restorations (if necessary as the result of extensive cavities or fracture and if restoration with amalgam, silicate, acrylic or plastic is not possible)	Once every 84 months	
Posts and cores	No limit	
Bruxism	Including, but not limited to occlusal guards and night guards	

[1] Anesthesia is covered when provided with two or more surgical extractions or three or more simple extractions. Anesthesia use during prophylaxis cleanings (e.g., nitrous oxide) is not covered by the Dental Coverage.

[2] Replacement of an existing partial removable denture, bridge, implant or crown, to replace extracted natural teeth will be considered only if the existing denture, bridge, implant, or crown was installed at least 84 months prior to its replacement and cannot be made serviceable according to common dental standards.

Table 16 – Major Restorative Care (Type C Services)

Definitions of Covered Major Restorative Care

Anesthetics are drugs that eliminate or reduce pain. General anesthetics (including analgesic gas and IV sedation) cause the patient to become unconscious and feeling is lost during a dental procedure.

Veneers are used to reshape the anatomy of an anterior (in the front of the mouth) tooth.

Crown is a dental restoration that covers the entire tooth and restores it to its original shape (also called a “cap”).

Inlay is a porcelain filling used to replace missing tooth structure within the tooth, between the cusps (the pointed or round mounds on the top or highest part, of the tooth). **Onlay** is a porcelain filling that covers one or all of the tooth’s cusps.

Denture is a removable appliance used to replace teeth. A complete/full denture

replaces all of the upper teeth and/or all the lower teeth; a partial denture is a removable appliance used to replace one or more lost teeth.

Bridge is a non-removable restoration that is used to replace missing teeth.

Oral surgery focuses on the diagnosis and treatment of diseases, injuries, and malformations. It involves surgery for both functional and esthetic aspects of the face, jaws, mouth, neck, and head. The Delta Dental Coverage option covers some oral surgery procedures, including extraction of impacted teeth, gingivectomy (removal of diseased gum tissue) and osseous surgery (removal of defects or deformities in the bone caused by periodontal disease and other related conditions), but certain oral surgery procedures may be covered by the medical plan option you elect. Check with Delta Dental and your Retiree Medical Coverage option for details on coverage.

Implant is an artificial device, usually made of a metal allow or ceramic material, that is implanted within the jawbone as a means to attach an artificial crown, denture or bridge.

Gold restorations involve several layers of pure gold to fill a cavity.

Bruxism is grinding of the teeth. Treatment for temporomandibular joint dysfunction (TMJ) is not covered under the Delta Dental Coverage option, but may be covered under your Retiree Medical Coverage. Check with your coverage for details.

Posts are fitted in the canal of a tooth that had root canal therapy to stabilize the tooth for a restoration. **Core** buildup materials are placed around the post to fill the tooth cavity before the restoration is cemented in place.

Orthodontic Services

The Delta Dental Coverage option covers orthodontic services at:

- 50% of reasonable and customary (maximum allowed) charges with no Deductible, if services are received from In-Network providers or Out-of-Network Dentists.
- Benefits are subject to a lifetime maximum benefit of $1,500 for each Covered Person.

Payments for orthodontic charges are typically made in two (2) installments. The initial payment is made when braces are first installed. Thereafter, a secondary/final payment will be made at the 12-month anniversary of the installation.

Orthodontic Services	Coverage
Preliminary X-rays, diagnostic casts and treatment plan	**In-Network *or* Out-of-Network:** 50% with no deductible
Fixed or cemented appliances	
Lifetime Maximum (In- and Out-of-Network combined)	$1,500 per person

Table 17 – Orthodontic Services

Alternate Benefits

When a condition can be suitably treated in more than one way, Delta Dental Coverage Benefits will be based on the least expensive alternative.

For example, the amount included as covered dental expenses for an inlay, gold filling or crown will be limited to the reasonable and customary (maximum allowed) charge for restoration of the tooth with an amalgam, silicate, acrylic, or equivalent filling, unless the

tooth can only be restored by using the inlay, gold filling or crown.

This provision enables the Delta Dental Coverage option to provide Benefits for professionally adequate levels of care, but not to provide Benefits for care or treatment that is a matter of choice or more expensive than is necessary.

Pretreatment Estimate of Benefits

A pretreatment estimate of Benefits allows you to find out, before you incur any expenses, the:

- estimated cost for treatment;
- estimated benefit payment; and/or
- Possible alternative treatments that may be more Cost-Effective.

A pretreatment estimate does not guarantee Benefits from the Delta Dental Coverage. However, it can help you understand more about how the Delta Dental Coverage option works for your specific need so you can make an informed decision about treatment.

You should use the pretreatment estimate of Benefits feature whenever your Dentist proposes extensive dental work in excess of $200 or to find out if the procedure your Dentist is recommending is covered under the Delta Dental Coverage option.

To request a pretreatment estimate of Benefits, ask your Dentist to describe the proposed work and its cost, using the dental claim form, and submit it to Delta Dental's claims office for review. Delta Dental will let both you and your Dentist know – in advance – which charges are covered and how much the Delta Dental Coverage option will pay. The actual Benefits payable, if any, will depend on the Benefits you qualify for when the work is completed. If there is a major change in your treatment plan, your Dentist should submit a revised claim form.

Claiming Benefits

You do not need a Delta Dental ID card when you visit the Dentist. All your Dentist will need to file a claim for you is your name, date of birth, and enrollee ID or Social Security number. If your family members are covered under your plan, Delta Dental will need your information. However, if you would prefer to have a paper or electronic ID card, you can print one from your computer or pull it up on your smartphone through Delta Dental's Online Services at deltadentalins.com/siemensenergy.

When you are treated by a Delta Dental PPO or Premier Dentist, Delta Dental will pay your Dentist directly and send you a notice explaining your portion of the bill. You are only responsible for your Annual Deductible and Coinsurance amount under the Delta Dental Coverage option. If you visit a non-Delta Dental Dentist, you may have to pay the full cost of treatment and submit a claim for reimbursement. You can obtain the appropriate claim form from Delta Dental's Online Services at www.deltadentalins.com/siemensenergy or by calling Delta Dental at **1-888-894-7039**. Representatives are available Monday through Friday from 8 a.m. until 8 p.m. Eastern time.

When submitting a claim for covered dental expenses:

- Complete your portion of the form in full (the Subscriber and Patient Information) and have your Dentist complete his or her portion. Be sure that all questions are answered, even if the answer is "no" or "N/A" ("Not Applicable," does not apply).

- Attach all necessary documentation to the form:
  - A description of the services and supplies provided with a detailed description of the charge for each item
  - The diagnosis
  - The date(s) of service
  - The patient's name
  - The provider's name, address, phone number and degree
  - The provider's federal tax identification number or social security number.

You should complete a separate claim form for each person for whom Benefits are being requested. If you also have coverage under another dental plan, ask your dental office to include information about both plans with your claim and Delta Dental will coordinate benefits.

Your Dentist may have the ability to file claims electronically with Delta Dental. This expedites the processing of your claim, along with payment to your Dentist as well as any reimbursement to you, if applicable. Mail claims to:

Delta Dental of New York
P.O. Box 2105
Mechanicsburg, PA 17055-2105

For information about a claim you have already submitted, call Delta Dental Claims Processing at **1-888-894-7039** or (717) 766-8500 (TTY/DD 1-888-373-3582).

You must file a claim for Benefits before the end of the year following the year in which the claim was incurred (that is, if the dental service occurs in 2020, claims must be filed with your dental plan before the end of 2021). No Benefits will be paid for claims filed after the deadline.

Expenses Not Covered

The Delta Dental Coverage option will not pay Benefits for charges incurred for:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which Delta Dental deems medically experimental or investigational in nature,
- Services for which you would not be required to pay in the absence of dental insurance.
- Services or supplies received by you or your Dependent(s) before the dental insurance starts for that person.
- Services which are neither performed nor prescribed by a Dentist, except for those services of a licensed dental hygienist, which are supervised and billed by a Dentist and which are for scaling and polishing of teeth or fluoride treatments.
- Services which are primarily cosmetic,
- Appliances which restore or alter occlusion or vertical dimension,
- Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition, and tobacco.

- Personal supplies or devices including, but not limited to, water piks, toothbrushes, or dental floss.
- Decoration or inscription of any tooth, device, appliance, crown, or other dental work.
- Missed appointments.
- Services:
  - Covered under any Workers' Compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving the services is not required to pay; or
  - Received at a facility maintained by Siemens Energy, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by Siemens Energy.
- Prescription drugs.
- Services when the submitted documentation indicates a poor prognosis.
- The following, when charged by the Dentist on a separate basis:
  - claim form completion;
  - infection control, such as gloves, masks, and sterilization of supplies; or
  - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide.
- Dental services due to accidental injuries to teeth and the supporting structures, except for injuries to the teeth due to chewing or biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics.
- Adjustment of a denture made within six months after installation by the same Dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration, or denture.
- Repair or replacement of an orthodontic device.
- Diagnosis and treatment of temporomandibular joint disorders.
- Charges in excess of reasonable and customary (maximum allowed) limits.

If you have a question about whether a particular dental procedure is covered, contact the Delta Dental claims office at **1-888-894-7039**.

Coordination of Benefits

The Delta Dental Coverage option contains a coordination of Benefits feature. This feature comes into play when you or a family member is covered by more than one group dental plan. It limits payments from all plans combined to no more than the Delta Dental Coverage option would have paid if there had been no other coverage. The coordination of Benefits provision does not apply to any personal policy, except No-Fault automobile insurance (regardless of whether you waived health coverage under your automobile insurance policy).

When the Delta Dental Coverage option pays Benefits second, it will pay Benefits for covered expenses the other plan does not fully cover – to bring your total Benefit up to the amount the Delta Dental Coverage option would pay if it were the only plan.

For example –
Suppose your Spouse's dental plan covers a bill at 80% – the same as this Plan would pay for the same service. Because your Spouse is entitled to receive benefits from his or her plan equal to what this Delta Dental Coverage option would pay, no additional Benefits are paid by the Retiree Program.

In determining what (if anything) it will pay, the Delta Dental Coverage option assumes that you follow the procedures of the other plan and will not cover any "penalties" you pay under the other plan for failure to comply with such procedures.

For further information, see Section 18, *Coordination of Benefits*.

Note: If your Spouse or Domestic Partner works for Siemens Energy, he or she may not be covered as both an employee and a Dependent, and only one of you may cover any Dependent children.

Dental Benefits Extension

If your dental coverage ends after the following treatment has started, your expenses to complete the treatment may be covered if they are incurred within three months after coverage ends:

- impressions for bridgework or dentures, or
- preparation work for crowns, inlays/onlays, or root canal therapy.

If you are not eligible for an extension of Benefits under Delta Dental Coverage rules, you may be eligible to continue coverage at your own expense through COBRA.

SECTION 16 – OVERVIEW OF YOUR RETIREE VISION PLAN OPTIONS

EyeMed is the Claims Administrator for the Retiree Vision Plan options. The three Retiree Vision Plan options – Basic, Enhanced, or Premier – are fully insured and are underwritten by Fidelity Security Life Insurance Company. All Retirees and their covered Dependents who are enrolled in coverage under a Retiree Medical Coverage option are eligible to elect Retiree Vision Plan coverage.

The Retiree Vision Plan options under the Retiree Program allow you to choose from almost 25,600 In-Network, as well as Out-of-Network providers. EyeMed's broad network includes optometrists and ophthalmologists in private practice and national retailers such as LensCrafters, Pearle Vision, and Target Optical. You will maximize your Benefits if you always confirm your provider is in the EyeMed ***Insight*** Network prior to receiving care. To find an In-Network provider, search the online directory at **https://member.eyemedvisioncare.com/siemens/en** or call **1-866-800-5457**.

In-Network Benefits or Out-of-Network Reimbursements – The Retiree Vision Plan options provide In-Network Benefits or Out-of-Network reimbursements each calendar year (January 1st through December 31st) for each Covered Person, subject to the following Benefit frequencies:

	Feature	Basic Vision Plan Option (Siemens Energy-Paid)	Enhanced Vision Plan Option (Buy-Up)	Premier Vision Plan Option (Buy-Up)
Frequency	**Eye Examination**	**Once every 12 months**		
	Spectacle Lenses *or* Contact Lenses	**Unlimited**	**Once every 12 months**	**Once every 12 months**
	Frame	**Unlimited**	**Once every 24 months**	**Once every 12 months**

Table 18 – EyeMed Vision Plan Options – Benefit Frequencies

In-Network Benefits – The Retiree Vision Plan options provide the following In-Network Benefits each calendar year (January 1st through December 31st) for each Covered Person, subject to the following benefit allowances:

	Feature	Basic Vision Plan Option (Siemens Energy- Paid)	Enhanced Vision Plan Option (Buy-Up)	Premier Vision Plan Option (Buy-Up)
In-Network Benefits				
Exam / Evaluation	Comprehensive Eye Examination with Dilation as Necessary	$10 copayment		
	Retinal Imaging	Up to $39 copayment		

Contact Lens Fit & Follow-up (once an Eye Exam has been completed)	Standard	Not covered	$40 copay, paid-in-full fit and two follow-up visits	$40 copay, paid-in-full fit and two follow-up visits
	Premium	Not covered	$40 copay plus 10% off retail prices, then apply $55 allowance	$40 copay plus 10% off retail prices, then apply $55 allowance
Laser Vision Correction	Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price		
Contact Lenses [1, 2]	Conventional	15% off retail price	$105 allowance, 15% off balance over $105	$150 allowance, 15% off balance over $150
	Disposable	Not covered	$105 allowance plus balance over $105	$150 allowance, plus balance over $150
	Medically Necessary (with prior approval)	Not covered	You pay $0, paid in full	You pay $0, paid in full
Frame [3]	Any Frame	35% off retail price	$130 allowance, 20% off balance over $150	$150 allowance, 20% off balance over $150
Standard Plastic Lenses [1, 2, 3]	Single Vision	You pay $50	You pay $10	You pay $15
	Bifocal	You pay $70	You pay $10	You pay $15
	Trifocal	You pay $105	You pay $10	You pay $15
	Lenticular	20% off retail price	You pay $10	You pay $15
	Standard Progressives	You pay $135	You pay $60 (includes base lens copay)	You pay $15 (includes base lens copay)
	Premium Progressives	Not covered	Tier 1 – You pay $90	Tier 1 – You pay $35
			Tier 2 – You pay $90	Tier 2 – You pay $45
			Tier 3 – You pay $100	Tier 3 – You pay $60
	Feature	Basic Vision Plan Option (Siemens Energy-Paid)	Enhanced Vision Plan Option (Buy-Up)	Premier Vision Plan Option (Buy-Up)
In-Network Benefits				
			Tier 4 – You pay $60, 80% of charge less $120 allowance	Tier 4 – You pay $15, 80% of charge less $120 allowance
Lens	UV Treatment	You pay $15	You pay $12	You pay $0
	Tint (Solid or Gradient)	You pay $15	You pay $0	You pay $0

Options [3, 4]	Standard Plastic Scratch Coating	You pay $15	You pay $0	You pay $0
Lens Options [3, 4]	Standard Polycarbonate	You pay $40	You pay $30 (kids under 19, you pay $0)	You pay $0
	Standard Anti-Reflective Coating	You pay $45	You pay $35	You pay $35
	Premium Anti-Reflective Coating	Not covered	Tier 1 – You pay $47	Tier 1 – You pay $47
			Tier 2 – You pay $58	Tier 2 – You pay $58
			Tier 3 – 80% of charge	Tier 3 – 80% of charge
	Polarized	20% off retail price	You pay $75	You pay $75
	Photochromatic / Transitions Plastic	20% off retail price	You pay $65	You pay $65
	Other Add-Ons	20% off retail price	20% off retail price	20% off retail price

[1] The Retiree Vision Plan Enhanced and Premier options pay a funded Benefit for one pair of Spectacle Lenses or for one pair of Contact Lenses each calendar year, as shown. In-Network, participants in the Enhanced and Premier Vision options will also receive a 40% discount off the retail price of each additional complete pair of eyeglasses and/or a 15% discount off the retail price of Conventional Contact Lenses once the annual funded Benefit has been used.

[2] Benefit Allowances are maximum amounts. Benefit Allowances provide no remaining balance for future use within the same benefit frequency. In certain states, you may be required to pay the full retail rate and not the negotiated discount rate with certain providers, and you may need to file a claim for reimbursement of the benefit allowance(s) for the service you have received. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

[3] Frame, Lens, and Lens Options discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, you will receive 20% off the retail price.

[4] Member pricing – add to Standard Plastic Lens prices above.

Table 19 – EyeMed Vision Plan Options – In-Network Benefits

Out-of-Network Reimbursements – If you decide to use Out-of-Network providers instead of EyeMed In-Network providers, the Retiree Vision Plan will provide the following Out-of- Network reimbursements each calendar year (January 1st through December 31st) for each Covered Person, subject to the following Reimbursement Allowances:

Feature	Basic Vision Plan Option (Siemens Energy-Paid)	Enhanced Vision Plan Option (Buy-Up)	Premier Vision Plan Option (Buy-Up)
Out-of-Network Reimbursement Schedule			
Exam / Comprehensive Eye Examination	Up to $40 allowance		
Exam / Retinal Imaging	Not covered		

Evaluation	Contact Lens Evaluation & Fitting	Not covered	Up to $40	Up to $40
Contact Lenses [1, 2]	Conventional	Not covered	Up to $40	Up to $80
	Disposable, planned replacement		Up to $40	Up to $80
	Medically Necessary (with prior approval)		Up to $40	Up to $80
Frame	Any Frame		Up to $40	Up to $60
Standard Plastic Lens	Single Vision		Up to $25	Up to $25
	Bifocal		Up to $40	Up to $40
	Trifocal		Up to $55	Up to $55
	Lenticular		Up to $70	Up to $70
	Standard or Premium Progressives		Up to $40	Up to $40
Lens Options [1, 2]	UV Treatment		Up to $5	Up to $10
	Tint (Solid or Gradient)		Up to $5	Up to $5
	Standard Plastic Scratch Coating		Up to $5	Up to $5
	Standard Polycarbonate		Up to $10	Up to $28
	Standard or Premium Anti-Reflective Coating		Up to $5	Up to $5
	Polarized		Up to $5	Up to $5
	Photochromatic / Transition Plastic		Up to $5	Up to $5
	Other Add-Ons		Not covered	Not covered

[1] The Retiree Vision Plan Enhanced and Premier options will pay an Out-of-Network reimbursement for one pair of Spectacle Lenses or for one pair of Contact Lenses each calendar year, as shown. You will not be eligible to receive an Out-of-Network reimbursement if you have already received an In-Network Benefit. You will not be eligible to receive an In-Network Benefit if you have already received an Out-of-Network reimbursement.

[2] Out-of-Network reimbursement allowances are maximum amounts. Your reimbursement will be the lesser of the listed amount or the Out-of-Network provider's actual charge. Out-of-Network reimbursement allowances provide no remaining balance for future use within the same benefit frequency.

Table 20 – EyeMed Vision Plan Options – Out-of-Network Reimbursements

Claiming Benefits

If you use an Out-of-Network provider, you and your provider will need to complete a Direct Reimbursement Claim Form, which is accessible from the EyeMed website. Receipts must be submitted within 12 months of the date of service. Submit claims to:

First American Administrators
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

If you have questions about your vision benefits, visit EyeMed's website at **www.eyemedvisioncare.com/siemensenergy** or call **1-866-800-5457**.

Expenses Not Covered

The following are among vision-related services and products that are not covered under the Retiree Vision Plan options:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Aniselkonic lenses.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Any eye or vision examination, or any corrective eyewear required as a condition of employment.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program, whether federal, state or a subdivision thereof.
- Plano (non-prescription) lenses and/or contact lenses.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Services rendered after the date a Covered Person ceases to be covered under the Retiree Vision Plan or the Retiree Vision Plan option that may have covered such services (as may apply), except when vision materials ordered before coverage ended are delivered and the services rendered to the Covered Person are within 31 days from the date of such order.
- Services or vision materials provided by any other group benefit plan providing vision care.
- Any replacement of lost or broken lenses, frames, eyeglasses, or contact lenses before the next Benefit frequency when vision materials would next become available.

SECTION 17 – OVERVIEW OF YOUR RETIREE LIFE INSURANCE COVERAGE

Eligibility

- Effective January 1, 2013, Siemens Corporation eliminated post-retirement life insurance coverage for all non-union retirees who were members of the Houston IBEW Local 716 and the Federation of Independent Salaried Unions and its affiliates in the Pittsburgh area ("FISU") (both those under and over age 65) who were until then eligible for coverage of less than $5,000.
- Post-retirement life insurance coverage for non-union retirees and union retirees who were members of Local 716 and FISU in each case with coverage of $5,000 or more has been continued. Post-retirement life insurance for all other union retirees continues, regard of the amount of coverage.
- Effective September 28, 2020, Siemens Corporation spun off the assets and liabilities from the Siemens Group Insurance and Flexible Benefits Program to the Siemens Energy, Inc. Group Insurance and Flexible Benefits Program for (1) former employees of Siemens Energy or one of its Affiliates, as defined in the Siemens Energy, Inc. Pension Plan; and (2) Transferring Employees, as defined in the Siemens Energy, Inc. Pension Plan, who in either case were eligible under the Siemens Group Insurance and Flexible Benefits Program - Part 2d Retiree Life Insurance on September 27, 2020.

The following information summarizes the main features of your Retiree Program - Retiree Life Insurance Coverage. The summary applies to you if:

- you terminated from Siemens Energy, Inc. or one of its affiliates, as defined in the Siemens Energy, Inc. Pension Plan, or are a "transferring employee" as defined in the Siemens Energy, Inc. Pension Plan; and
- you met the Eligibility Requirements defined in the *Eligibility, Enrollment and Cost* section of this Summary Plan Description.

Coverage for those Retirees who continue to have Retiree Life Insurance Coverage under the Retiree Program is insured by The Hartford Life Insurance Company (The Hartford).

Coverage Amount

You can confirm whether you are entitled to any post-retirement life insurance and the amount of such insurance by calling the SEBSC at **1-844-950-0359**. Representatives are available to assist you from 10 am to 6 pm Eastern Time, Monday through Friday.

The Life insurance benefit is paid when The Hartford receives a completed claim form with proof (certified copy of death certificate) that you died while insured under the program.

Cost of Coverage

Siemens Energy pays the full cost of your Retiree Life Insurance Coverage.

Payment of Benefits/Beneficiary

The full amount of life insurance for an eligible Retiree is paid to the Retiree's named Beneficiary if the Retiree dies from any cause. Payments for benefits under $10,000 are

in the form of a check. Payments in excess of $10,000 will be paid by The Hartford setting up an account in which the full benefit is deposited. The eligible Retiree's Beneficiary will receive a checkbook with which to draw funds from the account, and can draw out part of the funds or the entire amount.

If a Retiree eligible for Retiree Life Insurance Coverage has not designated a Beneficiary at the time of the Retiree's death or if the designated Beneficiary dies before the Retiree, the eligible Retiree's insurance will be paid to (in the following order): (1) the executors or administrators of the eligible Retiree's estate; (2) the eligible Retiree's surviving Spouse; (3) if the eligible Retiree's Spouse does not survive the eligible Retiree, in equal shares to the eligible Retiree's surviving children; (4) if no child survives, in equal shares to the eligible Retiree's surviving parents; or (5) if no parent survives, in equal shares to the eligible Retiree's surviving siblings.

Beneficiary

Important! A Retiree eligible for Retiree Life Insurance Coverage must designate a Beneficiary for the Retiree's Retiree Life Insurance Coverage. The Beneficiary an eligible Retiree has designated for the Retiree's active employee life insurance coverage will **not** automatically become the Beneficiary for an eligible Retiree's Retiree Life Insurance Coverage.

The "Beneficiary" is the person or persons you name to receive your Retiree Life Insurance benefit. Subject to certain state legal requirements, you can name anyone as your Beneficiary and may change your choice at any time and for any reason.

A Retiree eligible for Retiree Life Insurance Coverage can designate or change his or her Beneficiary by calling the SEBSC at **1-844-950-0359** and speaking with a customer service representative. Once the eligible Retiree provides the representative with the Retiree's security information, the representative can make the change to the Retiree's Beneficiary over the telephone. Security information is accepted as the Retiree's signature would be on a paper form. Paper forms are no longer accepted. Paper forms previously submitted are on file will be used if an electronic designation has not been made.

SEBSC representatives are available from 10 am to 6 pm (Eastern Time), Monday through Friday to assist you.

A change in Beneficiary takes effect on the date the change is made at the SEBSC. The Hartford is not liable for any additional payments, if a payment has been made before the change is received.

Claiming Life Insurance Benefits

In case of an eligible Retiree's death, the Beneficiary of the eligible Retiree should contact the SEBSC at **1-844-950-0359** immediately.

Upon being notified of the eligible Retiree's death, the SEBSC will notify The Hartford of the Retiree's death. The Hartford will mail claim forms to the eligible Retiree's Beneficiary. Upon receiving the completed forms and proof of loss (certified copy of death certificate), The Hartford will pay the claim.

SECTION 18 – COORDINATION OF BENEFITS ("COB") FOR RETIREE MEDICAL AND DENTAL COVERAGE OPTIONS

What this section includes:

- How your medical and dental Benefits under the Retiree Program coordinate with other health benefits plans
- How coverage is affected if you become eligible for Medicare
- Procedures in the event of Retiree Program overpayments

The Retiree Medical Coverage (including Prescription Drug) and Retiree Dental Plan options provided under the Retiree Program have a right of Coordination of Benefits ("COB"). COB applies to you if you are covered by this Retiree Program for Retiree Medical Coverage and/or Dental Coverage and another health benefits plan, including any one or more of the following:

- Another employer-sponsored health benefits plan.
- A medical component of a group long-term care plan, such as Skilled Nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit. In most circumstances, if you are eligible for Medicare, benefits under your Retiree Medical Coverage will coordinate with Medicare Part A and Part B even if you are not enrolled in coverage under either Part.

If coverage for a health service is available under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be partially covered under the other plan, which is considered secondary. How much (if anything) the Retiree Program will pay will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Determining Which Plan Is Primary

Order of Benefit Determination Rules

If you are covered by two or more group health benefit plans, the benefit payment follows the rules below in this order:

- If you are a Retiree who is not covered under another employer's group health benefits plan as an active employee or the Spouse of an active employee, this Plan is always primary for your covered expenses.
- The Retiree Program will always be secondary to medical or dental payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more health benefit plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

- Plans for active employees pay before plans covering laid-off or retired employees.
- If you are receiving COBRA continuation coverage under another employer plan, the Retiree Program will pay benefits first.
- A plan that covers a person as a Retiree or principal Covered Person pays benefits before a plan that covers the person as a dependent.
- If your Spouse or Domestic Partner is covered under the Retiree Program as a Dependent and under another group plan as an employee, the plan covering your Spouse or Domestic Partner as an employee is primary and the Retiree Program is secondary.
- If you have Dependent children covered by both the Retiree Program and your Spouse's or Domestic Partner's plan, the plan of the parent whose birthday (month and day) is earlier in the calendar year is primary; the other parent's plan is secondary. This is called the "birthday rule." If both parents have the same birthday, the plan that has covered either of the parents longer is the primary plan. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If you are separated or divorced, benefits for your children are determined in accordance with any court decree.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent without custody of the child; then
  - The Spouse of the parent without custody of the child.
- If the parent with custody has not remarried, that parent's plan pays benefits first; the other parent's plan is secondary.
- If the parent with custody has remarried, the plan of the parent with custody is primary, the step-parent's plan is secondary, and the plan of the parent without custody pays third.
- If none of the above apply, the plan covering the person for the longest period is primary.
- Finally, if none of the above rules determines which plan is primary or secondary, the Retiree Program will pay 50% of the Eligible Expense.

The following examples illustrate how the Retiree Program determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples
(1) Let's say you and your Spouse both have family medical coverage through your respective employer-sponsored medical plans. You are unwell and go to see a Physician. Since you're covered as a Retiree under the Retiree Program and as a Dependent under your Spouse's plan, the Retiree Program will pay Benefits for the Physician's office visit first if your Spouse's plan is also a retiree plan. The Retiree Program will pay second if your Spouse is still actively employed.
(2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. If your Spouse is still actively employed, your Spouse's plan will pay first, and the Retiree Program will pay second. If your Spouse's plan is also a retiree plan, the Retiree Program will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan Is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.
When the provider is an In-Network provider for both the primary plan and the Retiree Program, the allowable expense is the primary plan's network rate. When the provider is an
in-network provider for the primary plan and an Out-of-Network provider for the Retiree Program, the allowable expense is the primary plan's network rate. When the provider is an out-of-network provider for the primary plan and an In-Network provider for this Plan, the allowable expense is the reasonable and customary charge allowed by the primary plan. When the provider is an Out-of-Network provider for both the primary plan and the Retiree Program, the allowable expense is the greater of the two plans' reasonable and customary charges. If the Retiree Program is secondary to Medicare, please also refer to
Determining the Allowable Expense When This Plan Is Secondary to Medicare below.

When the Retiree Program pays benefits second, the Retiree Program will determine the amount it will pay for a Covered Health Service by using the following steps:

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

You will be responsible for any Coinsurance or Deductible payment as part of the COB payment. COB limits payments from the Retiree Program (if any) to no more than the Retiree Program would have paid if there had been no other coverage. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

The coordination of benefits provision does not apply to any personal policy, except No-Fault automobile insurance (regardless of whether you waived medical coverage under your automobile insurance policy).

For example, suppose your Spouse's medical plan covers a hospital bill at 85% — the same as the Retiree Program would have paid. Because your Spouse is entitled to receive benefits from his or her plan equal to what the Retiree Program would pay, the Retiree Program pays no additional benefits.

In determining the amount (if any) it will pay, the Retiree Program assumes that you follow the procedures of the other plan — for example, hospital pre-certification, second surgical opinion or pre-treatment estimate requirements. The Retiree Program will not cover any "penalties" you pay under the other plan for failure to comply with such procedures.

Different rules may apply to No-Fault automobile insurance.

If the Retiree Program is secondary to Medicare, please also refer to *Determining the Allowable Expense When This Plan Is Secondary to Medicare* below.

When a Covered Person Qualifies for Medicare

Determining Which Plan Is Primary

As permitted by law, the Retiree Program will pay Benefits second to Medicare when you become eligible for Medicare Part A or Part B, even if you don't elect coverage under either Part. Additionally, the Retiree Program will pay Benefits second to Medicare for the following Medicare-eligible individuals:

- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 and their eligible Dependents under age 65.

Determining the Allowable Expense When the Retiree Program Is Secondary to Medicare

When the Retiree Program is secondary to Medicare, the Medicare-Approved Amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare-Approved Amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare-Approved Amount) will be the allowable expense. Medicare payments, combined with Benefits paid under the Retiree Program, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and the Retiree Program 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 (this differs from a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under the Retiree Program and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating Provider.

When calculating the Benefits under the Retiree Program in these situations, and when Medicare does not issue an EOMB, for administrative convenience, United Healthcare will treat the provider's billed charges for covered services as the allowable expense for both the Retiree Program and Medicare, rather than the Medicare-Approved Amount or Medicare limiting charge.

Medicare Crossover Program

The Retiree Program offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Claims Administrator to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and the Retiree Program is your only secondary medical coverage.

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 the Retiree Program.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Retiree Program and other plans. The Claims Administrator of the Retiree Program option may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under the Retiree Program and other plans covering the person claiming benefits.

The Claims Administrator for the Retiree Program does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under the Retiree Program must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one health benefit plan, there is a possibility that the other plan will pay a benefit that the Retiree Program should have paid. If this occurs, the Retiree Program may pay the other plan the amount owed.

If the Retiree Program pays you more than it owes under this COB provision, you should pay the excess back promptly.

If the Retiree Program overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

The Retiree Program also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

Refund of Overpayments

If the Retiree Program pays benefits for expenses incurred on account of you or your Dependent(s), you, or any other person or organization that was paid, must make a refund to the Retiree Program if:

- The Retiree Program's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Retiree Program made exceeded the benefits under the Retiree Program.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Retiree Program paid in excess of the amount that should have been paid under the Retiree Program. If the refund is due from another person or organization, you agree to help the Retiree Program get the refund when requested. If the refund is due from you and you do not promptly refund the full amount owed, the Retiree Program may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for you that are payable under the Retiree Program.

The Retiree Program may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 19 – SUBROGATION AND REIMBURSEMENT

The Retiree Medical Coverage (including Prescription Drug) and Retiree Dental Coverage provided under the Retiree Program have a right to subrogation and reimbursement. Subrogation applies when the Plan has paid medical or dental benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The Plan has the right to reduce or deny medical or dental benefits otherwise paid by the Plan for any person covered and/or receiving benefits under the Plan as an employee, Spouse, Domestic Partner, dependent, or Beneficiary ("Covered Person") to the extent of any and all of the following: (1) any judgment, settlement, or payment made or to be made because of an accident or malpractice, including but not limited to other insurance; (2) any automobile or recreational vehicle insurance coverage or benefits, including but not limited to uninsured or underinsured motorist coverage; (3) any business medical and/or liability insurance coverage or payments; and (4) any attorneys' fees. The Plan's right to reimbursement applies when the Plan pays benefits, and a judgment, payment, or settlement is made on behalf of the Covered Person for whom the benefits were paid. Reimbursement to the Plan of 100% of these charges will be made at the time any such payment is received by a Covered Person, their representative, or any other entity. The Plan's right to reduction, reimbursement, and subrogation is based on the terms of the Plan in effect at the time of judgment, payment, or settlement.

Subrogation – Example
Suppose a Covered Person is injured in a car accident that is not his or her fault, and he or she receives Benefits under this Plan to treat his or her injuries. Under subrogation, this Plan has the right to take legal action in the Covered Person's name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that a Covered Person 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 considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which a Covered Person received a settlement, judgment, or other recovery from any third party, the Covered Person must use those proceeds to fully return to this Plan 100% of any Benefits he or she received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved, or waived in writing.

Reimbursement – Example
Suppose a Covered Person is injured in a boating accident that is not his or her fault, and he or she receives Benefits under this Plan as a result of his or her injuries. In addition, he or she receives a settlement in a court proceeding from the individual who caused the accident. The Covered Person must use the settlement funds to return to this Plan 100% of any Benefits he or she received to treat his or her injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused a Covered Person 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 in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, 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.
- Any person or entity against whom a Covered Person may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury a Covered Person alleges or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to a Covered Person on any equitable or legal liability theory.

Covered Persons agree as follows:

- You will cooperate with this Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying this 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 this Plan.
  - Signing and/or delivering such documents as this 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 this Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  A Covered Person's failure to cooperate with this Plan is considered a breach of contract. As such, this Plan has the right to terminate the Covered Person's Benefits, deny future Benefits, take legal action against the Covered Person, and/or set off from any future Benefits the value of Benefits this 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 this Plan due to the Covered Person or the Covered Person's representative not cooperating with this Plan. If this Plan incurs attorneys' fees and costs in order to collect third-party settlement funds held by Covered Persons or their representatives representative, this Plan has the right to recover those fees and costs from the Covered Person. The Covered Person will also be required to pay interest on any amounts he or she holds which should have been returned to this Plan.
- This Plan has a first priority right to receive payment on any claim against any third party before the Covered Person receives payment from that third party. Further, this Plan's first priority right to payment is superior to any and all claims, debts or

liens asserted by any medical 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.

- This Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to a Covered Person or his or her representative, estate, heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. This Plan is not required to help a Covered Person pursue claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from this Plan's recovery without this 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 the Covered Person has been fully compensated or made whole, this Plan may collect from the Covered Person the proceeds of any full or partial recovery that the Covered Person or his or her 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 this 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 this Plan's subrogation and reimbursement rights.
- Benefits paid by this Plan may also be considered to be Benefits advanced.
- If a Covered Person receives any payment from any party as a result of Sickness or Injury, and this Plan alleges some or all of those funds are due and owed to this Plan, the Covered Person and/or his or her representative shall hold those funds in trust, either in a separate bank account in the Covered Person's name or in his or her representative's trust account.
- By participating in and accepting Benefits from this Plan, a Covered Person agrees that (i) any amounts recovered by the Covered Person from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) the Covered Person and his or her representative shall be fiduciaries of this Plan (within the meaning of ERISA) with respect to such amounts, and (iii) the Covered Person shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by this Plan to enforce its reimbursement rights.
- This Plan's rights to recovery will not be reduced due to a Covered Person's own negligence.
- By participating in and accepting Benefits from this Plan, a Covered Person agrees to assign to this Plan any Benefits, claims or rights of recovery he or she has under any automobile policy
  – including no-fault Benefits, PIP Benefits and/or medical payment Benefits – other coverage or against any third party, to the full extent of the Benefits this Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, the Covered Person acknowledges and recognizes this Plan's right to assert, pursue, and recover on any such claim, whether or not the Covered Person chooses to pursue the claim, and the Covered Person agrees to this assignment voluntarily.

- This Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits a Covered Person receives for the Sickness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in a Covered Person's name or his or her estate's name, which does not obligate this Plan in any way to pay the Covered Person part of any recovery this Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of this Plan is governed by a six-year statute of limitations.
- A Covered Person may not accept any settlement that does not fully reimburse this Plan, without its written approval.
- This Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of a Covered Person's death, giving rise to any wrongful death or survival claim, the provisions of this section apply to the Covered Person's estate, the personal representative of his or her estate, and his or her heirs or beneficiaries. In the case of a Covered Person's death, this Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of him or her or his or her estate that can include a claim for past medical expenses or damages. The obligation to reimburse this Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by the Covered Person, his or her estate, the personal representative of his or her estate, his or her heirs, his or her beneficiaries or any other person or party, shall be valid if it does not reimburse this Plan for 100% of its interest unless this 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 any 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 a Covered Person to suffer a Sickness or Injury while he or she is covered under this Plan, the provisions of this section continue to apply, even after the Covered Person is no longer covered.
- In the event that a Covered Person does not abide by the terms of this Plan pertaining to reimbursement, this Plan may terminate Benefits to the Covered Person or his or her Dependents, deny future Benefits, take legal action against the Covered Person, and/or set off from any future Benefits the value of Benefits this 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 this Plan due to the Covered Person's failure to abide by the terms of this Plan. If this Plan incurs attorneys' fees and costs in order to collect third-party settlement funds held by the Covered Person or his or her representative, this Plan has the right to recover those fees and costs from the Covered Person. The Covered Person will also be required to pay interest on any amounts he or she holds which should have been returned to this Plan.

- This Plan and all Administrators administering the terms and conditions of this 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 this Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to this Plan.

Right of Recovery

This Plan also has the right to recover Benefits it has paid on your or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

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

If this Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, this Plan will:

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

If this 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, this Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. This 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 this Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to this Plan.

SECTION 20 – WHEN YOUR RETIREE COVERAGE ENDS

This section does not apply to the Retiree Life Insurance Coverage Program.

What this section includes:
- Circumstances that cause coverage under the Retiree Medical, Dental, and/or Vision Coverages to end
- Extended coverage
- How to continue coverage after it ends

When Your Entitlement for Benefits Ends

- **Retiree Medical Coverage –** Your entitlement to Benefits (including Prescription Drug Benefits) under the Retiree Program automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

  When your Retiree Medical Coverage ends, the Retiree Program will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

- **Retiree Dental Coverage –** Your entitlement to Retiree Dental Benefits under the Retiree Program automatically ends on the date that your coverage ends. When your coverage ends, Delta Dental will still pay claims for services that you received before your coverage ended. However, if your Retiree Dental coverage ends after the following treatment has started, your expenses to complete the treatment will be covered if they are incurred within three months after your dental coverage ends:
  - Impressions for bridgework or dentures
  - Preparation work for crowns, inlays/onlays, or root canal therapy.

- **Retiree Vision Coverage –** Your entitlement to Retiree Vision Coverage under the Retiree Program automatically ends on the date that your coverage ends. When your coverage ends, EyeMed will still pay claims for services that you received before your coverage ended. EyeMed will also pay for vision materials ordered before coverage ended if they are delivered and the services are rendered within 31 days from the date of such order.

If you are not eligible for an extension of benefits under Retiree Program rules, you may be eligible to continue coverage under your Retiree Medical, Dental and/or Vision Coverage option at your own expense through COBRA. References to "the Retiree Program" in this section of this SPD shall include any Retiree Medical Coverage (including Prescription Drug), Dental Coverage, and Vision Coverage option or options in which you were enrolled and eligible to receive benefits.

When Your Retiree Coverage Ends

Your coverage under the Retiree Program will end on the earliest of:

- The date the Retiree Program ends.
- The date you stop making the required contributions.

- The date you cancel your coverage.
- The date you die. Coverage for your dependents who are covered under the Retiree Program prior to your death may continue after your death for as long as your dependents meet the eligibility requirements.
- The date you are no longer eligible.
- The last day of the month preceding your 65th birthday (unless enrolled in the Retiree 90/10 Medicare Carve-Out Medical Plan option).

Coverage for your eligible Dependent(s) will end on the earliest of:

- The date your coverage ends other than on account of your death.
- The date you stop making the required contributions.
- The date you cancel coverage for your eligible Dependent(s).
- The date your Dependent dies.
- The date on which he or she loses eligibility for coverage as your Spouse or Domestic Partner.
- On the last day of the month in which he or she no longer qualifies as a Dependent (for instance, your child reaches age 26).

Other Events Ending Your Coverage

The Retiree Program will provide at least thirty days' 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If the Claims Administrator and/or Siemens Energy find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, the Retiree Program or Siemens Energy has the right to demand that you pay back all Benefits the Plan or Siemens Energy paid to you, or paid in your name, during the time you were incorrectly covered under the Retiree Program.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Retiree Program will continue to cover the child as long as you or your Spouse or Domestic Partner continue to be covered under the Retiree Program and:

- The child is unable to be self-supporting due to a mental or physical handicap or disability that occurred before the child's eligibility ceased or would have ceased had the child been a covered Dependent under the Siemens Energy Benefits Program medical plan option that covered you as an active employee. A final determination by the Claims Administrator of your medical plan option must be made as to the child's handicapped status *before* the child's eligibility ceased.
- The child depends mainly on you for support.
- At least 30 days before the child reaches age 26, or as soon as possible after you receive notice that the child has lost coverage because the child reached a certain

age or a prior certification of disability has expired, contact your Retiree Medical Coverage Claims Administrator for assistance in certifying the child's continuing eligibility for coverage. In addition to completing the form that will be provided by the Claims Administrator, you and your child's Physicians(s) will need to provide proof of the child's incapacity and dependency.

- Upon approval of your request, your Retiree Medical Coverage Claims Administrator will notify you and send notice to the SEBSC to continue or reinstate coverage for the child.

Periodic recertification may be required. However, you will not be asked for this information more than once a year. If you do not supply such proof within 30 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Retiree Program.

Continuing Coverage Through COBRA

If you lose your coverage under the Retiree Program, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you have the right to extend coverage under COBRA and you are losing coverage under more than one Retiree Program option, you have a separate right to choose to extend (or not extend) coverage under each of them. For instance, if you are enrolled in Retiree Medical, Dental and Vision Coverage options and are losing coverage, you may decide to continue Medical but not Dental or Vision.

Continuation Coverage under COBRA

Much of the language in this section comes from the federal law that governs continuation coverage. You should call the SEBSC at **1-844-950-0359** if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the Retiree Medical, Dental, or Vision Coverage on the day before a qualifying event:

- A Retiree.
- A Retiree's Spouse or Domestic Partner.
- A Retiree's former Spouse or Domestic Partner if the Qualifying Event is divorce or legal separation or termination of a Domestic Partnership.
- A Retiree's enrolled Dependent child, including, with respect to the Retiree's children, a child born to or placed for adoption with the Retiree during a period of continuation coverage under federal law.

Qualifying Events for Continuation Coverage under COBRA

Table 21 below outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse/ Domestic Partner	For Your Child(ren)
You divorce (or legally separate) or terminate your Domestic Partnership	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare[3]	N/A	36 months	36 months
Siemens Energy files for bankruptcy under Title 11, United States Code. [1]	Until death	36 months after Retiree death [2]	36 months after Retiree death [2]

[1] This is a qualifying event for any Retiree and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[2] Coverage will end upon the death of your Spouse/Domestic Partner or your child, if earlier.

[3] Medicare entitlement is only a qualifying event if such entitlement causes your Dependents to lose coverage under the Plan.

Table 21 – COBRA Qualifying Events

Getting Started

Your covered Dependents will be notified by mail if they become eligible for COBRA coverage because you become entitled to Medicare. The notification will advise them of the monthly cost and give them instructions for electing COBRA coverage. The monthly cost is the full cost, including both participant and Plan Sponsor costs, plus a 2% administrative fee or other cost as permitted by law.

Your Dependents will have up to 60 days from the date they receive notification or 60 days from the date their coverage ends to elect COBRA coverage, whichever is later. They will then have an additional 45 days to pay the cost of COBRA coverage, retroactive to the date your coverage under the Retiree Program ended.

During the 60-day election period, the Retiree Program will, only in response to a request from a provider, inform that provider of your Dependents' right to elect COBRA coverage, retroactive to the date their COBRA eligibility began.

While your Dependents are participants in a Retiree Medical, Vision (if enrolled in Retiree Medical Coverage), or Dental Coverage option under COBRA, they have the right to change their coverage election:

- During Annual Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2, *Eligibility, Enrollment and Cost*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Siemens Energy Benefits Service Center by calling **1-844-950-0359** within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Retiree Program.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the SEBSC when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the SEBSC of these events within the 60-day period, the SEBSC is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the SEBSC within 30 days of the birth or adoption of a child.

Once you have notified the SEBSC, you will then be notified by mail of your election rights under COBRA.

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that the enrolled COBRA participant first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment in timely manner (premium is not paid within 45 days of its due date).
- The date coverage ends for failure to make any other monthly premium payment in timely manner (premium is not paid within 30 days of its due date).
- The date Siemens Energy ceases to sponsor any group health plan.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under the Retiree Program, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

SECTION 21 – OTHER IMPORTANT INFORMATION

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree, or order issued by a court or appropriate state agency that requires a child to be covered for medical, dental, or vision benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Retiree Program receives a medical child support order for your child that instructs the Retiree Program to cover the child, the SEBSC will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the appropriate Retiree Program options as your Dependent, and the Retiree Program will be required to pay benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the SEBSC.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

If You Die

If you die while you are participating in the Retiree Program, your surviving Dependents will be allowed to continue their coverages (Medical (including Prescription Drug), Dental, and Vision) if they were participating as eligible Dependents before your death, for as long as they meet the eligibility requirements. Your surviving Dependent or other family representative should call the SEBSC as soon as possible at **1-844-950-0359** to report your death. The SEBSC representative will guide your family members through this process and will let them know which benefits will continue to be available to them and which benefits will no longer be available to them, as may apply. The SEBSC representative can also give your family members information on how to (1) file a claim for Retiree Life Insurance, if a benefit is available; (2) initiate your survivor pension benefit, if applicable; and (3) how to change your address on record, if appropriate.

Your Relationship with UnitedHealthcare and Siemens Energy under the Retiree Medical Coverage

In order to make choices about your health care coverage and treatment, it is important for you to understand how UnitedHealthcare interacts with Retiree Medical Coverage and how it may affect you. UnitedHealthcare administers the Retiree Medical Coverage option in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you decisions about whether the Retiree Medical Coverage will cover or pay for the health care that you may receive. The Retiree Medical Coverage pays for Covered Health Services, which are more fully described in this SPD.
- The Retiree Medical Coverage may not pay for all treatments you or your Physician may believe are necessary. If the Retiree Medical Coverage does not pay, you will be responsible for the cost.

Siemens Energy's and UnitedHealthcare's Relationship with Providers under the Retiree Medical Coverage

The relationships between Siemens Energy, UnitedHealthcare, and network providers are solely contractual relationships between independent contractors. Network providers are not Siemens Energy's agents or employees, nor are they agents or employees of UnitedHealthcare. Siemens Energy and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

Siemens Energy and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, UnitedHealthcare arranges for health care providers to participate in a network and administers payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. United Healthcare's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided. They are not Siemens Energy's employees nor are they employees of United Healthcare. Siemens Energy and UnitedHealthcare do not have any other relationship with network providers such as principal-agent or joint venture. Siemens Energy and UnitedHealthcare are not liable for any act or omission of any provider.

Your Relationship with Providers under the Retiree Medical Coverage

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying (or for verifying that payment is made from your Health Savings Account or Health Reimbursement Account, as may be applicable), directly to your provider, any amount identified as a member responsibility, including Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between Siemens Energy and you is that of Plan Sponsor and Retiree, Dependent, or other classification as defined in this SPD.

SECTION 22 – GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Retiree Program and the Retiree Program options are administered and how Retiree Program benefits are paid. This section defines terms used throughout this SPD, but it does not describe the benefits provided by any Retiree Program option.

Activities of Daily Living (ADLs) – the normal activities of daily living, including bathing, dressing, eating, transferring (such as from a bed to a chair), toileting and continence.

Allowance – the maximum Benefit or Reimbursement that will be paid by the Claims Administrator for a specified service, product, or feature during a period of time designated as a Benefit Frequency. For instance, under the EyeMed Retiree Vision Coverage options, the Out-of-Network Reimbursement Allowance for a Comprehensive Eye Exam is $40 once every calendar year.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis.

Amendment – any attached written description of additional or alternative provisions to the Retiree Program.

Annual Enrollment – the period of time during which eligible Retirees may enroll themselves and their Dependents in medical, dental and/or vision coverage under the Retiree Program. Siemens Energy determines the period of time that is the Annual Enrollment period.

Annual Deductible (or Deductible) – the amount you must pay for In-Network and Out-of-Network Covered Health Services in a calendar year before your Retiree Medical Coverage will begin paying In-Network or Out-of-Network Benefits in that calendar year. The Annual Deductible amounts for the Retiree Medical Coverage options are shown in Section 3 (Retiree Health Savings Medical Plan Option), Section 4 (Retiree Health Reimbursement Medical Plan Option), and Section 5 (Retiree 90/10 Medicare Carve-Out Plan Option), *Highlights*. An Annual Deductible also applies to In-Network and Out-of-Network services under the Retiree Dental Plan.

Autism Spectrum Disorder – a condition marked by enduring problems in communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Balance Billing – the difference between a provider's *billed* charge and the Eligible Expense (the maximum amount covered under the Retiree Program option, including any portion of the Eligible Expense applied to your Annual Deductible or Coinsurance) or the Medicare-Approved Amount. If you use Out-of-Network providers, or if you are Medicare-eligible and you use providers who are not Medicare Participating Providers, you are responsible for paying the full amount of any "balance billing," and the balance-billed amount will not be applied to your Annual Deductible or Out-of-Pocket Maximum balances.

Beneficiary – the person or persons you name to receive your Retiree Life Insurance benefit.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Retiree Program, your plan option, and any Addendum, Summary of Material Modification, and/or Amendment.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United Healthcare Services, Inc.) is the Claims Administrator, and its affiliates provide certain claim administration services, for the Retiree Medical Coverage options. CVS/caremark is the Claims Administrator for prescription drug and pharmacy services provided under the Retiree Medical Coverage options. Delta Dental is the Claims Administrator for the Retiree Dental Plan. EyeMed is the Claims Administrator for the Retiree Vision Coverage options.

Clinical Trial – a scientific study designed to identify new health services or medications that improve health outcomes. For more information, see ***Clinical Trials*** in Section 11, *Additional Coverage Information*.

COBRA – the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services after the Annual Deductible for your Retiree Medical Coverage Plan option is applied, as described in Section 3 (Retiree Health Savings Medical Plan Option), Section 4 (Retiree Health Reimbursement Medical Plan Option), or Section 5 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *How the Plan Works*. Coinsurance provisions also apply to prescription drug, dental and vision expenses.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited);

- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- Have no known cause.

Consumer Price Index for Urban Wage Earners and Clerical Workers (**CPI-W**) – the CPI-W is a number compiled by the Bureau of Labor Statistics of the U.S. Department of Labor that measures changes in consumer prices paid by certain groups of workers. The CPI-W is used to calculate Social Security cost-of-living adjustments and as an adjustment offset against the annual increase in cost of coverage for some participants covered under the Retiree Medical Coverage.

Copayment or Copay – a Copayment or Copay is a pre-determined dollar amount that you pay directly to an In-Network health care provider. For instance, a Copayment may apply to the cost of prescription drugs under the Retiree Prescription Drug Program or to In-Network vision expenses under the EyeMed Retiree Vision Coverage options. A Copayment sometimes covers the full cost of the service. Other times, further charges are payable.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the medical, dental or vision Claims Administrator.

Cost-Effective – the least expensive item or service that performs the necessary function. This term applies to Durable Medical Equipment, prescription drug and pharmacy services, and dental procedures, services and prosthetic devices.

Covered Expenses or Covered Health Services – those health services, including medical, dental or vision services, supplies or Pharmaceutical Products, which the applicable Claims Administrator determines to be:

- Medically Necessary or Dentally Necessary;
- Described as a Covered Expenses or Covered Health Service in this SPD under Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), or Section 10 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Schedule of Benefits*, and Section 11, *Additional Coverage Details* for the Medical coverage, or under Section 14, Section 15, or Section 16 for prescription drug, dental and vision coverages.
- Provided to a Covered Person who meets the eligibility requirements for the Retiree Program, as described under *Eligibility* in Section 2, *Eligibility, Enrollment and Cost*.
- Not otherwise excluded in this SPD under Section 12, *Exclusions and Limitations* for the Retiree Medical Coverage option, or under Section 14, Section 15, or Section 16 for prescription drug, dental and vision coverages.

Covered Person – either the Retiree or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for benefits under the Retiree Program.

Custodial Care – services that are any of the following:

- Non-health-related services, such as assistance in ***activities of daily living*** (examples include feeding, bathing, dressing, transferring, and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific

services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dentally Necessary – see Medically Necessary.

Dentist – an individual holding a degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) practicing within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided.

Dependent – an individual who meets the eligibility requirements described in Section 2, *Eligibility, Enrollment and Cost*.

Designated Provider – provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to organ transplantation services, specific treatments, conditions, and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all In-Network Hospitals or In-Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting United Healthcare at www.myuhc.com or the telephone number on your ID card.

Doctor (or Physician) – An individual holding a degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), Doctor of Podiatry Medicine (DPM.) or Doctor of Chiropractic (DC), practicing within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided. Under certain circumstances, this term may be applied to a licensed healthcare professional, such as a Physician's Assistant, Nurse Practitioner, Nurse Midwife, or Registered Nurse, who is permitted under the laws of the state or jurisdiction to provide services, including the right to prescribe medication, under the supervision of a doctor or physician. The term "Doctor" or "Physician" does not include you or any family member or domestic partner.

Domestic Partner – a person of the same or opposite sex with whom the Retiree has established a Domestic Partnership.

Domestic Partnership – a relationship between a Retiree and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.

- They must share the same permanent residence and the common necessities of life.
- They must be financially interdependent.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while coverage is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3 (Retiree Health Savings Medical Plan Option), Section 4 (Retiree Health Reimbursement Medical Plan Option), or Section 5 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *How the Plan Works* for the Retiree Medical Coverage, or under Section 14, Section 15, or Section 16 for prescription drug, dental and vision coverages.

Eligible Expenses under the Retiree Medical Coverage are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Emergency – a medical condition that arises suddenly and results from Injury, Sickness or Mental Illness that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention (generally received within 24 hours of onset) to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to coverage of an Emergency under a Retiree Medical Coverage option, both of the following:

- A medical screening examination (as required under *Section 1967 of the Social Security Act, 42 U.S.C. 1395dd*) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under *Section 1967 of the Social Security Act (42 U.S.C. 1395dd(e)(3*)).

Employee Retirement Income Security Act of 1974 (ERISA) – the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care, dental or vision 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 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 I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 11, *Additional Coverage Details* for a Retiree Medical Coverage option or in Section 14 for prescription drug coverage.
- If you are not a participant in a qualifying Clinical Trial as described under Section 11, *Additional Coverage Details* for a Retiree Medical Coverage option, or under Section 14 for prescription drug coverage, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.

- Any other reductions taken.
- The net amount paid by the Retiree Program.
- The reason(s) why the service or supply was not covered by the Retiree Program.

Gap Exception – if you are not eligible for Medicare, In-Network Benefits may be payable for Out-of-Network services with an approved Gap exception. There are two types of gap – a "geographical" gap and a "specialty" or service gap. A gap exists when there is no In-Network physician or In-Network qualified specialist or facility within a 30-mile radius of your home. Gap Exceptions are reviewed and approved by an Optum Care Coordinator, who may impose a limit on the duration of the exception and/or on the number of visits (for instance, 90 days and twice a week for Out-of-Network physical therapy). You may request a geographical Gap Exception or your In-Network provider may request a specialty Gap Exception. If you are eligible for Medicare, a Gap Exception will not apply to you.

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

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for

wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

- ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.
- ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- ♦ A strong preference for playmates of the other gender.
- ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- ♦ A strong dislike of one's sexual anatomy.
- ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospice Care Program – a program that provides:

- ■ a coordinated, interdisciplinary program to meet the physical, psychological, spiritual, and social needs of terminally ill persons and their families
- ■ palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness
- ■ a program for persons who have a terminal illness and a life expectancy of fewer than six months and for the families of those persons.

Hospice Care Services – any services provided by a hospital, skilled nursing care facility (or similar institution), home health care agency, hospice facility, or any other licensed facility or agency under a Hospice care program.

Hospice Facility – a facility, unit of a facility, public or private agency or subdivision of a public or private agency that meets federal certification requirements as a Hospice, or is comparably licensed under applicable state laws to provide care or management of the Terminally Ill.

Hospital – an institution, operated as required by law and that meets both of the following:

- ■ It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and

surgical facilities, by or under the supervision of a staff of Physicians.

- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care, or care of the aged and is not a nursing home, convalescent home, or similar institution.

In-Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator of a Retiree Medical Coverage option, or with its affiliate, to participate in the UnitedHealthcare Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the UnitedHealthcare Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common own-ership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be an In-Network provider for only some products. In this case, the provider will be an In-Network provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

In-Network Benefits – describes how Benefits are paid for Covered Health Services provided by In-Network providers under the Retiree Medical Coverage. Refer to Section 3 (Retiree Health Savings Medical Plan Option), Section 4 (Retiree Health Reimbursement Medical Plan Option), or Section 5 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *How the Plan Works*, and to Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), or Section 10 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Schedule of Benefits*, for details about how In-Network Benefits apply to your Retiree Medical Coverage option.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long-term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment – a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – Skilled Nursing Care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Manipulative Treatment – manipulative therapy may be employed as a treatment for many musculoskeletal disorders, such as low-back pain and cervical and thoracic spine disorders.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary (or Dentally Necessary) – health care services 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 (or for preventing, diagnosing, ameliorating or correcting a vision or dental disorder), 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 (or vision or dental) practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) 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 (or vision or dental) 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 (or Dentally Necessary). The decision to apply Physician specialty (or vision or dental) 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 for the Retiree Medical Coverage options 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 by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare-Approved Amount – In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount, a Retiree Medical Coverage option may pay part of this amount, and the Medicare-eligible or Medicare-enrolled participant is responsible for the difference.

Medicare Participating Provider – a health care professional, supplier, or provider, that has agreed to accept the Medicare-Approved Amount as full payment for a healthcare service, treatment, therapy, or device and is held accountable for understanding and complying with information received from the Centers for Medicare & Medicaid Services (CMS) and any Medicare FFS Contractor (Fiscal Intermediary [FI], carrier, or Medicare Administrative Contractor [MAC]).

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Out-of-Network Benefits – describes how Benefits are paid for Covered Health Services provided by Out-of-Network providers under the Retiree Medical Coverage. Refer to Section 3 (Retiree Health Savings Medical Plan Option), Section 4 (Retiree Health Reimbursement Medical Plan Option), or Section 5 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *How the Plan Works*, and to Section 8 (Retiree Health Savings Medical Plan Option), Section 9 (Retiree Health Reimbursement Medical Plan Option), or Section 10 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *Schedule of Benefits*, for details about how Out-of-Network Benefits apply to your Retiree Medical Coverage. When using an Out-of-Network provider, you may be subject to Balance Billing.

Out-of-Pocket Maximum – the maximum amount of Eligible Expenses you pay for Covered Health Services every calendar year. Refer to Section 3 (Retiree Health Savings Medical Plan Option), Section 4 (Retiree Health Reimbursement Medical Plan Option), or Section 5 (Retiree 90/10 Medicare Carve-Out Medical Plan Option), *How the Plan Works*, for a description of how the Out-of-Pocket Maximum works under your Retiree Medical Coverage. See Section 14 for a description of how the Out-of-Pocket Maximum works under the CVS/caremark Prescription Drug Program.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator of the Retiree Medical Coverage that focus on prevention, education, and closing the gaps in care. Personal Health Support is designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you are enrolled in Retiree Medical Coverage Plan option and you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Physician – any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Retiree Medical Coverage option.

Plan Sponsor – Siemens Energy, Inc.

Pregnancy – includes all of the following:

- Prenatal care.
- Childbirth.
- Postnatal care.
- Any complications associated with the above.

Prior Authorization – a decision by the Claims Administrator of your retiree medical, prescription drug, dental, or vision plan that a health care service, treatment plan, prescription drug, or durable medical equipment is Medically (or Dentally) Necessary and is a Covered Health Service under the plan. Prior Authorization is also called preauthorization, prior approval, PA, or precertification. Your plan may require Prior Authorization for certain services before you receive them, except in an Emergency. In the case of an Emergency, you need to call the Claims Administrator as soon as possible to provide notice of the service you have received or are receiving. For most services, your In-Network provider is responsible for seeking Prior Authorization on your behalf. You are responsible for seeking or verifying Prior Authorization for Out-of-Network services. If you fail to seek Prior Authorization for Out-of-Network services in timely manner, Benefits may be reduced or coverage may be denied. Prior Authorization is not a promise that your Retiree Medical Coverage will cover the cost.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per-visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure 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 which 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.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorder Services and requires full-time residence and full-time participation by the patient. A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retiree – a previous employee of Siemens Energy who meets the eligibility requirements for Retiree Medical Coverage specified in this Summary Plan Description, as described in Section 2, *Eligibility, Enrollment and Cost*.

Semi-private Room – a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to an Out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the Out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Retiree Medical Coverage coinsurance and deductibles will still apply to the reduced charge. Sometimes Retiree Medical Coverage provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by United Healthcare. In such a case, the Out-of-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 to request an adjustment of the charge. Shared Savings Program providers are not In-Network providers and are not credentialed by UnitedHealthcare.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Siemens Energy - Siemens Energy, Inc. and affiliated companies, as defined in the Siemens Energy, Inc. Pension Plan.

Skilled Care – Skilled Nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including feeding, bathing, dressing, or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Retiree Medical Coverage.

Spinal Treatment – detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse – an individual to whom you are legally married. An individual shall be considered legally married regardless of where the individual is domiciled if either of the following apply: (1) the individual is married in a state, possession, or territory of the United States and the individual is recognized as lawfully married in that state, possession, or territory of the United States or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the United States recognize him or her as lawfully married.

Substance-Related and Addictive Disorder Services – Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Summary of Material Modification – any attached written description of additional or revised provisions to the Retiree Program or any Retiree Program option. The benefits and exclusions of this SPD and any Amendments thereto shall apply to the Addendum or Summary of Material Modification except that in the case of any conflict between the Addendum or Summary of Material Modification and SPD and/or Amendments to the SPD, the Addendum or Summary of Material Modification shall be controlling.

Total Disability or Totally Disabled – a Dependent's inability to perform the normal activities of a person of like age and gender.

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.

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

Please note:

- If you are enrolled in Retiree Medical Coverage and have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care for a Sickness or Injury that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent Care is usually delivered in a walk-in setting and without an appointment. Urgent Care facilities are a location, distinct from a hospital Emergency department, an office or a clinic. The purpose of Urgent Care is to diagnose and treat Sickness or Injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms that do not qualify as an Emergency.

SECTION 23 – IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under *ERISA*
- Plan amendments and termination provisions

This section includes information on the administration of the benefits provided under the Retiree Program as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor

Siemens Energy, Inc. is the Plan Sponsor of the Retiree Program which includes medical, prescription drug, dental, vision and life insurance coverage. You may contact the Plan Sponsor at:

Plan Sponsor – Retiree Program
Siemens Energy, Inc.
4400 N. Alafaya Trail
Orlando, FL 32826
(407) 736-2000

By making a written request to the Plan Sponsor, you may request information about whether or not a specific employer affiliated with Siemens Energy has elected to participate in this Retiree Program.

Employer Identification Number

The Employer Identification Number for Siemens Energy is 13-3987280.

Plan Administrator

The Plan Administrator is the same as the Plan Sponsor. Communications to the Plan Administrator should be sent to:

Plan Administrator – Retiree Program
c/o Siemens Energy Benefits Department 4400
N. Alafaya Trail
Orlando, FL 32826
(407) 736-2000

Service of Legal Process

Legal Process may be served on the Plan Sponsor.

Administrative Information and Claims Administrators

The Claims Administrator for each coverage option offered under the Retiree Program is set forth in Table 22 below. Each Claims Administrator has full discretionary authority to determine claims under, and to interpret the applicable terms of, the applicable coverage option for which it is the Claims Administrator.

Plan Name	*Plan Number*	*Plan Type*	*Plan Funding*	*Claims Administrator or Insurer*
Siemens Energy Group Insurance and Flexible Benefits Program (Retiree Group Life, Medical, Dental, and Vision)	521	Welfare	Retiree and Siemens Energy Contribution	Group Life: *The Hartford* (claims administrator and insurer) Medical: *UnitedHealthcare* (claims administrator), except as listed below: *CVS/caremark* (claims administrator for prescription drug program) Vision: *EyeMed* (claims administrator and insurer) Dental: *Delta Dental* (claims administrator)

Table 22 – Claims Administrators and Insurers

The Administrative Committee of Siemens Energy Group Insurance and Flexible Benefits Program has full discretionary authority to determine claims and interpret the terms of the Retiree Program with respect to eligibility and other provisions of the Retiree Program outside of the scope of the Claims Administrators' responsibilities.

Plan Year

The plan year is a 12-month period beginning on January 1 and ending December 31 of each year.

Plan Documents

The plan documents for the Siemens Energy, Inc. Group Insurance and Flexible Benefits Program include this Summary Plan Description Part 2 for the Retiree Program; the Summary Plan Descriptions Part 2A; Part 2C for the Wellsville Union Retiree Program; the Summary Plan Description for active employees; Part 2D Retiree Life Insurance; and the applicable insurance company contracts, which legally govern the plans and are controlling in the event of a conflict with insurance-related terms of the Summary Plan Description. These documents, as well as the annual report of the Siemens Energy Group Insurance and Flexible Benefits Program, as filed with the U.S. Department of Labor, are available for review upon written request to the Plan Administrator. Copies of any of these documents will be furnished to a plan member or beneficiary within 30 days of receipt of a written request at a nominal cost.

Your ERISA Rights

As a participant in the Retiree Program, you are entitled to certain rights and protections under ERISA. ERISA provides that all Retiree Program participants shall be permitted to:

- Receive information about Retiree Program Benefits.

- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all plan documents and other Retiree Program information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the appropriate address indicated in Section 24, *Claim and Appeal Procedures for Retiree Coverages*.

You can continue health care coverage (medical, including prescription drug, dental and/or vision) for yourself, Spouse or Dependents if there is a loss of coverage under the Retiree Program option as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Retiree Program participants, *ERISA* imposes duties on the people who are responsible for the operation of the Retiree Program. The people who operate the Retiree Program, who are called "fiduciaries," have a duty to do so prudently and in the interest of you and other Retiree Program participants and beneficiaries. No one, including the Plan Sponsor, the Plan Administrator, or any other person may discriminate against you in any way to prevent you from obtaining a Retiree Program Benefit or exercising your rights under *ERISA*.

If your claim for a Retiree Program 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. For details, see Section 24, *Claim and Appeal Procedures for Retiree Coverages*

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan Administrator, and do not receive it 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Retiree Program, you may file suit in a state or federal court. In addition, if you disagree with the Retiree Program's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Retiree Program's fiduciaries misuse the Retiree Program'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.

If you have any questions about the Retiree Program, 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 write to the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 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* at **1-866-444-3272**.

Plan Amendments and Termination

Siemens Energy reserves the right to change, modify, suspend or terminate the Retiree Program, in whole or in part, at any time in its sole discretion, with or without advance notice to participants, subject to applicable law.

Siemens Energy reserves the right to change or terminate any of the rules related to any of the Retiree Program coverage or options, at any time, and to change the amount of contributions a Retiree may have to make for any type of coverage, including requiring retiree contributions in instances where no such requirement previously existed.

SECTION 24 – CLAIM AND APPEAL PROCEDURES FOR RETIREE COVERAGES

What this section includes:

- How to submit a **Level 1 Claim** if you have received a ***denial of eligibility or enrollment*** for a Retiree Coverage from the SEBSC or a Plan Administrator
- How to submit a **First-Level Appeal** if you have received a ***denial of Benefits*** from the Claims Administrator of your retiree medical, prescription drug, dental, vision, or life coverage
- Information you need to include with your First-Level Appeal
- Categories that describe the ***urgency*** of your Level 1 Claim or First-Level Appeal
- **Timeframes** for handling your Level 1 Claim or First-Level Appeal
- Appeal procedures specific to UnitedHealthcare, CVS/caremark, Delta Dental, EyeMed, and The Hartford

In this section, "you" and "your" will refer to any Retiree or Dependent who is or may be eligible for or enrolled in Retiree Coverages, to your authorized representative, or to any person making a claim as Beneficiary of your Retiree Life Coverage. Siemens Energy expects that you will generally be able to resolve any problem with eligibility and enrollment in Retiree Coverages if you call the SEBSC in a timely manner and speak with a customer service associate. Siemens Energy expects that you will generally be able to prevent or minimize almost any problem with coverage for a healthcare service or payment of Benefits if you or your Provider follow the procedures for Prior Authorization, file claims in timely manner, and work directly with the applicable Claims Administrator to understand and resolve any dispute. If you have made a good-faith effort to seek resolution and are not satisfied with the outcome, then this section describes your next steps under the Retiree Program.

Level 1 Claim for Denial of Eligibility or Enrollment

You have the right to file a **Level 1 Claim** for denial of eligibility or enrollment with Siemens Energy Claims and Appeals Management ("CAM"):

- If you have received a determination from the SEBSC or a Plan Administrator that you are ***not eligible to enroll*** or are ***not enrolled*** in a Retiree Medical, including Prescription Drug, Dental, and Vision Coverage option or Retiree Life Insurance. For example,
  - Your coverage was dropped due to nonpayment, and you are requesting a reinstatement of coverage.
  - You missed an opportunity to change your Retiree Medical Coverage option during Annual Enrollment, and you are asking to be enrolled in a different option.

You may designate in writing an authorized representative to pursue your Level 1 Claim.

CAM will not handle any Level 1 Claim that does not relate to an eligibility or enrollment issue.

You can submit your Level 1 Claim to CAM in the form of a letter of appeal, as described

below, or you can use a **Claim Initiation Form**. If you call the SEBSC at **1-844-950-0359** and it is determined that a claim must be filed to resolve the issue, the SEBSC will either mail the Claim Initiation Form to you or send you an email confirming your intent to file a claim. The email will contain a link to yourenergybenefits.com, where you will see a "Your Action Needed" message with a link to the claim submission process. (The form is not directly available on the website.) Once your claim is submitted and accepted, a Claims and Appeals tile appears on the website and allows you to track the progress of your claim.

Send your completed Claim Initiation Form or letter, along with copies of any pertinent documentation and any further correspondence, via U.S. Mail addressed to:

Claims and Appeals Management – Siemens Energy
P.O. Box 7105
Rantoul, IL 61866-7105
or fax: 1-224-523-7043

You may use any type of regular or express delivery offered by the U.S. Postal Service. CAM does not accept deliveries via DHL, UPS, Federal Express, or other possible vendors. CAM does not accept any communications sent by email. CAM will not reply to you via email or by fax.

To follow-up on your Level 1 Claim, you may call the SEBSC at 1-844-950-0359, Monday through Friday, from 10:00 a.m. to 6:00 p.m. EST.

Level 1 Claims for Denial of Eligibility or Enrollment are determined on the basis of Siemens Energy's plan rules and guidance.

For Level 1 Claims, provided you have submitted all requested documentation, you may expect a determination of your Level 1 Claim for Denial of Eligibility or Enrollment within 90 days of its receipt. However, if your documentation was incomplete or other special circumstances intervene, CAM may request an extension of up to 90 days.

If your Level 1 Claim is denied (that is, you receive an "adverse determination"), you have the further right to file a Level 2 Appeal within 180 days of the date of the denial. Your Level 2 Appeal will be reviewed and determined by the Administrative Committee, which will receive research assistance from CAM. Send your Level 2 Appeal, with copies of all pertinent documentation, which may include documents that were not included or considered in your Level 1 Claim, addressed to:

Attn: Administrative Committee of Siemens Energy
P.O. Box 7105
Rantoul, IL 61866-7105
or fax: 1-224-523-7043

The Administrative Committee will review the facts, the reasons for the claim decision, and the information you have provided. The Administrative Committee will respond in writing within 60 days following the receipt of your appeal. The decision of the Administrative Committee is final and binding.

First-Level Appeal for Denial of a Benefit

Your request for Prior Authorization or continuation of a health plan service under the Medical, including Prescription Drug, Dental, or Vision Coverage options is an "initial claim" or initial "Request for Benefits." Your request for payment or reimbursement of a health plan service or your beneficiary's Retiree Life insurance "claim" is also an "initial claim" or initial "Request for benefits." You need to submit your initial claim for benefits

to the Claims Administrator of the Plan option. Any claim for Out-of-Network Medical or Vision Benefits must be submitted to UnitedHealthcare or EyeMed for processing within 12 months of the date of service.

Prescription drug claims must be submitted to CVS/caremark for processing within 12 months of the date of purchase. Dental claims must be submitted to Delta Dental for processing before the end of the calendar year following the year in which the service was incurred.

If your initial claim for health plan benefits is denied in part or in whole (that is, you receive an "adverse benefit determination"), you may call the number on your member ID card before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below. The decision of the health plan Claims Administrator (UnitedHealthcare, CVS/caremark, Delta Dental, or EyeMed, as may apply) on any appeal will be based only on whether or not benefits are available under the Retiree Program for the proposed treatment or procedure.

You may designate in writing an authorized representative to pursue your medical, prescription drug, dental, vision, or life appeal. In the case of an Urgent Care or Urgent Concurrent Care appeal, a health care professional with knowledge of your medical condition may act as your authorized representative.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you. In addition to a first level of appeal, the Claims Administrator may offer a second level of appeal.

Below, the general guidelines and timeframes for filing and determination of an appeal are followed by claim and appeal procedures that apply specifically to UnitedHealthcare, CVS/caremark, Delta Dental, EyeMed Vision Care, and The Hartford.

Information to Include in Your Letter of Appeal

Use this section as a checklist of information that needs to be included in your First-Level Appeal (or in your Level 1 Claim, if you decide to send a letter instead of using a Claim Initiation Form, or in your Level 2 appeal). If you are requesting review of an Urgent Care Claim, however, you may also request review orally; and all communications may be done by telephone, facsimile, or other similar method.

- Under most circumstances, your appeal is a formal written letter and should include:
  - your name and address;
  - the fact that you are disputing the denial of a claim;
  - the date of the initial notice of denial;
  - a description of the service that was denied;
  - the reason(s) why you disagree with or are disputing the denial;
  - the form of resolution of dispute that you are seeking; and
  - your signature and the date of your signature.
- An appeal or request for review of a denial of a claim under a health plan option should also include all of the following:

- a specific request for a review (internal, expedited, external, as may apply);
- the name, address, and member ID number of the primary Covered Person;
- your designated representative's name and address (when applicable);
- the patient's name and ID number as shown on the ID card;
- the provider's name and contact information;
- the date(s) and location where the medical, dental, or vision service was or will be performed; and
- copies of any materials or records that support your claim – including any new, relevant information that was not provided previously.

Categories That Describe the Urgency of Your Claim or Appeal

The following categories are used to describe the urgency of your initial request for a Benefit and set the timeframes for the handling of your Level 1 Claim, your First-Level Appeal, and your Level 2 Appeal both for you and for the Claims Administrator.

- **Urgent Care Claim** – a request for Benefits provided in connection with Urgent Care services. As defined by the Department of Labor, a claim is considered a Group Health Urgent Care Level 1 Claim only if the patient needs immediate access to care and the delay of medical care or treatment caused by the longer timeframes for making non-urgent determinations could do one of the following:
  - Be considered a life-or-death situation,
  - Seriously jeopardize the health of the patient or the ability to regain maximum function, or
  - In the opinion of a healthcare professional with knowledge of the patient's medical condition, subject the patient to severe pain that cannot be managed without the care or treatment that is the subject of the claim.
- **Pre-Service Claim –** a request for Benefits which the Plan must approve or for which you must notify the Claims Administrator before non-urgent care is provided.
- **Post-Service Claim –** a claim for reimbursement of the cost of non-urgent care that has already been provided.
- **Concurrent Care Claim –** a request for extension of Benefits for an on-going course of treatment that was previously approved for a specific period of time or number treatments. As defined by the Department of Labor, a claim is considered a Group Health Concurrent Urgent Care Level 1 Claim only if it is a Group Health Urgent Care Level 1 Claim involving ongoing care.

Timeframes for Handling Your Level 1 Claim or First-Level Appeal

Separate schedules, depending on the urgency of the initial request, apply to the handling of claims and appeals. Tables 23, 24, and 25 below describe the timeframes which you and the Claims Administrator are required to follow depending on the category of your Claim or Request for Benefits or appeal.

Urgent Care Request for Benefits or Appeal *	Timing
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**24 hours**

You must then provide a completed request for Benefits to the Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	**72 hours**
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination (if a second-level appeal is available) no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

Urgent Care Request for Benefits or Appeal *	**Timing**
* For UnitedHealthcare, you do not need to submit an Urgent Care Appeal in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care Claim or request for Benefits. The initial notice of denial of your Urgent Care Claim may be provided orally, if that written notification is provided to you within three days after the oral notification.	

Table 23 – Urgent Care Claim, Request for Benefits or Appeal

Pre-Service Request for Benefits or Appeal *	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**15 days**
You must then provide a completed request for Benefits to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
• If the initial request for Benefits is complete, within:	**15 days**
• After receiving the completed Request for Benefits (if the initial Request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first-level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first-level appeal (if a second-level appeal is available) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second-level appeal decision within:	**15 days** after receiving the second level appeal
* The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Claims Administrator.	

Table 24 – Pre-Service Request for Benefits or Appeal

Post-Service Claim for Benefits or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
• If the initial claim is complete, within:	**30 days**
• After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

Post-Service Claim for Benefits or Appeal	Timing
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first-level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first-level appeal (if a second-level appeal is available) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second-level appeal decision within:	**30 days** after receiving the second level appeal

Table 25 – Post-Service Claim for Benefits or Appeal

Concurrent Care Decisions. This section applies if you have already received approval for an ongoing course of treatment to be provided over a period of time or a specified number of treatments.

- **Benefit Reduction or Termination in Course of Treatment.** Any decision to reduce or terminate benefits for a previously approved course of treatment (unless the Plan is being terminated altogether) will be considered a denial of a claim for benefits. You will receive sufficient advance written notice of the benefit reduction or termination to allow you to obtain a review of the decision before benefits for the course of treatment are reduced or eliminated.
- **Requesting an Extension on a Course of Treatment.** If you wish to request an extension of a course of treatment beyond the initial period of time or number of treatments for which you previously received approval, and if the request involves urgent care, you must make such request at least 24 hours prior to the expiration of the previously approved course of treatment. You will be notified in writing of the decision whether to extend your course of treatment as soon as possible, but no later than 24 hours after receipt of your request. If your request does not involve urgent care, your claim will be treated as a regular pre-service claim.

Notification of Determination on Review

If you submit a Level 1 Claim or file a formal First-Level or Second-Level Appeal, CAM, the Claims Administrator or Administrative Committee (as applicable) will:

(a) provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the initial claim;

(b) permit you to submit written comments, documents, records and other information relating to the initial claim;

(c) provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination;

(d) provide a review that does not afford deference to the initial claim determination and that is conducted by a plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person);

(e) if the decision is based on a clinical judgment, consult with a health care professional with experience in the appropriate field;

(f) provide you with the identity of those health care experts whose advice was obtained in connection with the initial claim; and

(g) ensure that any health care professional consulted during the review is someone other than the person consulted in the initial claim determination (or a subordinate of that person).

The applicable Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim or appeal. Also, before you receive an adverse benefit determination on review based on a new or additional rationale, the applicable Claims Administrator will provide you, free of charge, with such rationale to give you a reasonable opportunity to respond.

If your request is denied upon review, the written notice will contain the following information:

(a) the specific reason for the decision and specific reference to the provisions of the Plan on which the decision is based;

(b) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits;

(c) a statement explaining your further right to appeal, if applicable, and your right to bring a civil action under Section 502(a) of ERISA following the denial;

(d) if any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you free of charge, upon request; and

(e) an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided free of charge, upon request.

CAM, the Claims Administrator, or the Administrative Committee, as applicable, has full and exclusive discretionary authority to interpret all provisions of the Retiree Program for which it is responsible for determining Level 1 Claims or first-level and/or second-level Appeals, to determine material facts and eligibility for Benefits, and to construe the terms of the applicable Plan option. Interpretations and determinations made by CAM, the Claims Administrator, or the Administrative Committee, as applicable, with respect to the Retiree Plan options for which it is responsible for determining appeals, will be final, conclusive and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious.

Procedures for UnitedHealthcare

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-Service Request for Benefits, Post-Service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You or your authorized representative may send a written request for an

appeal to:

UnitedHealthcare – Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

If you have tried to file a Pre-Service Claim under a Retiree Medical Coverage option (including an Urgent Care Claim) but have not properly followed the Plan's procedures for doing so, you will be notified of the failure and of the proper procedures for filing a Pre-Service claim. You will receive such notification, orally or in writing, no later than five days after your initial attempt to file a claim (or 24 hours in the case of an Urgent Care Claim). You will be considered to have attempted to file a Pre-Service Claim if you have communicated with the appropriate person with the applicable Claims Administrator who normally handles group health benefit matters and if you have named a specific medical condition, symptom, treatment, service, or product for which you are seeking approval.

Second-Level Appeal Procedure for UnitedHealthcare

Your Retiree Medical Coverage option offers two levels of appeal. If you are not satisfied with the first-level appeal decision, you have the right to request a second-level appeal from UnitedHealthcare within 60 days from receipt of the first-level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

External Review Procedures for UnitedHealthcare

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- An adverse determination involving medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, or effectiveness of a covered benefit, or the determination that treatment is Experimental or Investigational.

- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

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 the number on your ID card 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.

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.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

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

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all 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 exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

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

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Retiree Program 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 UnitedHealthcare completes 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 as new 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 the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Procedures for CVS/caremark

If you have submitted a claim for benefits and your claim is denied in whole or in part, you will be notified in writing of the denial by CVS/caremark. If you are not satisfied with CVS/caremark's decision on the initial claim, you have the right to request and receive a first-level appeal that the claim be reviewed.

The request for a first-level appeal on claim decisions is made in writing to Caremark Inc., Attn: Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084. Appeals may be sent by fax to (866) 443-1172, Attn: Appeals Department. Your written appeal should include your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s) for disputing the denial. Copies of any materials or records that support your claim should be sent with the appeal.

The appeal must be submitted within 180 days after a denial. However, if you are requesting review of an Urgent Care claim, you may also request review orally, and all communications may be done by telephone, facsimile, or other similar method.

Second-Level Appeal Procedure for CVS/caremark. Some drugs contained on the list of preferred or formulary drugs under the Plan require Prior Authorization (see **https://www.caremark.com/ 1-888-996-0024**). If the reason your appeal to CVS was denied was because you had not obtained Prior Authorization from CVS, you have the right to request and receive a second-level appeal as to whether your usage of that drug should be covered for reasons of Medical Necessity.

The second-level appeal must be submitted in writing within 180 days after your receipt of the prior appeal denial. The second-level appeal should be sent to CVS/caremark, Attn: Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084, or by fax to (866) 443-1172, Attn: Appeals Department.

Your second-level appeal will be forwarded by CVS/caremark to an Independent Medical Review Organization for review and determination. Your written appeal should include your name and address, the fact that you are disputing the denial of a claim, the dates of the initial notice of denial and the first-level appeal denial, and the reason(s) for disputing the denials, particularly as to why that drug should be covered for reasons of medical necessity. Copies of any materials or records that support your claim should be sent with the second-level appeal.

Please note that a second appeal will only be permitted in those cases where the reason for the denial of your first appeal is due to your not obtaining Prior Authorization from CVS/caremark for the use of one of the drugs contained on the list of drugs under the Plan and for no other reason. You will be notified by CVS/caremark at the time you receive a decision on your first appeal as to whether you have a right to receive a second appeal.

CVS/caremark has full and exclusive discretionary authority to interpret all provisions of the Plan, to determine material facts and eligibility for benefits, and to construe the terms of the Plan. Interpretations and determinations made by CVS/caremark will be final, conclusive and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious.

External Review Program, Independent Third-Party Review for CVS/caremark. If your claim is denied in whole or in part, upon review by CVS/caremark and, if applicable, by the Independent Medical Review Organization that CVS has retained, the notice of denial will include instructions for submitting your claim for review by an independent review organization (IRO). You have a right to submit your claim to the IRO even if your claim has been denied by the Independent Medical Review Organization CVS has retained for second-level appeals.

Your written request for review by an IRO, together with all accompanying medical documentation, will be forwarded to the IRO by CVS/caremark. The IRO will be selected using a random algorithm that distributes cases among MCMC Ltd., Network Medical Review Co. Ltd., and MES Peer Review Services.

The IRO will have full and exclusive discretionary authority to interpret all provisions of the Plan, to determine material facts and eligibility for benefits, and to construe the terms of the Plan. Interpretations and determinations made by the IRO will be final, conclusive and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious.

Claims Appeal or Grievance Procedure for Delta Dental

Delta Dental will notify you and your healthcare provider if Benefits are denied, in whole or in part, for services submitted on a Claim Form, stating the reason(s) for denial. If your request for prior authorization of a dental service or treatment or your request for payment of Benefits submitted on a Claim Form is denied by Delta Dental, in whole or in part, you or your representative or your healthcare provider have at least 180 days after receiving a notice of denial to request a written appeal or grievance that gives reasons why you believe the denial was wrong. You or your representative or your healthcare provider may also ask Delta Dental to examine any additional information that may support the appeal or grievance. You or your representative or your healthcare provider may submit your appeal by mail to Delta Dental, One Delta Drive, Mechanicsburg, PA 17055-6999.

Delta Dental will send you a written acknowledgment within five days upon receipt of the appeal or grievance. Delta Dental will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially.

If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment, or clinical judgment in applying the terms of the Delta Dental Retiree Plan or Delta Dental's contract with your healthcare provider, Delta Dental will consult with a dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review nor the subordinate of such individual. Delta Dental will send you or your representative or your healthcare provider a decision within 30 days after receipt of the appeal or grievance.

Procedures for EyeMed Retiree Vision Coverage Options

There are two types of claims under the Vision Coverage, In-Network claims and Out-of-Network claims. All In-Network claims will be processed by your In-Network provider directly through EyeMed. You can obtain an Out-of-Network claim form by using https://member.eyemedvisioncare.com/siemens/en, the EyeMed website for Siemens Energy participants, or by calling EyeMed Member Services at **1-866-800-5457**. Any claims that are incurred through an Out-of-Network provider should be sent by mail to Vision Care Processing Unit, First American Administrators, Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111, within 12 months of the date of service.

If you are not satisfied with EyeMed's decision on the initial claim, you or your representative or your healthcare provider can request that the claim be reviewed on appeal. The request for a first-level appeal on claim decisions is made in writing to EyeMed and must be sent within 180 days after receiving the Notice of Benefit Determination. The address for EyeMed is Attn: Quality Assurance Department, 4000 Luxottica Place, Mason, OH 45040. The telephone number is **1-866-800-5457**.

If you complete the appeal process and the initial denial of claim is upheld, you or your representative or your healthcare provider have the right to request a second-level appeal within 180 days of receiving the first-level appeal denial.

Procedure for Claims for Retiree Life Insurance Coverage

The claims procedures discussed in this section apply to benefit claims under the Retiree Life Insurance Coverage under the Plan. If you believe you are entitled to a benefit under the Retiree Life Insurance Coverage, and have not been notified that one is payable, or if you disagree with the amount of the benefit that is payable, you may file a written claim with the Plan's Claims Administrator, The Hartford Life Insurance Company (The Hartford). You or your beneficiary may designate in writing an authorized representative to pursue the claim and any appeal.

A decision on a claim will be given to you or your beneficiary as soon as possible, but no later than 90 days after a claim is filed, or 180 days in special cases, if a decision on a claim cannot be made within 90 days. You will be notified in writing before the end of this 90-day period of the special circumstances that require an extended period of consideration of your claim, and the approximate date *when* a decision is *expected* on your claim.

If a claim is denied in part or in whole, you, your dependent, or your beneficiary will receive written notification from the Plan's Claims Administrator, The Hartford. The notification will contain:

(a) the specific reason or reasons for denial;

(b) a reference to specific Plan provisions on which the denial is based;

(c) a description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary; and

(d) an explanation of the claims review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial upon review of the claim.

An appeal on claim decisions for the Retiree Life Insurance Coverage under the Plan is made to The Hartford. The appeal must be submitted within 60 days after the date you receive a denial, by writing to The Hartford. The address for The Hartford is The Hartford Life Insurance Company, Attn: Group Life Claims Appeals Unit, P.O. Box 14299, Lexington, KY 40512-4299. The telephone number for The Hartford is **1-888-563-5615**.

Your written appeal should include your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s) for disputing the denial***.*** Copies of any materials or records that support the claim should be sent with the appeal.

The Hartford will:

(a) provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

(b) permit you to submit written comments, documents, records and other information relating to the claim; and

(c) provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination***.***

Unless special circumstances require an extension of time, a decision on an appeal will be made within 60 days of the date the written appeal is received. Special cases can require 120 days. You will receive a notice of the special circumstances that require an extension before the end of the 60-day period. The notice will indicate the circumstances requiring the extension and the date by which The Hartford expects to render a decision. The extension may be for up to 60 additional days. Other extensions of time will not be made unless there is an agreement in writing that good cause exists for the extension.

The Hartford has full and exclusive discretionary authority to interpret all provisions of the Retiree Life Insurance Coverage and to determine material facts and eligibility for benefits. Interpretations and determinations made by The Hartford will be final, conclusive, and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious. The decision on an appeal is final.

If your appeal is denied upon review, The Hartford will give a written notice containing:

(a) the specific reason(s) for the decision and specific reference to the provisions of the Plan on which the decision is based;

(b) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits; and

(c) a statement that you have the right to bring a civil action under Section 502(a) of ERISA if you or your beneficiary believes the claim is improperly denied.

Time Limit for Bringing Legal Actions for Denied Benefit Claims Under Plans That Are Part of the Retiree Program

If you want to bring a legal action against the Retiree Program or a Claims Administrator or Insurer, the Plan Sponsor, the Plan Administrator or, if applicable, the Administrative Committee of Siemens Energy with respect to the denial of your claim for benefits or any other claim relating to your benefits, you must do so within one years (three years for Retiree Life Insurance Coverage) of the date you or your beneficiary, as applicable, are notified in writing of the final decision on your appeal on your claim, or you or your beneficiary, as applicable, lose any rights to bring any such legal action. Also, you cannot bring any such legal action until you have first completed all the steps set forth in the claims review and appeals process set forth in this Summary Plan Description.

Non-Assignment of Benefits

Generally, your benefit from the Retiree Program may not be assigned, sold, transferred, or pledged to anyone else.